‘Being fat’ from a child’s point of view

Experiences and perceptions on body size in overweight children

Translation: ‘Being fat is not nice. It is difficult when you do not fit clothes. You are bullied very much and that is not nice. I am often jealous of my friend because she has nice clothes that I also want. Girl: “I do not like these trousers”. Mother: “We will go to another shop, but I thought they were nice”.'
Thesis
for
AMMA
The Amsterdam Master’s of Medical Anthropology
University of Amsterdam

‘Being fat’ from a child’s point of view

Experiences and perceptions on body size in overweight children

Research period: 10th of May – 9th of July 2004
Research location: De Dikke Vrienden Club, overweight treatment program for children aged 8-12 years in the Netherlands
Date: 8th of October
Supervisor Dr. Ria Reis, director AMMA, Medical Anthropologist

Jet Derwig
Wilhelminastraat 181-3
1054 WE Amsterdam
e-mail: jderwig@tiscali.nl
Studentnummer: 8964831
Acknowledgments

This thesis is the product of conversations with 8 children who were very kind in allowing me to document their experiences and insights. I am very grateful to each of them for helping me to come to an understanding what it means to be a fat child in the Netherlands.

Sandra, Randy, Dewi, Darrell, Kim, Denise, Linda and Anna, you were of great help to me and I loved your stories, drawings and photo’s. I thank you all for the time you spent with me.

I am also thankful to the parents of these children who also shared their experiences and ideas and welcomed me at their homes. Their stories were helpful to get a better understanding of the everyday lives of their children and to learn their experiences in the health care system.

I would also like to thank the team members of the Dikke Vrienden Club and the other experts in the field of child overweight and obesity who found time in their busy schedules to talk to me about their work and experiences with overweight and obese children.

Erica van den Akker gave access to the Dikke Vrienden Club and was very supportive and enthusiastic about my research project. I am very grateful to her for giving me this opportunity. I also like to thank the other team members: Mieke Groen, Marion Christiaans, Marisca Renzen, Astrid van Meggelen, Karen Meiners and Anne Clair Nuyens for their time and experiences. I am very happy that I was able to get insight in the ideas behind the treatment program and discuss these with the diverse disciplines present at the DVC.

Olga van de Baan provided information on the treatment program for severely obese children and shared her ideas about the causality of child overweight and obesity and experiences she encountered with her fat patients. Henriette Delemarre also shared her ideas about the causality of child overweight and briefed me on the developments of treatment programs at the Free University.

I also like to thank Anita Beerthuizen and the teachers of group 5-6 for helping me to perform focus group discussions at a school in Diemen. The FGD were a good way of learning the notions on overweight and health among ‘non-overweight’ children. I also like to thank Ingrid Sturkenboom for facilitating the focus group discussions.

The development of my research proposal was aided by the remarks of Ria Reis, Nicolette van Duursen and Diana Gibson. During the entire research process Ria Reis was of great support to me, she always believed in my abilities and encouraged me to continue.

I thank my fellow AMMA classmates who provided support and entertainment during the research period. I also thank my partner for his everlasting patience and support in helping to accomplish my research. I also like to thank my mother for reading this thesis and making it accessible for outsiders.

Last but not least, I like to thank Professor Dr. Heymans who made it possible to do this research in the first place. I am very happy he supported me to take a year from my training in paediatrics to study medical anthropology and accomplish this research.
**Table of contents**

**Introduction**

<table>
<thead>
<tr>
<th>Chapter 1: The construction of overweight</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 The need for a child perspective in overweight and obesity</td>
<td>3</td>
</tr>
<tr>
<td>1.2 Historical overview</td>
<td>3</td>
</tr>
<tr>
<td>1.3 Child overweight in the Netherlands</td>
<td>5</td>
</tr>
<tr>
<td>1.4 The medical perspective</td>
<td>6</td>
</tr>
<tr>
<td>1.5 Different concepts of obesity within the medical discourse</td>
<td>8</td>
</tr>
<tr>
<td>1.6 Obesity as a eating disorder</td>
<td>11</td>
</tr>
<tr>
<td>1.7 The social and cultural construction of overweight</td>
<td>12</td>
</tr>
</tbody>
</table>

**Chapter 2. The research setting, objectives, methodology and reflections**

| 2.1 Research setting: ‘Dikke Vrienden Club’ | 14 |
| 2.2 Research objectives and research questions | 18 |
| 2.3 Methodology | 19 |
| 2.4 Research process and reflections of the researcher | 21 |

**Chapter 3 Contextualizing**

| 3.1 The children of the study | 28 |
| 3.2 Perceptions on body size and health in ‘non-overweight’ children | 31 |
| 3.3 Parents’ perceptions on body size and ideas on causality | 34 |
| 3.4 Health workers ideas and practices | 41 |

**Chapter 4. When they are confronted with their body size**

| 4.1 Being fat in everyday life | 44 |
| 4.2 Bullying, side effects and strategies | 50 |
| 4.3 Clothing and how to hide being fat | 56 |

**Chapter 5. Perceptions on body size**

| 5.1 Children’s body images and the influence of messages around them | 59 |
| 5.2 Body dissatisfaction and perceptions of beauty | 62 |
| 5.3 The importance of a normal body size | 64 |

**Chapter 6. Being fat within the health care system**

| 6.1 Medical background and why they want help | 67 |
| 6.2 Reasons for being fat | 72 |
| 6.3 Being fat and health | 75 |
| 6.4 Perceptions on food and strategies to resist food | 77 |
| 6.5 Experiences with the Dikke Vrienden Club | 81 |

**Discussion**

| 88 |

**Conclusion and recommendations**

| 97 |

**References**

| 100 |

**Appendixes**

| 104 |
Introduction

Since the fast growing prevalence of overweight among children and adolescents, child overweight has become an emerging ‘disease’ in the Netherlands. Child overweight is seen as a serious health problem that needs to be diagnosed, explained, treated and prevented. In addition, because of unsuccessful ‘treatment’ of obese adults, the attention of the health sector is primarily focused on the prevention and treatment of overweight and obesity in children to stop them from becoming overweight and obese adults.

Yet, the dominant notion in the popular and medical discourses that child overweight and obesity are largely caused by poor diets, inactive lifestyle and genetic factors overlooks the social and cultural factors. These factors are important to be able to understand what overweight means to overweight children in their daily lives.

Although the increase of weight in children is a very important problem that needs to be taken seriously, child overweight is not ‘just a disease’. Overweight and obesity also have socially constructed meanings and cultural definitions. Child overweight and obesity thus are complex constructions influenced by on the one hand biomedical and behavioural factors, but more importantly by cultural beliefs and practices, and by social interactions with family, friends, teachers and other actors in the daily lives of children.

The research took place at the Dikke Vrienden Club, the ‘Club of good friends’ (‘dikke vrienden’ means good friends, but ‘dik’ literally means ‘fat’), a treatment program for moderate overweight at the Sint Franciscus hospital in Rotterdam. The Dikke Vrienden Club (DVC) is one of the ‘oldest’ programs for treatment of overweight children in the Netherlands. It was founded in 1995 as the first multi-disciplinary treatment-program for overweight children aged 8 to 12 years old.

This thesis explores the broader social and cultural context of overweight children in the Netherlands and tries to uncover the meaning of ‘being fat’ for children with overweight from their point of view. What does their daily life look like and when are they confronted with their body size? In what way do parents, peers, school or the media influence the perceptions of overweight children and how do they deal with their body size in their daily lives?
Since the study sample consists of children that have been ‘diagnosed’ with overweight and receive or will receive treatment for their body size this thesis also explores the ideas on health in relation to their body size. How do overweight children perceive the medical discourse that indirectly blames the ‘overweight victims’ for their unhealthy ‘life style’ and lack of attempts to avoid ‘the causes’?

The outline of the thesis is as follows: the first chapter describes the context of child overweight and attempts to construct child overweight in a wider sense and to show its complexity. The second chapter describes the research objectives and methodology used. All data collection techniques will be explained and evaluated. The third chapter introduces the children that have participated in the study, their parents and the health professionals working at the Dikke Vrienden Club and health professionals working in the field of child overweight and obesity in general. In this chapter the children that participated in the Focus Group Discussion to gain more insight in the context of children aged 8-12 in general and their perception on body size will be described too. Chapter four, five and six present the research findings and interpretations. Chapter four focuses on the experiences of overweight children in their daily lives and chapter five deals with their perceptions on body size. Chapter six examines being fat in relation to the health care system and chapter seven discusses the findings that are most salient. The thesis ends with a conclusion and recommendations.

In conclusion, this thesis focuses on the experiences of overweight children themselves, the ‘experts’ of being overweight or fat and will hopefully help health professionals and others relating to overweight children to better understand what being overweight means to overweight children in the context of every day life. Hopefully this will contribute to the improvement of the quality of life of the overweight children themselves.
Chapter 1: The construction of child overweight

Child overweight is a complex construction influenced by biomedical, epidemiological, psychological, social and cultural discourses. In this chapter I will first explain the importance of the child perspective and consequently I will describe the problem in the Netherlands. In the subsequent sections I will look at (child) overweight from different perspectives present in literature and examine and critically review the ways in which child overweight is constructed. According to Evans (2002: 207) we constantly need to keep in mind that ‘fat’ is neither a feeling nor a pathological disease but a social construct.

1.1 The need for a child perspective in overweight and obesity

To uncover the complex social and cultural context of child overweight as it is experienced by overweight children in their daily lives we need to look at it from the child’s point of view. We need to know their perceptions and cultural constructions.

The child perspective is embedded in the anthropological discourse. According to Hahn (1995), anthropology wants to understand the inner world of members of particular societies. Anthropologists want to know the native’s point of view and analyse the patterns of interaction and social organisation that accompany the native’s point of view. In the case of child overweight this means to understand the inner world of overweight children and to analyse their patterns of behaviour and social interactions associated with overweight and how these patterns and interactions influence their point of view. How do the perceptions of overweight children and that of their family and their treating health professionals fit together? How do these perceptions contribute to the construction of the concept of overweight? Anthropologists study the unique characteristics shared by human beings and social life everywhere by looking at rituals, symbols and social structures. In this way, anthropologists recognize that the social and cultural environment that people live in contributes to meanings of overweight. The child perspective takes children seriously in their ability to construct their own meanings and definitions of overweight in their daily lives.

Psychological and behavioural models mostly view children as incomplete and passive without ‘present’ and without ‘agency’. ‘Children constructed without a ‘present’ are not studied in their own right. Accordingly, in order to understand children as active agents of culture their presence
and action in the immediate world must be acknowledged' (Caputo 1995: 30). Christensen agrees in saying that unfortunately the emphasis is put on understanding children in terms of ‘becoming’ rather than ‘being’ a social person. (Christensen 1998: 188)

Therefore, to fully understand the meaning of overweight in overweight children we need to know how they themselves interpret the existing powerful dominant discourses in society on overweight and body image, how these discourses interact with other aspects in daily live and how they can push towards actions which can be damaging or on the contrary harmless and even good to their body and self. How do children interpret the discourses present in the media? How do they perceive the powerful medical discourse? Do children use their agency to maybe resist or transform the shared cultural ideas on overweight and obesity? How do they deal with the stigma of overweight? How do they challenge the stigma and attain a positive identity while being among peers? What skills have they taught themselves and what behaviours have they undertaken to cope with their overweight?

Qualitative research on the perceptions and experiences of children in the middle age group (8-12 years) with overweight has until now not been done in the Netherlands. In the United States, Borra et al (2003) performed a qualitative study among children aged 8 to 12 years with perceived -by their parents- normal weight or overweight, their parents, and their teachers to better understand children’s, parents’, and teachers’ attitudes, perceptions, and behaviours about preventing overweight in childhood and to explore potential avenues for communicating overweight prevention messages. They explored issues children view as most relevant and important to their lives and examined attitudes, perceptions, and behaviours related to healthy lifestyles and overweight.

In general, physical appearance and performance were important to these children. They wanted to “fit in” and not seen as “different.” The acceptance by friends and peers was especially important and increased with age. They valued parents, grandparents and other relatives, best friends, special teachers and coaches, and famous performers or athletes. ‘Healthy’ meant eating fruits or vegetables they did not like, instead of eating their favourite foods and had negative connotations. Weight concerns were present as the result of failed athletic performance (more for boys) or body dissatisfaction (Borra et al 2003: 273).
1.2 Historical overview

In the past, in many societies obesity was seen as a status symbol and was regarded as healthy and attractive. However, in modern society obesity is seen as an unhealthy, unattractive and even deviant condition. Wilkinson (1996) describes that during the ‘epidemiological transition’ in rich developed countries slenderness for the first time in history became a socially desirable condition. In the early part of the twentieth century rich developed countries went through a transition of causes of death. In richer countries the predominately infectious causes of death changed to causes of death due to degenerative diseases. In addition, the epidemiological transition marked a change in social distributions of a number of important conditions, like obesity and other ‘diseases of affluence’. Obesity became more common among people with lower socio-economic standards and among the rich slimness was emphasized. ‘As the poor ceased to be hungry, slimming became socially desirable’ (Wilkinson 1996: 44-45).

During the last century people tried to find solutions for the problem of obesity. Sobal (1995) claims that in this century fatness has moved from a moral conception of fat as badness or failing self control, to the medicalisation of fat as sickness. The moral model suggests that fat people, seen as bad, sinful and ugly were responsible for their own condition and should be punished as a means of social control for being fat.

The medicalisation of obesity took off in the 1950s with widespread claims that obesity is best dealt with using medical intervention (Levenstein cited in Sobal 1995) in this way the medical profession made powerful claims over control of fatness. Medicalisation is a process by which certain behaviours and conditions become defined and treated as medical problems, usually in terms of diseases or disorders (Conrad cited in Sobal 1995) and medical interventions become the focus of remedy and social control (Chang&Christakis 2002). In the process of medicalisation the term obesity was used as the main term and additionally the morally classified bad terms as fat, chubby and plump changed into more neutrally valued and scientific terms, for example terms like overweight, adipose and obese. Related terms like laziness changed into the neutral and scientific term inactivity. In 1990 obesity was for the first time classified as a disease in the International Classifications of Diseases and was promoted as an important risk factor for cardiovascular diseases, a leading cause of death in the affluent societies. Medical interventions, like drugs and surgery were launched and even dieting became more and more medicalised. Other (para)medical professionals, like
psychiatrists and psychologists became increasingly interested in the condition of obesity and used existing theories to explain the causes of obesity (Sobal 1995).

Despite all efforts of the medical profession to control fatness in the last century, obesity and overweight are still increasing problems in Western society. The prevalence of child obesity and overweight is alarming in the Netherlands as in many other countries with established market economies, especially in the United Kingdom and the United States and is also rising in the affluent parts in larger cities in poorer countries such as India, China and even in Sub Saharan Africa (Evans 2002). In 1997 the World Health Organisation for the first time launched a campaign to fight obesity as a global epidemic (WHO 1997).

1.3 Child overweight in the Netherlands: a chronic disease increasing in numbers
In the past decades the prevalence of overweight among children and adolescents has enormously increased in the Netherlands. In 1997, the prevalence of overweight in 3-18 year old children in the Netherlands fluctuated around 11% and of obesity it was approximately 1,2 %. More girls (11,1%) than boys (10,7%) suffer from overweight and more boys (1,3%) than girls (1,1%) have obesity. Comparing these figures to 1980 the prevalence of overweight has doubled and the prevalence of obesity multiplied by 4. It is salient that already in very young children (aged 3-4 years) one can notice an increase in prevalence (Renders et al. 2003).

Another observation is that overweight children also become more overweight than twenty years ago (van Winckel&van Mil 2001). Since 2001, after a decision of the Dutch Minister of Health to focus on child obesity and after a publication that showed the rising prevalence of overweight among children (Frederiks et al 2001), child overweight and obesity have become extensively discussed topics in the (public) health sector, in television programs, in magazines and newspapers, in schools, within families and among peers.

To define child overweight and obesity one can use either the ‘weight to height’ growth charts or the ‘Body Mass Index (BMI=weight in kilograms divided by height in metres squared) to age’ curves and tables. The BMI has its disadvantages- the BMI does not correspond to the actual percentage of fat and older children and children with short legs can have a higher BMI without being overweight (Renders et al 2003, Van Winckel&van Mil 2001). Therefore health professionals, also at the Dikke Vrienden Club find it more practical to use the percentage of overweight. It is calculated by dividing the actual weight by the mean weight
for the actual height times 100. Normal weight corresponds with an overweight percentage of 90-120%, overweight with a percentage of 120-140%, moderate obesity with 140%-160% and severe obesity with more than 160% (Van Winckel & van Mil 2001). In this study the BMI is calculated with the BMI calculator, recommended by the Dutch Society of Dieticians.

Children at risk for overweight and obesity in childhood or adulthood in the Netherlands are children with overweight and aged over 10 years, immigrant children, especially of Turkish and Moroccan origin, children from families with lower socio-economic status, children with low educated parents or with mothers at work, children with at least one obese parent and children born as large babies or babies born with low-birth weight and rapid catch up. However, the exact causes of the increased prevalence of overweight and obesity within these groups are still unknown. One suggestion is that for example immigrant children might have different ideas about body size and notions of beauty. These groups might employ the same cultural meanings to ‘overweight’ and ‘obesity’.

Treatment in the Netherlands
Changes in diet and inactive lifestyle are given as the main reasons for the development of child overweight. Therefore, treatment strategies focus on changing ‘life-style’ behaviour within the entire family, such as changing to healthy food, stimulating physical activity and discouraging physical inactivity or sedentary behaviour. The main difference with the treatment of adults is that young children should not necessarily loose weight. Since they still grow in height, they only have to refrain from gaining additional weight. Psychological therapy is often included in the programs for overweight children.

Currently, children with overweight are treated for their condition when they or their parents seek help or when health professionals that see these children because of various other reasons advice treatment. All children between 0 and 4 years old in the Netherlands are monitored regularly for their weight and height and their health in general and checked again at the age of 5 and 11 years old. Overweight children are referred mainly to dieticians, physiotherapists, paediatricians and psychologists. Special multidisciplinary programs for overweight children such as the Dikke Vrienden Club, are still scarce in the Netherlands. Severely obese children are treated in a six months multidisciplinary treatment program in

---

1 the BMI calculator can be found at www.gezondebasis.nl.
Heideheuvel. Since the ‘outbreak’ of the overweight epidemic more initiatives develop, like ‘2-weeks Victory summer camps’ for overweight teenagers. The medical experts argue that overweight should be ‘diagnosed’ as early as possible in order to change ‘life style’ behaviour more effectively (Renders et al 2003).

1.4 The medical perspective: overweight as an imbalance of intake and expenditure

Nowadays, the dominant notion in the field of child overweight and obesity as in adults is that they are largely caused by a positive imbalance between dietary intake and physical activity or in more neutral and scientific terms a positive imbalance between energy ingested and energy expended. The redundant energy converts to fat and eventually leads to overweight and obesity. The basic explanation is that it results from poor diets -not necessarily too much food- and a progressively inactive lifestyle.

Research has shown that the in the last ten years average dietary intake among children has not increased or even decreased (Centre of Nutrition cited in Renders et al 2003), although one can question the validity of reported food intake in children. Changed patterns in food intake such as skipping breakfast and eating far more snacks instead of proper meals seem to contribute to the increase of weight in children.

Dieticians argue that the development of eating habits and taste for food already start from a very young age (Zijlstra 2002). Bouchard (in Braet 2001) proved that children’s’ preferences for certain types of food is learnt behaviour formed by various learning processes mostly between parents (mothers) and their children. Children primarily observe their parents and siblings while in the meantime they learn how to manipulate their parents. They whine for food and keep whining when parents give in and whining becomes rewarding. From this point of view it is interesting to see that parents of obese children think their children have more perseverance and are more demanding (Braet 2001). Another point mentioned by dieticians is that parents should not force their children to eat, because it hinders the development of self-regulation and self-control. Children should learn to eat when they are hungry and feel when they are satisfied. Braet (2001) also argues that praising children for eating like finishing their plates decreases the appeal of the food that is eaten. She also states that rewarding with sweets, food restrictions or categorizing food in ‘bad’ and ‘good’ food have proven ineffective in the prevention of overweight.
The progressive reduction of active is caused by watching too much television, spending too much time behind the computer, transportation by car instead of by foot or bike to school, sport or leisure clubs and less games outside because of unsafe streets. Young children aged 3-5 years already feel very attracted to the computer.

Modern society with its improved standard of living, the overproduction of food, especially fast food, sweets, soft drinks, chips and chocolates and its aggressive advertisements is often blamed for changing children in consumers of too much sugar and too much fat. However, modern society cannot explain the major increase in the last decades entirely. The aetiology of overweight is considered much more complex than only blaming modern society.

Multiple and complex genetic factors also play an important role in the development of overweight, moreover because not all children become overweight while influenced by similar environmental factors. Yet, there is still far too little knowledge to expect a solution from the field of genetics (Schepper 2001).

Braet (2001) acknowledges the influence of social factors on the development of child overweight. She states that parents when making decisions about food and exercise observe and consult their own social network primarily. In this way, some parents of obese children think that their lifestyle is not very different from their friends, family and neighbours and sometimes do not recognize that their children are fat. Braet also recognizes that the media influences children in their perceptions on body size, food and exercise.

Since changes in diet and inactive lifestyle are given as the main reasons of child overweight medical professionals suggest that changing ‘life-style’ behaviour within the entire family, such as changing to healthy food, stimulating physical activity and discouraging physical inactivity or sedentary behaviour are the most effective way in challenging the ‘disease’. Rengers et al (2003) describe that physical activity in children can be best stimulated by creating activities that children like and successfully can accomplish, by introducing role models such as parents, peers and media stars, by verbally encouraging obese children to become physical active and by eliminating fears and worries about their physical competence. Public campaigns, policy makers and medical experts encourage children, parents, teachers in school and health professionals working with children to promote a healthy diet and a more physical active lifestyle and strive for fitness and health at home and at school. In this way,
children and their parents have to work hard at being strong, fit and healthy and to conform to the new regimes and control their behaviour. Overweight children are required to become active agents in their dietary habits and physical activities.

Critiques on the medical perspective

Although the medical discourse criticises modern society as harmful, most emphasis is put on the individual children and even more important on their parents. Health professionals want to train overweight children to live cautiously, take responsibility and have self-control. These self-regulatory practices focus very much on the child as an individual and its responsibility to make 'healthy choices' and constitute 'health' in terms of a moral imperative of 'self control' (Rich 2003: 3). However, these self-regulatory practices can have a broader meaning than just changing diets and being more active and may even lead to discrimination and stigmatisation.

Rous and Hunt (2004) state that for example children with food allergies that are given the responsibility to self control their diets feel isolated and stigmatised because they have to eat differently from their peers.

In the medical model parents in particular are hold accountable for the overweight of their children. Some medical experts argue that children, except from adolescents, cannot be seen as agents in the causality and prevention of overweight. They contest that parents have to be re-educated and children can only be considered as passive and innocent food addicts. In this way, also parents and the rest of the family are stigmatised, especially because observational learning that suggests that children just copy the bad behaviours of the rest of the family is promoted as one of the most important factors for the development of eating habits. Parents therefore feel guilty for their overweight children and thus feel pressured to do anything to help them to loose weight. However, this may increase the feeling of being deviant in their children and more crucial may create the feeling of not being accepted by their parents, which can be very harmful to their self-esteem. Research shows that obese children are harmed most by discrimination by their own parents and siblings (Jeurissen & Spanje 2002). Parents face the dilemma that when they seek help for their children they will feel deviant, because they receive treatment for a 'disease', but when on the other hand they do not seek help their children feel deviant too, because of their body size and the ruling prejudice towards fat people in society (Jeurissen & Spanje 2002). In this way, Jeurissen and Spanje (2002) state that an effective treatment of overweight children that tries to make fat children thin or creates adults with high self-confidence is illusionary.
Parents also get frustrated when their overweight children are already active and in their opinion neither take snacks nor skip breakfast while on the other hand they read that changes in diet and a more active lifestyle can make their overweight children lose weight or at least refrain from weight gain. However, parents may not always be able to control their children and prevent them from spending their pocket money on food. The study "what kids say they do and what parents think kids are doing" illustrates that children aged 9-18 years buy snacks in several shops, eat more often extra food after dinner, eat often out of boredom or feeling low, and value their bodies less than their parents would know (Moag-Stahlberg et al 2003).

It also seems that because of increasing numbers of overweight children health professionals and policy makers, especially through their public campaigns render every child as a potential big fellow. Already young mothers are taught that their babies should not eat too gluttonous and that they should never give in on a whining child. Rittenbaugh (in Evans 2002) stresses that there is still too much focus on weight, articulated in the current health policies and education. In this way, large numbers of children are by measurement pathologised, while from a public health perspective, ideally, someone should only be considered ill and too fat if the degree of overweight really associates with a higher risk to ill health. Currently health professionals can still not predict which degree of overweight associates with a higher risk to develop obesity in adulthood or to acquire cardiovascular diseases, diabetes or premature death (Van Winckel&van Mil 2001). Brodley et al (in Evans 2002) argue that distributing alarming figures on overweight and obesity only emphasizes the ideal body weight and culture of slenderness. Discrimination and pursuit of slender ideals may also increase when children are classified as overweight also in other discourses outside the medical discourse such as in schools, in sports, and in other social practices (Evans 2002).

1.5 Different concepts of obesity within the medical discourse

In literature the medical model of obesity has been frequently criticised. Through medicalisation obesity is scientifically reduced to a disease and the focus of attention is mainly directed towards the individual or in case of child obesity towards the individual and its parents. Structural conditions such as social and cultural context are often obscured or

---

2 At www.gezondebasis.nl mothers show how they feel about the low fat and active lifestyle campaigns.
ignored in favour of isolated individual factors such as lifestyle and personal behaviours (Conrad and Schneider in Chang & Christakis 2002: 153).

Nonetheless, even within the medical discourse the ideas on causality vary. Neumark-Sztainer (2003) states that some medical experts emphasize the individual factors while others look at the effects of the society at large. The ideas range individual choices to eating and exercise behaviours, as a function of one's family or society-at-large. 'Family structure, relationships, support, meal patterns and leisure activities may have a strong impact on a child's eating and exercise patterns'. (Neumark-Sztainer 2003: S32)

These different viewpoints also influence the degree of 'controllability' that health professionals attribute to child overweight.

'It ranges from the individual that may not be held accountable for a condition since it is primarily genetic in origin towards the individual and/or the individual's family (in particular if referring to an overweight child) that may be viewed as being accountable for a condition which is primarily behavioural in origin. There is an increased emphasis on individual control, which may lead to increased “victim-blaming” of the individual and the family. (Neumark-Sztainer 2003: S33)

A study done by Chang and Christakis (2002) illustrates that the medical perspective in itself can be considered a social construction. They conducted a content analysis on obesity in a series of the Cecil Textbook of Medicine, covering a time-span of seven decades from 1927 till 2000. Their research shows clearly, that psychological, social and political factors determine the biomedical construction of obesity, keeping in mind that the Cecil Textbook of Medicine represents primarily the American context. Despite a relatively stable idea that obesity is caused by an imbalance of intake and expenditure, explanatory models and constructions of responsibility and acceptance of obese persons are constantly changing over time. Medical science is influenced by new emerging technologies as can be seen in the power that is given to genetic factors as causal factors of obesity. Medical science is also subjective to trends in society and politics, like in the United States where the growing numbers of obese people lead to more acceptance of obesity.

1.6 Obesity as an eating disorder
Child overweight is often associated with psychological factors and then labelled as eating disorder. Over eating and obsession with food might lead to overweight and obesity.
Psychologists differentiate three types of eating patterns that are at risk for the development of an eating disorder: external eating, emotional eating and dieting. Children that execute external eating have an extreme appeal to food; they love the taste, smell and presentation of food. Children that exhibit emotional eating eat because of emotional stress, which can range from very subtle stress such as boredom and stress in daily life to the effect of child abuse. Emotional stress can also be an outcome of being fat already, because of bullying and not feeling attractive. Dieting can have various side effects. Children can acquire disturbed feelings of hunger and satisfaction after dieting and most of the time become obsessed by food and slenderness which may lead to binge eating and less resistance to food and will therefore lead to overweight. It is hard to say if children start dieting because of their actual overweight or because of their perceived overweight. The ‘culture of slenderness’ in modern society creates even in young children and especially girls, awareness of ‘ideal’ body size and informs them about ways to control their weight (Braet 2001a).

This becomes even more problematic as body dissatisfaction is not limited to people with overweight and has been characterized as a ‘normative discontent’ (Rich 2003: 4-5). According to Kaboem, a Dutch Internet site for children, almost half of the Dutch children that filled in a questionnaire, perceived themselves as being too fat. 43% of the girls and 30% of boys perceived themselves as “somewhat heavy” and 16% and 7% as much too heavy. Children that perceived themselves as too fat did not diet more often or ate less sweets or snacks and did not have different ideas about healthy and unhealthy food as children that perceived themselves as not being fat3. Research on British girls shows that body dissatisfaction in young women may start as young as 8 years (Hill in Grogan&Wainwright 1996). According to Grogan and Wainwright (1996: 668) girls from the age of 8 years have already ‘internalised adult’s ideals of slimness’. They question if girls can challenge the dominant cultural representations of femininity. What strategies do they use to accept or reject ‘these current concepts of body image, in the knowledge that rejection of the norms will mean non-acceptance by the dominant cultural group?’(Grogan&Wainwright 1996: 672). These studies show that the ‘culture of slenderness’ already teaches young children and especially girls the ‘ideal body size’. This may contribute through dieting and disturbed eating patterns to the development of overweight and low self-esteem (Braet 2001a).

The psychological perspective in treatment

Cognitive-behavioural therapy is currently recognized as an important part of the treatment of child overweight. In therapeutic sessions psychologists focus on the children’s point of view and recognize the fact that food and eating is a social process. They discuss the ideas and feelings of overweight children about food, about their body size and about themselves as an individual. They talk about their existing coping strategies regarding bullying and practice new strategies to be able to better cope with the stigma in the future. Unfortunately, this discourse is very much influenced by the medical model of obesity where changing ‘bad’ food habits and promoting physical activity are dominant activities within the therapeutic sessions. The ideology trying to make children more active, fit and thin is very much alive in these sessions and reproduces the slender ideals that might contribute through dieting to the development of overweight and low self-esteem. The therapeutic sessions also focus very much on the child as an individual and its responsibility to make ‘healthy choices’.

1.7 The social and cultural construction of overweight

Examples of social and anthropological discourses used to understand overweight are the concept of body image, the meaning of food, perceptions on health and illness, the feministic and the multilevel perspective

Body Image

According to Fisher (cited in Helman 2001: 12) the body image includes the collective attitudes, feelings and fantasies about the body. The socio-cultural context teaches us how to perceive and interpret our own body and the bodies of people around us. We can differentiate an old body from a young one, a disabled from a ‘normal’ one and a fat from a thin one. We learn to distinguish private and public body parts and know which bodily functions are socially acceptable or to the contrary morally intolerable. Helman (2001) describes that in every society the human body has a social and a physical reality. ‘That is, the shape, size and adornments of the body are a way of communicating information about its owner’s position in society, including information about age, gender, social status, occupation and membership of certain groups, both religious and secular’ (Helman 2001: 12). Very much linked to the concept of body image are the culturally defined notions of ‘beauty’. Especially women alter or ‘mutilate’ their bodies to conform to the culturally defined standards of beauty through plastic surgery or reducing their weight to ‘attractive’ levels. Rittenbaugh (in Evans 2002)
states that weight standards for females show an obvious downward trend, influenced by cultural factors and reflected in popular media imagery. Paquette and Raine (2004) argue that the construction of body image is influenced by the 'impersonal' industry and mass media, but more importantly by 'taken for granted and “normalized” social conventions- the well-intentioned gestures of caring and friendship' and 'the internal reproduction of socio-cultural norms within each woman' (Paquette & Raine 2004: 10).

### Meaning of food

Another perspective used in social sciences is to use the meaning of food as a concept to better understand eating disorders and overweight. Anthropologists have studied food rules and taboos to explain cultural constructions of gender, class, nature, religion, morality, health and social order in many traditional cultures. Counihan (1999) states that 'food is a central, readily available battleground for issues of 'autonomy, control and love’ in the growing girl’s relationship with her parents. Overeating can be a way to assert control, demand attention and express anger’. (Counihan 1999: 86-87).

Counihan (1999) also studied the meaning of food among students. She argues that because eating is such a basic condition of existence, people take their food ways for granted and rarely subject them to conscious examination. People eat according to their own food rules that are constructed by the complex meanings food has to them. Students differentiated food as good and bad food and include the rule that allows breaking the food rules at certain occasions. They define food as fuel for the body, but more important as comfort and love. They showed that eating is a moral behaviour through which they construct themselves as good or bad human beings. Food is used to distinguish between gender and class and food rules express an ideology of life that focuses on how and what is eaten and how to be in control (Counihan 1999).

Van Dongen (1997) argues that the meaning of food in the understanding of eating disorders is underestimated and should be given more attention in the analysis of anorexia since it is interwoven with cultural and social ideas about food and words. Food brings people together, but can also separate people; it can satisfy the desire to change or have new experiences and it can control reproduction (van Dongen 1997).
Perceptions on health and illness

Other social scientists have highlighted that any diagnosis of an illness like overweight requires a belief in the existence of the disease and its aetiology (Evans 2002). From the biomedical perspective, once a person has been diagnosed 'to have' overweight or obesity no relevance is attributed to the possibility that the person may not accept his or her condition as an illness or that he or she may not even feel 'sick' or abnormal (Trakas&Wirsing 1996). Anthropological approaches assume that the ways in which the patient subjectively perceives, interprets or evaluates the condition is one of the most important forces governing behaviour and wellbeing (Trakas&Wirsing 1996). Children with overweight and their parents as all people apply the Thomas theory that states that ‘if men define situation real, they are real in their consequences’ (Merton cited in Streefland1998: 62) and will only change diets and inactive lifestyle when they perceive themselves as having a condition that needs ‘treatment’.

Everybody assumes that children are aware of their overweight and view it as an illness that needs treatment, but do children with overweight perceive themselves as ill or do their parents that need to be ‘re-educated’ consider themselves or their children as ill?

Feministic perspective

A large number of feminist analyses have already centred attention on the social perspectives of eating disorders and overweight. They emphasize the powerful notion that women are obsessed with food and the slender, or thin ideal marketed in modern society. Counihan (1999) reviewed five volumes that address the meaning of fat and thin in contemporary North America and provide social–psychological analyses of women’s obsession with fat and social explanations of eating disorders. They all link the obsession of food to individualism: fat women suffer and practice rituals in secret. ‘Women’s isolated, competitive individualism in their struggle with food is an internalization of the competitive values and practices fundamental to Western society.’ (Counihan 1999: 85). Another theme is that women are socialized to believe that their problems come from being too fat. Being thin then becomes a totally absorbing quest that will give them the power and control in a world where women suffer institutionalized powerlessness: ”Once I will be thin, everything will change” (Counihan 1999: 84). All five books share the perspective of popular feminism that the cultural subordination of women is part of the explanation of the denigration of their bodies.
Rich (2003:4) criticises the feminist perspective in the way it presents women as uncritical consumers of media images of thin femininity, while she argues that people can variously interpret media and other social messages and do not simply and passively reproduce socially constructed representations of the body. Rich also claims that the emphasis on body image, on ‘slenderness’ acting as a contemporary metaphor, neither explicates fully the complex relationships between the image and eating practices, nor those between young women, men and other elements of their lives (such as schools or families). The vantage point of the feministic perspective is that women are obsessed with food and ideal body size. Little is known about this in young children. We do know that a lot of girls feel unhappy about their body size and practice some form of dieting. We also know that children are very well informed by the media and health education and are aware of the dominant notions on what is healthy and unhealthy. But how do they transform these powerful messages to their daily lives? Medical experts consider overweight children as food addicts and psychologists see overweight as an eating disorder, which implies that they are obsessed with food. Are overweight children obsessed by food?

**Multilevel perspective**

Another perspective in the field of overweight and eating views overweight and eating disorders as a field wherein multiple agents and institutions compete for dominant interpretations and meanings. Rich (2003) in her study on the connections between the social construction of eating disorders and the context of schooling states that

Anorexia is as situated, learned and practiced in a ‘field’, a relational social space defined by a dynamic configuration and positioning of people and structures. This not only involves a process of constructing ‘anorexia’ but power relations in which some have the authority to ‘diagnose’ what this ‘condition’ should or should not be. Psychiatrists, teachers, anorexics, parents, health professionals etc are seen as agents participating in this process in a variety of contexts (Rich 2003:5)

She shows that the meaning of eating disorders is socially (re) constructed by bringing the medical and other more ‘populist’ or ‘media’ based discourses, language and social practices together within particular social institutions such as schools. She concludes that in this way the current discourses on anorexia might be challenged or even changed (Rich 2003). I think this perspective could be very useful to study the complex meaning of child overweight.
Chapter 2: Research setting, objectives, methodology and reflections

In this chapter I will describe the research setting, the research objective and the most important research questions. Furthermore I will discuss the methodology used in this study, including the study type, the sample, the data collection techniques, the data analysis, a section on validity and reliability and some ethical considerations. In conclusion I will reflect as a researcher on the research process.

2.1 Research setting: The Dikke Vrienden Club

The Dikke Vrienden Club (DVC) is a multi-disciplinary treatment-program for overweight children based in the Sint Franciscus hospital in Rotterdam, in the Netherlands. The multidisciplinary team consists of a paediatrician, a dietician, two physiotherapists, two psychologists and a psychological assistant and treats 20 children with overweight a year in groups of 10 children each. The aims of the program are to try to make fat children more healthy and eat less, to increase their fitness, to make them exercise more, to help them cope better with the consequences of being fat like bullying and finally to gradually come to a normal and healthy weight.

Only after an intake by the paediatrician and the psychologist children and their parents are accepted to participate. The paediatrician examines the overweight children for underlying diseases that need to be treated first and the psychologist looks for possible underlying psychological disorders, that if present also exclude participation. Both professionals judge the children and their parents for their motivation, an essential qualification to be accepted to participate. If the children and their parents agree to participate they have to be present at all children or parent sessions.

The program is specially designed for children of 8-12 years old and is mainly based on behavioural therapy. It focuses on changing eating and exercise patterns and coping with the psychosocial consequences of being fat. The children sessions contain of seven weekly meetings of 2,5 hours and one concluding session with an interval of two weeks on Wednesday afternoons. Each session consists of two parts; the first part deals with food patterns and the consequences of overweight and is presented by the dietician and a psychologist, who teach and practice how to actually change eating and exercise habits which
is more easily said than done'. During the second part two physiotherapists exercise with the children and teach them how to enjoy exercise and how to become fit.

The parents have three parent sessions in which they receive information and health education, and have the possibility to speak to other parents. They also learn how to cope and how to support and boost their children in changing their food and exercise patterns.

The children finish the program with an evaluation session (the 'uitnaha'), in which all professionals evaluate their progress: their weight, their eating and exercise patterns and their fitness. If they have succeeded in refraining from weight gain they receive a diploma. Follow-up sessions are scheduled during the succeeding year. After a year all children are evaluated again and receive their final diploma. Evaluations of the program show that parents and children have positive experiences. Moreover, a study done in cooperation with the Erasmus University concluded that treatment given at the Dikke Vrienden Club is effective.

2.2 Research objectives and research questions
Since the fast growing prevalence of overweight among children and adolescents, child overweight and obesity have been and still are extensively studied from many different angles. The dominant notion in the popular and medical discourses is that child overweight is a serious health problem that needs treatment and is largely caused by poor diets, inactive lifestyle and genetic factors. Research within the medical discourse focuses primarily on the prevalence, effects of treatment and at the determinants of food and physical activities (cf Kohl&Hobbs 1998, Bouckaert&Matthys 2001, Strauss et al 2001, Spruijt-Metz et al 2002, Borra et al 2003); psychologists look mostly at the relations between self-esteem, weight concerns, stigmatisation and overweight and how children internalize the body image present in the media (cf Grogan&Wainwright 1996, Cramer&Steinwert 1998, Smolak et al 1999, Sands&Wardle 2002) while social scientists emphasize that social and cultural factors must also play a role in the development of overweight. They for example studied the construction of body image in women (Paquette&Raine 2002) or looked at the meaning of food (Counihan 1999). They also looked at the influences of society with its culture of slenderness on the one hand and consumerist mentality on the other hand (Grogan&Wainwright 1996).

---

4 Information retrieved from brochure of the Dikke Vrienden Club
5 Results of the evaluation of treatment are not yet published
However, little research has been done from the perspective of the ‘experts’, the overweight children themselves. Likewise, research that focuses on the experiences and perceptions of overweight children is still lacking in the Netherlands. Therefore, this study aims to gain insight into how children construct and define overweight and how overweight children, especially, perceive and experience their body size and use their definitions and meanings in their daily lives and in their social interactions with family, friends, teachers and other actors.

The main objective of the study
The aim of this study was to explore how ‘children with overweight’ experience and perceive their body size and how they manage it in daily life.

This study tried to answer the following questions: How does the daily life of children with overweight look like and when are they confronted with their body size? What notions and feelings do they have about their body size and being fat? How do they feel about themselves in relation to their family members, friends, other children and the images present in the media? What are their experiences of their body size in relation to being healthy and fit and the health care system? What is their history of ‘treatment’? What strategies do they use to manage their body size in daily life? In what way do they accept, resist or transform the ideas of being slender, fit and healthy?

As I consider children as social and cultural actors in the construction of overweight I assume that they have agency and therefore have the potential ability to negotiate their own meanings of being fat and construct their own strategies to deal with it. Strategies in this context can be understood as acts and choices that children make consciously and actively to deal with their body size in the reality of their every day life. For example, do they have strategies to accept or reject the ‘current concepts of body image, in the knowledge that rejection of the norms will mean non-acceptance by the dominant cultural group?’ (Grogan&Wainwright 1996: 672).

In my research I purposely chose to look at the experiences and perceptions of body size in specific and not at the body in general. Looking at the body per se involves more than just size and shape –like body functions and body parts- and in my opinion will change the purpose of my research. All the ways individuals consciously or unconsciously conceptualize and experience their body fall within the term body image. The body image, including the beliefs about the optimal shape and size of the body are shaped by the beliefs and practices
within a particular family, society or culture. Very much linked to the concept of body image are the culturally defined notions of 'beauty' and 'healthy' (Helman 2001: 12)

Since the children in the study have been diagnosed as having overweight and are treated or will be treated for their 'illness' and also because of the notions in the popular discourses that overweight is a 'disease' that needs treatment I studied the perceptions on health and illness and asked children to tell their notions and feelings about the process of how they became diagnosed as having overweight, how they 'treated' their body size and what they consider healthy, fit and unhealthy. Helman (2001) states that 'children have their unique understanding of illness, what causes it and how it should be treated. Their Explanatory Models are usually a blend of ideas derived from personal experiences and family influences, from school and the media' (Helman 2001: 98).

2.3 Methodology

Study type

This study has a qualitative design since ‘qualitative research produces more insight and in-depth information’ (Hardon et al 2001: 187). The power of qualitative research is that by studying the beliefs and practices of people’s everyday life it gives insight in the way people perceive and act within a particular context (Goethals et al 1997). Qualitative research methods like in-depth interviews with children can provide a detailed understanding of the everyday interactions and cultural meanings of child overweight. It looks at problems in a holistic way by including the context they live in.

Because little is known about the experiences and perceptions of body size in overweight children that are actually diagnosed as having overweight and receive or will receive treatment the study has been an exploratory and descriptive one.

Theoretically, I will use the child perspective in this study. The child perspective focuses on the agency of children and emphasises children as social and cultural actors in the construction of overweight. The child perspective makes use of the cognitive symbolic perspective. The latter places the relation of culture and illness at the centre of analytic interest and views disease as an entity that belongs to culture. The cognitive symbolic perspective makes use of the emic approach, which means the ‘insider’s point of view’. I want
to know how children with overweight view their own situation and how they solve their problems in daily life. The contrasting etic approach is based on ideas that outsiders for example parents and health workers have about overweight children.

Sample
During my fieldwork I interviewed 8 children with overweight aged 8 to 13 years and their parents. All children had been ‘diagnosed’ with overweight and had been referred and accepted for treatment at the Dikke Vrienden Club. I decided to see both children treated at the Dikke Vrienden Club and children still on the waiting list for treatment. Since the aim of the study was to better understand what being overweight means to overweight children in the context of every day life and to describe their experiences, perceptions and existing strategies, I strived to see children that had not been influenced yet by the treatment program, but had been diagnosed has ‘having overweight’. Nonetheless, I also interviewed children that received treatment to better understand the context of the Dikke Vrienden Club (DVC). In the end, I saw three children that were treated but were in different phases of their treatment and 5 children on the waiting list. I tried to interview as many girls as boys, however I only managed to interview 2 boys and 8 girls.

Both children and parents received their own letters to inform them about the research. The children of the waiting list received their letters through the paediatrician and were asked to react by email or phone to me or to the DVC if they wanted to participate. The children that had already received treatment I met at the hospital or were informed by the paediatrician. They either reacted themselves or were phoned by myself to ask to participate.

Data-collection techniques
Interviews
I performed semi-structured interviews with children, their parents, the health professionals working at the Dikke Vrienden Club and two key participants working in the field of child overweight using a topic list to ensure all issues were discussed. ‘Semi-structured interviews with open-ended questions give the researcher the ability to ask additional questions on the spot to gain as much useful information as possible’ (Hardon et al 2001: 209).
Interviews with children

I interviewed the children three times, except for two children whom I interviewed twice. During the first interview I mainly focused on their daily life and social relationships that were important to them and explored when they were confronted with their body size. I used a poster, ‘my daily life’ poster ‘to fill in’ their daily lives. When the poster was completed the children put stickers to indicate what and whom they liked and disliked and what or whom they felt was important or unimportant. While doing that I asked them to explain their choices to me. If they had not introduced their experiences and perceptions on being fat already while describing their daily lives, I specifically asked for their perceptions on their body size and past and present experiences. I used the poster to see where and when they were confronted with their body size and how they experienced being fat.

In the second interview I more in depth asked for their perceptions and good and bad experiences of being fat. I first asked them to describe themselves and then I used silhouettes of a fat, moderate and thin girl or boy to find out their perceived and ideal body image. These silhouettes I also used to explore when in their everyday life they were confronted with their body size by asking, “when do you feel like this girl”. I also explored their notions and feelings about their bodies in relation to the bodies of their family members, the bodies of other children and images present in the media, as well as their notions and feelings about what is normal and different. I used cards with statements, for example “I would like to resemble people you see in magazines or watch on television” or I showed them pictures from the media as starting points for discussion. I also asked them their reasons for their body size and their ideas on accountability. I also asked for their strategies, like their existing coping strategies regarding bullying and the stigma of being fat. From the focus group discussions I learnt that most strategies focused on how to change their body size and how to loose weight and become thin. Therefore, the second interview also dealt with their ideas of how they ‘treated’ their body size. I also discussed if they wanted any treatment and why they were on the waiting list or treated at the Dikke Vrienden Club. To explore their strategies I used two fake problem letters of ‘fellow-sufferers’ that they had to pick from pile of closed envelops and read and reflect on: one on bullying strategies and the other about seeking treatment.

In the third interview I focused on the ‘illness narratives’ to gain insight in their perceptions on health and illness. I asked for their history and experiences of the ‘treatment’ and wanted to know if they perceived being fat as a disease since they received or were going to receive
treatment in a hospital. I was also interested in their perceptions on food and exercise, and if these had changed while being treated and if they were influenced by the dominant notion that overweight is caused by poor diets and inactive lifestyle. Furthermore, I used a game to learn their ideas on what is healthy, fit and unhealthy and to explore in depth their strategies in dealing with being fat.

Drawings of Children
After the second interview I asked children to draw or write what they thought being fat meant to them using a given drawing titled ‘Being fat is.’ They were asked to hand in the drawing during the last interview to give them more time and privacy and to give me the chance to discuss it to bring up additional perceptions and experiences on being fat.

Photographic visuals exercise
As a way to explore the children’s notions and ideas about what is beautiful, healthy, fit, good and normal I asked six of the eight participating children (two children entered the field study at a later stage) to make pictures with a disposable camera of themselves and/or of other people or objects. I also asked them to make pictures of the opposite. To help the children I accompanied the camera with a list of instructions.

Interviews with parents
To gain more insight in the particular context of the child I also interviewed the parents of the children. I asked the parents about their notions and ideas about body size in general, the reasons why their child is overweight, their perceptions on food and exercise and what role they attribute to themselves and their child in the causality and treatment of overweight. I also explored how they thought their children experience, perceive and deal with their body size. In five occasions the children were present at the interview with their parents, two children choose not to participate and one child thought he was not allowed to participate.

Interviews health professionals
I interviewed the members of the Dikke Vrienden Club team6 to gain more insight in the particular context of the Dikke Vrienden Club. I asked them their ideas and notions on the causes of child overweight, the treatment of overweight in children and what role they attribute to the children themselves and their parents in the causality and treatment. I also enquired how they thought overweight children experience and perceive their body size.

6 Names of the team members of the Dikke Vrienden Club are included in the appendix
Interviews with key participants
To gain more insight in the context of child overweight and obesity in general, the causes, the treatment and the role of children and their parents I interviewed two experts in the field of child overweight and obesity; Prof. dr. Delemarre, professor in child endocrinology at the Free University of Amsterdam and Mrs. van de Baan, paediatrician at Heideheuvel in Hilversum, an institution for the treatment of severely obese children.

Focus group discussions
Before I started my interviews I organised four Focus Group Discussions (FGD’s) at a school in Diemen to learn more about the context of children aged 8-12 in general, about their daily lives and their perceptions on body size and health and illness in relation to body size. I choose this particular school in Diemen because the children present at the FGD’s had similar backgrounds as the participating overweight children in the study. The participants are of Dutch origin and mostly live in smaller municipalities nearby Rotterdam. At this school most children were also of Dutch origin and lived in Diemen a small municipality near Amsterdam. According to the teachers none of the children had been diagnosed for overweight.

I was present in two classes containing group 5-6, which means children aged 9 and 10 mainly. First I divided each class in two parts of which one part started to fill in the ‘daily life’ poster guided by the teacher and the other part engaged in the focus group discussion, after half an hour both parts exchanged. In the first class the groups were divided in boys and girls, in the second class both groups were mixed. During the focus group discussions I introduced different silhouettes of a fat, average, and thin girl and boy, accompanied by questions such as ‘this is Maaike, she will be a new pupil in your class what do you think of her’, to gain insight in their perceptions on body size. To discuss their perceptions on health and illness I brought a decorated box in which were closed envelops, containing statements on health, body image, food and exercise and two fake problem letters of ‘fellow-sufferers’ that I later on also used in my interviews. Answering a simple question correctly, for example ‘who has its birthday in January’, was the means to pick one of the envelopes, read it aloud and answer it first before the group discussion took off.

Participant observation
I only observed the children shortly during the interviews and those with their parents and during the short conversations when entering and leaving their homes. These observations
gave me the opportunity to observe the interactions between the parent(s), possible siblings, other family members, friends and the child itself, especially in relation to daily activities. I also observed two of the participating children during their individual follow-up activities at the Dikke Vrienden Club and joined the paediatrician of the DVC for one day. In this way I could observe the interactions between children, their parents and the health professionals.

Other activities

Feedback session DVC

At the end of my fieldwork I discussed my fieldwork methods and preliminary results briefly with the health professionals working with the DVC to get feedback.

The popular discourses

During the research period I tried to read all the newspapers and see all the programs about child overweight and obesity to find out the notions and ideas present in the popular discourses. Since child overweight has become epidemic, the topic is discussed extensively.

Seminar on Overweight and Obesity in Children

On the 24th of June I participated in a seminar on overweight and obesity in children: a search for causes, solutions and chances from the marketing and family perspectives organised by IPM Kid Wise (research based consultancy) and the University of Amsterdam.

Data analysis

The process of data analysis is a systematic process of data collection, data analysis, further collection of data, analysis etc. In this way, the data analysis is not a separate phase in the research process, but starts as soon as the qualitative research begins. ‘Formally, it starts to take shape in analytic notes and memoranda; informally, it is embodied in the ethnographer’s ideas and hunches’ (Hammersley&Atkinson 1997:205). Data analysis is the process of observing patterns, recurrent behaviour, characteristics, objects or bodies of knowledge in relation to the research objective and research questions, sorting and categorizing these data into themes, summarizing, evaluating, comparing and interpreting these themes in terms of social theory, the settings in which it occurred and the ideas of the researcher in order to construct assumptions or possible conclusions, then collecting extra data, confirming or refuting the assumptions and conclusions made, continuing analysis, asking additional questions, seeking more data, discovering more themes, furthering the analysis and so forth. (cf. Hardon et al 2001). Ideally, the process stops when additional data collection does not contribute to new themes and ‘saturation’ in getting further data has been reached. Along
these lines I have collected data from the focus group discussions, the interviews with the participating children, their parents, the members of the Dikke Vrienden Club and two key participants, ordered and reduced into a final coding system of analytic themes. These findings I compared and contrasted with the existing literature while looking for differences and similarities and searching for associations. In the end I drew up my conclusions.

Validity and reliability

The strength of the quantitative approach lies in its reliability (repeatability)... The strength of qualitative research lies in validity (closeness to the truth)...

Validit"y refers to the degree to which scientific observations actually measure or record what they purport to measure (Hardon et al. 2001: 202). In other words it means that you find what you wanted to know and more important that your findings represent the truth or reality as much as possible I wanted to know how overweight children experience, perceive and deal with being fat in their daily lives. Therefore I choose to use qualitative research methods including in depth interviews and projective techniques like drawing, showing pictures of magazines, games and problem letters of ‘fellow sufferers’ to get sound observations and data on how these overweight children themselves experience, perceive and deal with their body size. To maximize validity I used literal quotations of the children, since I recorded all interviews and I decided to see all children thrice, which gave me the opportunity to ask feedback from the children themselves. Furthermore I used different data collection techniques, organised focus groups discussions among ‘non-overweight’ school children and compared all data to the available literature.

Reliability refers to findings that are scientifically repeatable and generalizable. This qualitative study does not strive for ‘universality’ or ‘reproducibility’ as do quantitative studies, but focuses on ‘the uniqueness of a particular setting’ (Hahn 1995) and therefore will not have high reliability. This study wants to gain insight in the experiences and perceptions of overweight children that have already been diagnosed and receive or will receive treatment in the particular setting of the Dikke Vrienden Club. However these insights might eventually lead to more generalizable quantitative research questions.
Ethical considerations

All children, parents and health workers volunteered to participate in this study. Since almost all participants were younger than 13 years old I requested consent to participate in this study both from parents and the participants themselves after I had explained the purpose and the process of the study. Although in the Netherlands consent from children under 12 years old is not obligatory for scientific research, I presented both of them a consent form to be signed, before I started my research. From the child perspective children are seen as social actors and therefore they primarily had to decide if they wanted to participate in this study. All children wanted to participate themselves and had consent of their parents. I explained both children and parents that their participation was voluntarily and that if they wanted to drop out they were free to do so at any time. In addition, all collected information remains anonymous and the identification of participants will not be revealed and dealt with confidentially. I have changed the names of the children and if necessary of their parents and other significant people. I have not changed the name and town of the treatment program since the program already exists for almost 10 years and has already treated nearly 200 children and has many children on the waiting list. Children and parents were informed about this decision.

2.4 The research process and reflections of the researcher

A paediatrician in the role of child researcher

The role of child researcher was an enjoyable one, but also a difficult one. As a paediatrician I was taught that child overweight foremost is a health hazard with major consequences for the health care system and with enormous costs. As a health professional I felt the urge to act: to diagnose, treat and educate these overweight children. However I did not realise how complex the problem of childhood overweight is and how overweight children can only be understood within their social and cultural context. Especially the children helped me to go beyond the medical explanations of child overweight in emphasizing their social problems and prevented me to only ask for their feeding and exercise practices.

Dealing with the stigma of being fat

When I first “met” the overweight children in a session of the Dikke Vrienden Club where I was allowed to shortly introduce my research I had many difficulties to even pronounce the word “fat”. I told them that I was interested in their daily lives and that I wanted to learn from them and know how they dealt with body size. When no one reacted the psychologist
explained that I was interested in their lives being fat, which they seemed to understand better. During the interviews the children found it easier to talk about being fat than to talk about their body size or posture. Many times when I asked their experiences using the neutral terms ‘body size’ or ‘posture’ they told stories about being too tall or too old. I remember that I was shocked by the reactions of the children in the focus group discussions who confirmed the findings in research that as early as preschool age, children stereotype and develop prejudice against fat people. Nonetheless, I also felt hindered by the same stereotyping and prejudice: in the first interviews I felt anxious to ask the children for their experiences being fat, because I was afraid to make them feel sad or angry. It felt as if I also blamed them for eating too much and being lazy when I asked them why they were fat. Later on I felt more at ease asking them about being fat, also because the children talked very openly about their experiences and were very happy to share their stories. All the children were very pleased to be interviewed and to receive the attention. While preparing this study I had the idea to also interview the siblings of the overweight children as a control group of non-overweight children. Looking back I am glad I did not, since the children I interviewed felt proud to be the focus of a research project.

Access to the children
As mentioned before the children on the waiting list were sent letters by the paediatrician and were asked to react by email or phone to me or to the DVC if they wanted to participate. In total nine letters were sent that is to five girls and four boys of which all girls affirmed participation and none of the boys reacted. Since the information of the children on the waiting list is confidential I unfortunately could not enquire the reasons for the boys not to participate. Two girls responded themselves by email. One of them replied that she was looking forward very much to talk about being fat and that I could arrange an appointment with her mother. The other girl was very happy that she herself received a personal letter and asked me to phone her to set a date. The other children joined after their mothers called the DVC or me. One of the mothers warned me that her daughter wanted to participate on the condition that I did not talk too much about being fat since that would make her cry. In practice the first girl that had sent me an email did not like talking about being fat very much, while the girl that did not want to talk about being talked very openly.

Meeting the children was quite difficult since they go to school and have many activities outside their school life. This meant that I could only interview them right after school, preferably on Wednesday afternoons. Taking into account that I had only seven weeks and
that the addresses were scattered around Rotterdam I am happy that I managed to meet almost all children and their parents thrice.

_Evaluation of data collection techniques_

**The interviews**

The children liked to be interviewed. The interviews took an hour maximum, which some children that wanted to play outside perceived as endless, while other children even wanted to continue after one hour. I noticed that the children liked the games and cards very much and made an effort to answer the questions they had said out loud themselves. When I asked them questions it seem easier to just respond typically with ‘I really do not know’. The letters of fellow-sufferers were also very helpful. Some children believed they were real and therefore made an effort to give good advice.

**Drawings**

The children liked ‘their homework’ as they indicated it themselves. Only one boy did not prepare his picture in advance but drew it on the spot in a couple of minutes. Some children really took an effort and were excited to show it to me and to explain what they had drawn.

**Photographic visuals exercise**

When I explained the exercise and presented the children the disposable camera they all were very excited. However the exercise proved more difficult (one boy did not succeed). Most pictures were of people they knew like their parents, their siblings and some of their friends. Only a few pictures were made of the ‘negative’ characteristics like unhealthy and abnormal. One girls choose to take pictures of the Internet instead which in the end was more helpful to discuss their perceptions on the subjects of health, fitness and beauty. In the future I will rather ask children to make a picture collection out of glossy magazine and other publications.

**Focus Group Discussions**

Children liked the focus group discussions very much, although their judgment was influenced by the fact that the FGD replaced their normal school work and that they were allowed to raise their voices and to talk without waiting for their turn. They liked discussing the statements but were most occupied with their wish to pick an envelop from the box, for example, if I asked “who has his birthday in January” to choose someone to pick a card, the entire group argued how unfair it was since they had their birthdays in December or whom they wanted to invite for their birthday party. The time (30 minutes) proved to be too short and the number of children (11) too big. Dividing the groups in boys and girls proved helpful.
Chapter 3: Contextualizing

This chapter introduces the children that participated in the research and presents the particular context they live in, taking into account children of the same age who are not ‘diagnosed’ overweight, their parents and the health workers who work with overweight children in the Dikke Vrienden Club or elsewhere. The first part is a short description of the participating children including a list of some of the basic characteristics of the children and their families, like age, weight and Body Mass Index. The second part deals with the daily lives and perceptions on body size and health of the ‘non-overweight’ children that have been interviewed during the focus group discussions. The third part presents the perceptions of body size of the parents and their ideas on the causality and treatment of overweight and their concerns while part four deals with the notions and practices of health workers working at the Dikke Vrienden Club (DVC) or in the field of child overweight.

3.1 The children of the study
Eight children participated in this study, 2 boys and 6 girls. Their ages range from 8 to 13 years old. 3 children, 2 boys and a girl participated in the Dikke Vrienden Club; the other 5 girls were waiting to participate and were registered on the waiting list of the Dikke Vrienden Club (DVC). All children were of Dutch origin; seven lived in the neighbourhood of Rotterdam and one in the neighbourhood of Amsterdam.

All children came from a two-parent family, although one father did not share the same house but lived around the corner. One child had two younger siblings, one child had none and the rest had one brother or sister all of which, except one, were older than the participants. Seven children went to primary school and one went to secondary school (brugklas MAVO/ HAVO/VWO). In six families both parents worked, one mother did not work at all and one father who was a painter did not work at the moment. All other fathers worked full time, three fathers worked as chauffeurs, one as a psychologist, one a supervisor of a store and two as managers. One mother worked full time, all others worked part time, as teachers, staff in a shop, nurses, social workers or in home care. 7 parents were highly educated. 6 of the 8 children have lunch at school during the biggest part of the week.
Darrell, Sandra and Randy participated in the DVC; they all succeeded to loose weight and even Darrell managed to reach 'normal' weight (90th percentile). Dewi knows that she is going to participate in the DVC soon and looks very much forward to it. Linda and Anna have already had a consultation with the paediatrician of the DVC and are waiting for their invitation to the intake by the psychologist of the DVC. Anna was still too young for the DVC when she met the paediatrician. The paediatrician excluded possible medical causes for their overweight and she is now waiting for another appointment with the paediatrician. Finally, Kim and Denise are still waiting for their appointment with the paediatrician.

On the next page all children are listed with their age, their sex, their weight and their own Body Mass Index (BMI) and the BMI's of their parents and if present of their siblings.

The correlation between overweight and obesity in children and their BMI's as mentioned before varies with age and sex. Therefore a table is included indicating the meaning of the BMI of the participating children.

Most children have one obese or overweight parent, while the other parent has a normal weight. Two children have one parent with overweight and one obese parent. None of the children has two parents with normal weight.

It is noticeable, as can be drawn from the table that all siblings have a normal weight.
**Characteristics**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>Weight</th>
<th>BMI</th>
<th>BMI mother</th>
<th>BMI father</th>
<th>BMI sibling</th>
<th>Age</th>
<th>Sib.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darrell</td>
<td>13y</td>
<td>boy</td>
<td>50 kg</td>
<td>19,5</td>
<td>25</td>
<td>29</td>
<td>16</td>
<td>7y</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>64 kg before DVC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sandra</td>
<td>12y</td>
<td>girl</td>
<td>79 kg</td>
<td>28</td>
<td>37</td>
<td>28</td>
<td>21,5</td>
<td>18y</td>
<td>5y</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>84,5 kg before DVC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denise</td>
<td>11y</td>
<td>girl</td>
<td>59 kg</td>
<td>23</td>
<td>23</td>
<td>28</td>
<td>20</td>
<td>15y</td>
<td></td>
</tr>
<tr>
<td>Randy</td>
<td>10y</td>
<td>boy</td>
<td>49,5 kg</td>
<td>23,5</td>
<td>29</td>
<td>24</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>53 kg before DVC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kim</td>
<td>10y</td>
<td>girl</td>
<td>61,5 kg</td>
<td>27</td>
<td>23</td>
<td>28</td>
<td>18,5</td>
<td>12y</td>
<td></td>
</tr>
<tr>
<td>Linda</td>
<td>10y</td>
<td>girl</td>
<td>63,4 kg</td>
<td>30,5</td>
<td>24</td>
<td>33</td>
<td>18/16</td>
<td>7/5y</td>
<td></td>
</tr>
<tr>
<td>Dewi</td>
<td>9y</td>
<td>girl</td>
<td>48 kg</td>
<td>26</td>
<td>24</td>
<td>34</td>
<td>18,5</td>
<td>13y</td>
<td></td>
</tr>
<tr>
<td>Anna</td>
<td>8y</td>
<td>girl</td>
<td>59 kg</td>
<td>29,5</td>
<td>29</td>
<td>26</td>
<td>19</td>
<td>11y</td>
<td></td>
</tr>
</tbody>
</table>

In children the BMI changes for their age and their sex. Girls have a higher BMI in average than boys. According to the BMI calculator the limits for underweight, ideal weight, overweight and obesity are the following:

<table>
<thead>
<tr>
<th>Name</th>
<th>BMI</th>
<th>underweight</th>
<th>normal weight</th>
<th>overweight</th>
<th>obesity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darrell</td>
<td>19,5</td>
<td>&lt;14,8</td>
<td>14,8-21,91</td>
<td>21,91-26,84</td>
<td>&gt;26,84</td>
</tr>
<tr>
<td>Sandra</td>
<td>28</td>
<td>&lt;14,4</td>
<td>14,4-21,68</td>
<td>21,68-26,67</td>
<td>&gt;26,67</td>
</tr>
<tr>
<td>Denise</td>
<td>23</td>
<td>&lt;13,9</td>
<td>13,9-20,74</td>
<td>20,74-25,42</td>
<td>&gt;25,42</td>
</tr>
<tr>
<td>Randy</td>
<td>23,5</td>
<td>&lt;13,7</td>
<td>13,7-19,84</td>
<td>19,84-24,00</td>
<td>&gt;24,00</td>
</tr>
<tr>
<td>Kim</td>
<td>27</td>
<td>&lt;13,6</td>
<td>13,6-19,86</td>
<td>19,86-24,11</td>
<td>&gt;24,11</td>
</tr>
<tr>
<td>Linda</td>
<td>30,5</td>
<td>&lt;13,6</td>
<td>13,6-19,86</td>
<td>19,86-24,11</td>
<td>&gt;24,11</td>
</tr>
<tr>
<td>Dewi</td>
<td>26</td>
<td>&lt;13,3</td>
<td>13,3-19,07</td>
<td>19,07-22,81</td>
<td>&gt;22,81</td>
</tr>
<tr>
<td>Anna</td>
<td>29,5</td>
<td>&lt;13,1</td>
<td>13,1-18,35</td>
<td>18,35-21,57</td>
<td>&gt;21,57</td>
</tr>
</tbody>
</table>

**In adults:**
- Underweight: BMI of < 18,5
- Normal weight: BMI of 18,5-25
- Overweight: BMI of 25-30
- Obesity: BMI of > 30

---

7 BMI= Body mass index= Kg/m²
8 BMI calculator http://www.gezondebasis.nl
3.2 Perceptions on body size and health in ‘non-overweight’ children

38 children participated in the Focus Group Discussions (FGD), of which 16 were girls and 22 were boys. Their ages varied from 8 until 11 years old: five were 8 years old; fourteen were 9 years old, seventeen were 10 years old and two were 11 years old. They came from two different classes; both were combination classes (group 5 and 6 were mixed).

Daily lives

Most children drew or wrote things randomly in their daily life poster, 5 children used a time scheme like in an agenda and 5 children made a pie diagram (some examples are given at the end of this section). Most mentioned domains were sports (33), school (24), food and drinks (20) and sleeping (20). 9 children mentioned computer and 9 television of which 4 mentioned both television and computer; two named playstation.

Most important were sleeping (19), school (17), sports (17) and food and drinks (14).

Nobody considered television, computer or playstation as important and some children even considered television (5), computer (3) and playstation(2) as unimportant. Many children described their daily routine activities, like waking up, dressing themselves; their activities at school like maths and drawing; some mentioned (7) playing outside and some (8) friends.

The teacher had explained that the Focus Group Discussion would be about what is healthy and unhealthy. This information might have influenced which domains they mentioned and what they found most important in their daily lives: some mentioned being ill as important (but not pleasant) and eating fruits and vegetables as important. Unfortunately their posters on daily life were not discussed. 2 children mentioned their body image: ‘clothing is important’ and ‘I am not fat and not thin’.

Perceptions on body image

To learn the perceptions on body image the children were presented with silhouettes of a chubby and a thin girl or boy. The reactions on the question “what do you think of your new pupil” were mild when they were shown the thin girl or boy (before the showing the chubby boy and girl). The children considered them healthy, normal and fit (‘because of her sport

---

9 The vignettes will be included in the appendix. Those vignettes used at the FDG were slightly different: each had a different coloured t-shirts and a different hairdo, which distracted the discussing on body size. They have been ameliorated.
shoes'). The boy had muscular legs and was like a model and the girl looked thin because she did not have a belly, she had beautiful legs and was thinner, but not really thin.

The reactions on the fat girl and boy were loud. The children first laughed and then started calling them names: ‘she is a fat-guts’ (vetzak), ‘she is really fat’, ‘she is an elephant’, ‘I don’t want to look at her’, ‘she is not a nice chick’, ‘he can not join the army’, ‘what a fatty’, ‘he is ugly’ and ‘he is round’. The children looked at the belly, the head and legs to indicate if someone was fat. Most of the children thought that the chubby boy and girl were not normal, because of their fatness and ‘because he is much too fat to be in our class’. One boy, who was a bit chubby himself defended the boy: ‘you can look like that and then you still can be normal’, but many children disagreed. Most children also considered the fat children ugly and stupid: ‘she is stupid because she eats too much’, although some children disagreed: ‘they may like to be fat’ or ‘they can be nice and smart’. They would only bully them when they were a nuisance or when they bullied themselves first. Advices what to do when bullied were: ‘if you are bullied you should ignore it and tell the bullies that they themselves are ugly’ and ‘you should also try to believe that you are beautiful yourself’. The only advantage of being fat that the children could think of was that you could float more easily and some joked that fat people were cosier. One of the classes contained one girl that was considered fat but who was not present herself during the FGD: ‘she admits that she is fat, but she lies about her weight’ and ‘she told me she has a disease but she just eats too much’.

Perceptions on health

The chubby children were also considered unhealthy, because they eat unhealthy and eat too much fatty foods and food like mayonnaise (‘3 kilos or each day a jar’), burgers, chips, pancakes and ice cream. One boy explained that ‘being fat is unhealthy because then your vessels squeeze and then your blood doesn’t run any longer and then you can die’. This story made the group consider the boy a bit healthy, because he was not that fat and because fat people only die when they are really fat.

Being fat was not considered a disease. Some children associated it with diabetes, but were corrected by their peers that diabetes does not make you fat. They agreed that there was no need to go to a doctor since you could do it yourself as most children stated that fatness is something that you can act upon yourself. The children instantly gave advice what these chubby children had to do: ‘she should go to a dieting school’ (afvalschool) to loose weight,
or fitness, or eat less and do sports, drink a lot of water, or eat healthier and no ‘tussendoortjes’ (an ‘in between’; food that you eat in between meals). Some though said that they could not help it. You can be born fat: ‘baby fat’, you can get it from your parents or when you are handicapped.

Some children had ‘dieted’ themselves because their parents said so or because they themselves wanted to loose weight. Dieting according to them was to only eat healthy food and less sweets and less fatty food.

Being healthy stands for eating healthy food and doing sports that makes you sweat; healthy food are fruits, vegetables, bread, meat and potatoes. Being unhealthy means eating unhealthy foods, watching too much television or sitting behind the computer for more than two hours a day and not going outside, smoking or breathing in smoke, too much alcohol and going outside in winter without a coat. Unhealthy food stands for too many sweets and too much fat: ‘one lolly a day does not make you fat’.

It was notable that the question “do you buy sweets of your pocket money” was answered very differently depending on the group. If someone had ‘admitted’ he did buy sweets, the rest of the group would also be more open. However if the first asked; said ‘I never did’ the rest of the group had also never done so. Moreover, talking about pocket money already caused many different emotions.
Leeftijd: 10

mijn dagelijks leven

Teken of schrijf de dingen die je doet in je leven in de cirkel.

Wat doe je normaal op een dag? Wat deed je bijvoorbeeld gisteren of een week geleden?
Vakantie, sporten, school, bedenk maar...

Jongen/
mijn dagelijks leven

Vrienden hebben

School

Ziek in

Sporten

Afwassen

Eten

Pasteren

Vakantie

Wat doe je normaal op een dag? Wat deed je bijvoorbeeld gisteren of een week geleden? Vakantie, sporten, school, bedenk maar..........
mijn dagelijks leven

ik sta meestal op om 8:00 als ik naar school ga en dan eet ik wat en drink ik wat en poets mijn tanden. Dan ga ik naar school en als ik op school Bin ga ik in de kring zitten dan rekenen en buiten spelen vruchten eten stil werken brood eten buiten spelen naar binnen en dan wat leuke dingen doen dan naar huis met Robin spelen avond eten nog naar buiten

8:30 naar binnen
Half 9 naar bed

Teken of schrijf de dingen die je doet in je leven in de cirkel.

Wat doe je normaal op een dag? Wat deed je bijvoorbeeld gisteren of een week geleden? Vakantie, sporten, school, bedenk maar..............
3.3 Parents’ perceptions on body size and ideas on causality

One or both parents of the participating eight overweight children were interviewed during this study. In practice this meant that four mothers and one father were interviewed on their own and three mothers and fathers were interviewed together. In two families of which the mother was interviewed on her own, the fathers were present before or after the interviews with their children and shared their ideas too.

Perceptions on body size

Most mothers are concerned about their own body size: the mother of Sandra is dissatisfied about her own body size and wants to lose weight. She has also been fat in her past and therefore knows how it feels to be fat as a child. Randy’s mother is also not happy about her body size but stopped dieting. The mother of Kim wants to lose 2 kilo’s herself and Anna’s mother wants to be a little slimmer. She used to be as skinny as her oldest daughter. Darrell’s mum is working on her weight and Dewi’s mother just lost unintentionally a lot of weight through acupuncture. However she still wants, if she could, change her firm upper legs. Denise’s and Linda’s mother are more or less satisfied with their own postures. Denise’s mother calls herself not too fat and not too thin, but just fine (‘ik voel me lekker’) and Linda’s mother only wants to be 10 cm taller. Of the fathers that were present during the interviews, some are concerned about their body size: Sandra’s father tries to lose weight through cycling and Darrell’s father feels too heavy. Randy’s and Linda’s father are satisfied with their posture. Some mothers brought up the body size of the fathers that were not present: the father of Denise is considered ‘not that fat’, but did diet sometimes and Anna’s father is slim, but used to be chubby as a child.

Their perceptions of normal body size are more or less the same: ‘when your weight suits your height’, ‘when you fit the standard sizes for clothes’ or when you are ‘not too fat and not too thin’. They all agree that not everyone should be slender and skinny and that being super slim as is forced by the media is nonsense or even unhealthy. Denise’s mother says that someone just has to feel happy in your body (‘dat je jezelf lekker in je vel voelt zitten’).

Most parents are also concerned about the body size in relation to health. According to them a normal body size is that size that does not threaten your health or gives problems like difficulties in breathing while running or walking. Kim’s mother stated that even a bit of overweight is fine, but too fat is not good for your health.
Ideas on causality

Most of the parents struggle with what has caused their children to be fat. They all mention the main causes that are given by the medical discourse: too much food or too little exercise and predisposition, although they question it because of different reasons. Nearly all parents state that their children were probably predisposed to become fat as the first reason, although Denise’s mother questions it too, ‘because we aren’t fat’. Sandra comes from a robust family and in Darrell’s family both sides are heavy. Anna has it in her genes, since her father used to be chubby and Linda, Dewi, Randy and Kim have the build of one of their parents or another family member, like Dewi that has the build of her Italian family. When they talk about food they mention the following possible reasons: ‘Kim likes food and even wakes up hungry’, ‘if I do not control her food, Linda will grow tight (‘groeit Linda dicht’), ‘Anna can eat till she feels sick’, ‘Denise just eats a lot, even bread, she takes big portions’, ‘Sandra ate a lot of sweets, as we all like nice food’, ‘Darrell did not have breakfast and ate too many chips’ and ‘Dewi had a need to eat since she was breastfed as a baby’. Their children have a need to eat, eat too much or cannot stop eating because they never feel saturated or full. Linda’s mother doubts if it is a reason since Linda does not gain in summer while eating two ice creams a day and does gain when she is in school being active. Anna’s mother wonders if Anna’s eating pattern is psychological, but what would she be eating away? In the case of the Denise the dietician even questioned what caused Denise’s fatness since she had a healthy diet. Talking about exercise all parents state that their children exercise a lot, except for the father of Darrell who says that Darrell did have too little exercise since he watched television or sat behind the playstation all day long. However the parents doubt if they exercise enough in comparison to what they eat since they still gain and Anna’s mother feels caught in a vicious circle: ‘she is fat and that is why she moves less.’

Most parents agree that children when they are young take what they are offered and do not realise what too much food can do to you. Especially the parents that also have ‘normal size’ children agree that their overweight children seem to have a bigger need for food.

The parents of Randy are convinced that Randy did not become fat of eating too much or too little exercise. Randy became fat after an appendix operation. The mother of Denise and Kim ask themselves if there is nothing wrong with their children’s metabolism. Although Denise’s mother rules out a disease because Denise is very healthy except for her fatness. Some parents have ruled out medical reasons like thyroid diseases or diabetes at the GP or paediatrician.
The role the parents attribute to themselves is that they have to watch what their children can and cannot eat and see to it that they exercise enough. They consider this role sometimes as difficult and tiring, since you cannot always control what they eat when you are not there. They also do not want to say 'no' all the time and be like a police officer that dictates what they cannot have or when it is enough. Most mothers shared this opinion. Darrell’s and Randy’s father both were of the opinion that they as fathers are stricter, but they agree that they do not spend that much time with their children as the mothers do. A final role is that they also support their children in the consequences of fatness, like how to deal with bullying, buying cloths and in their treatment for it. The parents seem to have a good knowledge of what their children experience in their daily lives, sometimes they do not know about the severity of the bullying, since their children do not tell them.

The question of guilt

Some parents partly blame themselves for the fatness of their children: they should have watched what their children ate from an earlier age or be stricter. Some parents on the other hand feel guilty because of refusing food all the time. Denise’s mother asks herself if parents do something wrong, since there are so many fat children; ‘we are the ones that buy the food and if you have the financial means and you are both working then it is easy to buy pizza’s for dinner’, but she also says ‘that can not be the only reason, because we also have a daughter that is not fat’. Most parents accuse the abundance of food: ‘there is just too much food around us and you can get it everywhere: it starts at the day care where they get biscuits and chocolate milk’ (Kim’s mother). Most parents state that there is a group of children that have unhealthy diets and therefore become fat, but they don’t feel that their children are part of that group since they eat healthy and are predisposed to fatness.

Parents feel the burden of accusatory remarks, looks and advice of other people and the media: Anna’s mother feels not understood. She feels that doctors think that she is ‘such a mother that stuffs her child’ and often hears, even from her close family ‘every pound goes through the mouth’ (elk pondje gaat door het mondje). The remarks often come when their child is eating something considered ‘unhealthy’ and Dewi’s mother sometimes hesitates in giving it in the presence of other people. However, ‘you can not feed your child water and bread only’ (mother of Anna). Randy’s fathers gets remarks from his friends in the pub when Randy asks for water: ‘shouldn’t he drink coke’. Kim’s father is unhappy how overweight children are presented in the media and their superficial idea that overweight is caused by too
much to eat and too little exercise: all children are different and there are many factors, like the affluent society with its abundance, the stress economy were everyone is busy and has no time to cook and the loss of norms and values.’ Sandra’s parents agree that the messages of the media are not sufficient: just eating less and more exercise is not a solution to fatness.

Parents concerns and their search for help
Most parents are concerned about the medical problems that are related to overweight and obesity. Parents see that the overweight burdens their children progressively while they are gaining weight and some children already have medical problems like incontinence for urine, backache, painful feet and knees. These medical problems and possible future problems, like diabetes, of which they have heard through the media, are one of the main reasons for most parents to seek help. Another concern is that parents are afraid their children will get even fatter and fatter since they themselves cannot stop or control the increasing weight. Most parents have difficulties dealing with their overweight children and the fact that they have to control their food intake. Some parents refer to some conflicts they have had since their children won’t take no for an answer. Some mothers are also afraid to put too much emphasis on food because food might become an obsession and this might lead to eating disorders.
They also worry about their children going to secondary school. The children there are much tougher and looks and clothes are even more important than in primary school as most parents know from their experience with older siblings. They worry that their children might not cope and feel insecure and the problems they already face in their daily lives will increase, like problems with fashion, with bullying and getting friends.

Randy’s father describes his son as sad and Kim’s mother finds it difficult to see that Kim has to bear the consequences. Parents seek help from the Dikke Vrienden Club because they want their children to loose weight, especially for the abovementioned medical reasons but also to lessen the burden for their children in their daily lives. They seek new ways since most of them have experienced failed actions by themselves or with the help of a dietician. They hope that their children will for once achieve success to motivate them in their fight to loose weight. They also wish the children themselves will become aware of what food and exercise does to them and learn how to make choices, for example to take an ice-lolly instead of a Magnum. For this purpose, they hope that strange eyes will be more successful (‘vreemde ogen dwingen’). They also feel that meeting other fat children, their fellow-sufferers, will be very helpful for their motivation and support. They hope that their children will become more
secure and resistant. For themselves they would like to get practical information and guidance how to deal with the conflicts and how to get more control from the health workers and possible from other parents.

What parents want from health professionals
From their experiences in the health care system some parents brought up some issues that they thought were insufficient. For example they experienced that the dietician treated their children too much as adults. Also the long periods, mostly 2 months, in between the appointments at the dietician did not stimulate the children to lose weight. Sandra’s mother even remembers that the dietician rewarded Sandra with recipes for cookies, which she did not like. Anna’s mother feels that health workers do not really understand what it is like to have an obese daughter or to be an obese child. The health workers should learn how hard it is in daily life. Dewi’s mother also feels that health professionals are still ignorant about what being fat means for children and that these children need help and guidance for the psychological consequences too. ‘What should you do as a parent when you child says that it does not want to continue living like this’. A health professional should not just refer to a dietician without psychological guidance, especially not if parents are already conscious about their diets. Paediatricians should definitely not advice to take thyroid medication to lose weight as Dewi’s mother experienced. Randy’s mother was also disappointed in the knowledge of their general practitioner. He just said that they should not worry and that he would grow over it, while Randy’s mother asked for help because of Randy’s lack of self-confidence. The GP had also not heard from the DVC and referred to a dietician first. Darrell’s father feels that general practitioners should be more interested in the well being of his patients in general and not only in their diseases. He would have preferred it, if his GP had advised Darrell to lose weight at an earlier stage.

3.4 Health workers ideas and practices: experts in the field of child overweight
All team members of the Dikke Vrienden Club and two experts in the field of child overweight and obesity were interviewed about their experiences with overweight children and their ideas about the causes of child overweight and what roles they attribute to both children and parents.
Why do children or their parents seek help

According to Olga van de Baan, paediatrician at Heideheuvel, a treatment centre for severely obese children, both children and parents seek help, but for different reasons. Children want help because of the difficulties they face in their daily lives with their body size. Their parents seek help because they are worried about the health of their children.

Most children name bullying as their number 1 and most important problem. Bullying often starts when they are 6 and 7 years old (in group 3-4) and increases with age. Number 2 and 3 are more practical problems such as buying clothes they want and not being able to keep up with other children during physical education; they feel tired quicker, get remarks like: ‘don’t pant like that’ and they are mostly chosen last in games. Mrs. van de Baan thinks that younger children mind not being able to run fast more than not being able to choose the clothing they like, while older children find clothing more important. Mieke Groen, the psychologist and project leader of the DVC also says that among 8-12 years old children, ‘who runs fastest’ is very important for their popularity in a group and for getting friends. According to the physiotherapists Meiners and Nuyens some children do not experience their physical abilities as problematic until they realise during treatment that they can run faster and pant less. Moreover, most overweight children have a negative self-image. They dislike how they look and are very much influenced by the judgmental looks and remarks they get from both adults and other people including children around them. Non-overweight children have a negative concept of overweight children—that is they are ugly, stupid and filthy – already from the age of 5-6 years old. Olga van de Baan feels that these disturbances in their self-image in early life determine the kind of adults they will become even though their overweight might be treated. Other consequences that children face but often do not tell spontaneously is that they feel isolated and ashamed and that they experience conflicts with their parents especially about the food that their parents try to restrict. Although in the last years the number of fat children has increased the abovementioned consequences of being fat are still impressive and do not seem to decrease, which contradicts the idea that if there are more fat children the stigma of being fat will lessen, says Olga van de Baan. According to Mariska Renzen, the dietician, the children also face difficulties with food since for they see it as one of the causes for being fat. They feel most tempted at parties, at the swimming pool, when they have their holidays, when their friends eat sweets and crisps, and when they come home hungry from school.
The advantages children derive from their body size are minor; examples are that their large posture gives them the power to get what they want or to deal with bullies. Some children use their body size to be pitied and in this way get attention.

Parents are most concerned about the health of their children especially when diabetes is present in the family, but they also feel sad about the social and psychological effects of overweight on their children. Most of the time they also feel ashamed and guilty, powerless and in loss of control. Some have the feeling their upbringing failed. Groen states that some parents at a certain stage only see their child as too fat and fail to see other characteristics.

The group of overweight and obese children they treat is very diverse, as Erica van den Akker says: ‘every child is unique and every family is unique too, that is what makes this work attractive’. For example, one child comes from a cultural background in which food is very important, another likes to sit in front of the television all day long. Another one is already very active, but has an incorrect eating pattern. Some children eat too much because of a dramatic experience like a divorce, others live in an unsafe area and therefore do not exercise or some have obese parents. On the other hand, Astrid van Meggelen, psychology assistant to the contrary, was struck by the fact that some mothers of the children they treat are really thin. Olga van den Baan and Marion Christiaans, the psychologist of the DVC also see some resemblances among the overweight and obese children they treat and their parents: both children and parents have difficulties in problem solving, are easy-going and do not have the need to explore or develop. One can even wonder if this passivism is not a consequence of them being fat and the stigmatizing effects on their self-image. Some parents just pass on their problems to others, like ‘fatness runs in the family, so he can not do anything about it.’ Olga van de Baan in her population of severely obese children also feels that a certain style of upbringing can lead to obesity like in very unstructured families or in families in which something has to be compensated such as single parent families or families in which both parents work or have their own enterprise.

*Perceptions of causality and the role of parents and children*

According to most health workers overweight is a complex condition caused by many different factors. Most important is that children that are predisposed to become fat eat too much and exercise too little. It is necessary to understand why these children eat too much or exercise too little. Do they eat for comfort because they have been bullied in the first place or
do they fear to exercise for any particular reason. Do they eat because they eat ‘with their
eyes’- external eaters- or do they have a disturbed saturation and never feel full? We still do
not know why children become that fat; what is the chicken and what is the egg? One knows
from experience that the burden the overweight and obese children feel and the problems they
face in their everyday lives just lead to more problems and more weight: a fat child only
becomes fatter. Their low self-image asks for comfort, which they mostly find in food and
their shame leads to inactivity and retired behaviour. Additionally, child overweight is a
problem that is rooted in the society in which we live. You cannot isolate the overweight child
from its family or from the society. Within the family certain structures have disappeared: the
basic structure of breakfast, lunch and dinner often does not exist because of time constraints
and because replacements are available. Also the relations between parents and children have
changed. Children become more independent and parents educate their children according to
the ‘negotiating model’. This means that there are fewer rules including food rules and blurred
limits. Parents want their children to be happy but sometimes forget that what all children
want is to spend time with their parents irrespective of what they do together. According to
the different health workers our society changed in many different ways. First of all there is
the abundance of food. Food is just everywhere: in canteens in schools, in the streets and even
in cinemas that nowadays are designed to eat while before it was considered rude to eat
during a film. The food industries have become very powerful and have changed food into
something that has to be delicious instead of healthy and useful. They also target their
advertisements and marketing especially for children in order to make them consumers too.
Then, our society has no space for a healthy lifestyle because it takes too much time and
instead people take fast food and take away menus and have too little time to exercise. In
addition, because of technological development and because people can afford it families
have computers with games that reward the children every few minutes, televisions and
second cars to do the shopping and fetch and bring children to school and sports clubs, which
all increase inactivity. Other reasons for more inactivity is that cities have become unsafe and
physical education in schools decreases because of cut subsides.

Most health workers do not agree that it is just the fault of parents that their children are too
fat. Parents do have a role in teaching their children a healthy and active lifestyle and how to
make choices. They are responsible for the food that is available at home, but are also
influenced and pressured by the changed society. Most health workers think that children
have no role in the causality of their fatness. Children have to be educated first. They are the
products of what is offered to them by their parents and by the world around them. Parents have to teach them how to deal with what is offered to them and to make them more powerful to resist. ‘We cannot expect children to have a task in their own health’ (van de Baan). Children accept what they are used to and taught at home. However, when in treatment children have to take their own responsibility and learn to make their own choices.

In conclusion, obesity and overweight are much more complex problems than just to say that is the fault of the parents or it is the fault of the aggressive advertisements. Ideally the society should change instead of spending a lot of money on the treatment of overweight children. As for now, both parents and their children have to learn how to deal with the changed society with its abundance and how to counter force it. Additionally, parents may have to become stricter again in the upbringing of their children. According to the team members of the DVC and Olga van de Baan it is not sufficient to send an overweight child just to a dietician or to only advice them to eat healthy and to exercise. Children and their parents have to learn how to implement healthy behaviour in their daily lives through behavioural therapy to be able to understand all the processes that have hindered them thus far to have a healthy lifestyle. To treat children instead of adults has some advantages. Children have a relative short history of ‘unhealthy’ behaviour and are more honest about their behaviour -I have eaten a lot of sweets- They also have a limited social life –just school and family- and their parents can be used as co-therapists. Furthermore children only need to stabilize their weight because of their natural growth. However, loosing weight has proved to be a strong motivation for children, especially when their body feels in better shape.

**Ideas health workers of this study versus the medical discourse**

Within the current medical discourse the real cause of the sudden increase of child overweight and obesity is still unknown, but most emphasis is given to the imbalance of intake and expenditure. It blames parents directly and children indirectly for their ‘unhealthy life style’ behaviours such as eating too much fat and sugar, skipping main meals and increasing physical inactivity. Prof. Dr. Delemarre, professor in child endocrinology at the Free University of Amsterdam also emphasizes that parents and their children do not know what is healthy and unhealthy and therefore have to take their own responsibility and learn how to eat healthy. The other health workers in this study mention predisposition to overweight and obesity as an important reason for the development of child overweight and obesity, mostly in combination with too much food and not enough exercise. They also state that children and
their parents have to change their life style to a healthier life style in order to loose weight, but do not blame the parents only for the body size of their children. They attribute a large role to the society with its changing structures and time constraints at home, its changing relations within the family, its abundance of food and its powerful food industries and its increase of technology and welfare. They do, as the medical perspective, want to re-educate parents to change to a healthier lifestyle and teach them to recognize their personal barriers to accomplish this healthier life style. Both the medical discourse and the health workers in this study do not blame the overweight children themselves for their overweight, nonetheless they both want to teach the children self-control and responsibility and also help them to change their eating and exercise behaviours into more healthier ones. The health workers at the Dikke Vrienden Club and Olga van de Baan also ascribe psychosocial factors to the development of overweight and therefore try to find out why the overweight children eat too much or exercise too little. They know from experience that the reasons for eating too much or not enough exercise can be very diverse and that overweight itself can lead to an increase in food intake and inactivity. They are very much aware of the psychosocial consequences of overweight and realise that overweight in most cases if not 'treated' will lead to an increase in weight.

Recommendations of health workers
The health workers recommended during the interviews that health professionals, politicians, food industries etc should realise that child overweight is a huge health problem with an enormous impact on the health care system, but also on the future health, including social well being) of the overweight children themselves. Until now most health workers were not really interested in child overweight, because child overweight made them feel powerless and frustrated. Fortunately, more paediatricians, youth doctors and psychologists feel that they have to contribute and general practitioners follow gradually. Yet, politicians still do not realise the consequences on the long run. Health workers, parents and other non-professionals therefore should try to get politicians interested in the problems of child. They should focus mainly on prevention in schools and with families and organise treatment within the first line (de eerste lijn). Treatment in hospitals is ineffective (at the DVC only 20 a year) and far too expensive.
Chapter 4: When they are confronted with their body size

This chapter describes the everyday lives of the participating children and how they are confronted with their body size in their daily lives. The first part describes the experiences children have with their body size in the most important domains of their daily lives, including friends, playing outside, sports, and food. The second and third part deal with the most mentioned confrontations: bullying and clothing.

4.1 Being fat in their everyday life

While each first interview started with an explanation of the research and its goal to gain their ideas and experiences of being fat in their everyday lives, only two children mention being fat in their descriptions of their daily lives. Denise says 'if I think about my daily life, I think about my mother and father, my sister, my horses, and yet also that I am fat' and Dewi starts the interview by asking if she can also mention things she does not like and tells that they recently called her 'sumo-wrestler with tits'.

When asked “when do you feel fat” most children mention that they feel fat when they are bullied or get looks from other people around them; when they have to buy, fit or change clothes; when they exercise or do sports; when they weigh themselves and when they eat. The stories they tell about their experiences of being fat take place within their families, when they are among peers and friends, when they play outside or are at school, when they do sports, when they are going to the swimming pool, when pictures are taken and when they are in contact with the health care system. All children feel ashamed for their fatness, for what others might say about them, for being bullied, for their inability to run fast, for not being like other children, for their failure to make friends and be part of a group and for their bodies when changing for physical education or when they are in the swimming pool. Their stories show that being fat influences their everyday lives to a large extent.

Describing their daily lives most children come up with activities. Most important are school or items related to school, like making homework or presentations, sports and playing outside. Only two out of seven mention food as important. Important persons in their lives are their parents, siblings, other close family and best friends. School is important because of their friends, getting good marks and for their future work. Sports are important because it is fun
and you practice it together with friends; also because you can get diplomas or you can win. They also mention: ‘because you don’t feel fat while you do it’, “because you have to do it to loose weight and become thin’ or ‘because it makes you fit’.

Seven children actually practice sports: they do streetdance, fitness or judo, swim, play hockey or tennis, skate and ice skate and ride horse. Three girls even practice two or three different kinds of sports all together. They all like doing sports and exercise. Sandra, the only girl that does not practice any type of sports, does not really like exercising, but still wants to try dancing soon.

**Friends and being part of a group (erbij horen)**

Friends and being part of a group (erbij horen) are two important themes in the daily lives of the children. They forget their fatness or hunger when they are with friends and most children mention friends and being part of a group as a useful strategy to deal with bullying, also because good friends do not bully. Friends support you and can help you: ‘friends make you feel good’ (Randy) and ‘friends cheer you up when you are angry’ (Sandra).

Being part of a group according to the children means that you are not on your own and that you belong to a group of other children. To become part of a group you should make friends and a good way of making friends is to introduce yourself and talk about where you come from and what you like. You can also just ask if you can become friends, play together or go to their homes to play. To make friends you have to be friendly yourself and you should act normal, just like other children and not be different from the rest. Friends you find among ‘people of your own kind’ according to Linda. That is also why Kim, Dewi and Linda sometimes feel that they cannot join in because of their fatness. Linda thinks that if you are thin or normal more people want to be with you, while if you are fat they do not want to play with you.

Kim: ‘Being fat is not nice, because some children do not have friends; if you are fat you are not necessarily unfriendly; if you are thin then they would like you for sure and that is not nice; unfriendly” [10].

Dewi: ‘you just want to be slim like other children,...then that makes you think I am just wrong’ and ‘I do everything wrong...and that is because I am fat’.

[10] Text of the drawing made Kim on the theme: “being fat is.”
Randy has similar feelings because he cannot run as fast as his friends and therefore he has difficulties in making friends. According to Kim and Denise to solve this problem, you should be active yourself in asking or contacting.

Denise: 'I look for contacts myself and I just join them quickly in their games, because they will initially think, what is she doing here, and then I am just part of them'.

Sometimes to become part of a group they have to follow certain rules, like wearing cool clothes or acting cool or doing cool things like to ring doorbells and run for it (belletje trek). A description of Denise demonstrates how difficult it sometimes is to determine why someone is or is not part of a group:

'there is this girl in my class. I don’t know, but she is, I do not know if that is the reason, but she is a little, she studies a lot and she always has good grades and she is also a bit chubby and she has glasses, so she is not the coolest girl in class, but then she is not part of the group, and sometimes I ask myself, she has glasses, but that is for her own eyes and more [children] wear glasses. Is it because she is fat, but I am fat too and I am just part of the group, so that is strange. I do socialize with her mostly, but it is just strange, because it is just her and she is also not a girl that mingles quickly.'

The theme of boyfriends and girlfriends in relation to being fat is not mentioned frequently. Only Dewi and Randy come up with the theme spontaneously. Randy mentions that he became friends with a girl nearby while participating in the DVC while Dewi states that being fat means that you cannot get boyfriends or girls friends.

Dewi: 'at a birthday party my friend asked the boy I am in love with if he wanted to go out with me and then they were going to make a list of what he thought of me and what he did not like and why he did not like me and then he said 'you have to change' and he did also not like me, because I was fat, but I do not like that because before he had told me when I asked him 'what do you care about most one’s inner self or one’s outer self' and then he said ‘the inner self’ and at this birthday party he said that he did not like me because of my looks'.

'Playing outside is actually really good for you' (Anna)

All children mention playing outside as something important and something they like very much. Playing outside means doing things: they play games, like tag and hide and seek- both in all kinds of variations they climb, swing and sometimes have fights. Randy learns his football tricks outside. Dewi sometimes plays 'sports team' which is a game that involves exercises to get fit with the goal to improve from a DD meaning a starter to an AA as someone that is really good. She loves to become an AA. The children they play with they meet outside or they pick up from their homes. Playing outside is important to meet old

\[\text{11} '\text{slingertikkertje', 'museumtikkertje', 'tien tellen in de rimboe', 'boer en kwajongens', 'busje trap'}\]
friends or to make new friends that are different from your friends at school. It is also important for playing games, for exercising and: ‘it leaves less time to watch television’ (Darrell). Playing outside gives the children the opportunity to chat to friends about things they have done the day before or during the weekend, about boys and about music. Sandra plays outside for two hours every day, but cannot keep up sitting and chatting for more than a quarter of an hour. Denise likes playing outside, because then she ‘just thinks about playing’. Kim says that playing inside does not teach you anything, while outside you for example learn about nature. Darrell agrees in saying that ‘being fat means that you know less of certain things because you do not like to go outside so much’. His statement also shows how his fatness isolated him and hindered him to go outside’.

Other reasons not to play outside are: when they have fights with other children outside, when they are bullied, when they are not allowed to go outside- in at least four of the families this was used as punishment for bad behaviour-, when there were no children of their age to play with, when the surroundings were bad or unsafe or when the weather was bad.

Most of the children played outside before or immediately after the interviews. These observations were made in June when the weather was fine, which may have influenced the ideas of the children on playing outside, since some parents argue that they often have to send their children outside as they also find playing outside very important. Anna’s mother complains that she sometimes has to throw Anna outside, because ‘then she also gets more exercise’. Darrell’s father also complains that he has to urge Darrell to go outside ‘if it depends on you only, you would lie on the couch or on my bed to watch television or to sit behind your playstation during the entire weekend’. Sandra’s mother is happy that Sandra is now old enough to pick up her school friends to play outside with, because she knows not many other children near her house to play outside with. Dewi’s mother mentions that Dewi plays outside more often since she started physiotherapy, while Dewi states that it is because her fight has been solved. Randy, Kim, Anna and Denise according to their parents are real ‘buiten kinderen’, children that always play outside.

**Television and computer**

Six children mention television, computer or play station as domains in their daily lives. They all like watching television and playing with computers, but also state that both are unimportant. Anna says:’ when you watch television, you don’t do sports and when you are
behind the computer you are inside and then you cannot play outside’. They only consider television and computer important if they teach you something or if it is useful for school, like preparing presentations on the computer and Discovery on television.

All children state that they only watch television, mainly Nickelodeon or Fox Kids, when they have nothing else to do. Watching television is used as one of the strategies to overcome boredom. Being bored makes them feel bad; they rather do things ‘in your free time you need to have something to do’ (Darrell). Other strategies against boredom are phoning friends, going outside to play, listening to music or having a busy schedule like Denise that proudly ends her description of her daily life with the words: ‘so I have something the entire week’. Playing games on their game boy or playstation or chatting on MSN and surfing to other websites on their computers is also done when bored, however when they do it with friends it is considered an important activity.

Sports
Most children complain that they are not good at sports because of their body size. Randy notes that he is not good at running because of his fatness: ‘my friends are very slim and they run really very fast and I cannot keep up with them.’ They notice that it is more difficult for them to do sports,. They cannot keep up with other children, become tired quicker and are chosen last or not chosen at all, if their friends are not allowed to choose. They feel their bodies when they run, like Dewi who feels her body ‘going up and down’ and Linda who feels pain in her legs ‘when I have walked a couple of minutes’.

Being fat and eating
Most children associate being fat with food or eating. An example of this association is noticeable in Denise’s phrase: ‘when I feel good (...) I forget everything: that I am a bit fat and eating much and all that’. She feels fat mostly when she is hungry.

Denise: ‘then I think should I eat now or not, if I will eat than I will grow fatter again, but if I do not eat, then later on I will be hungry again and then I will empty the complete cupboard again and then I am hesitating and most of the time I do eat and that is why I am fat’.

Anna also mentions at the start of her first interview that she just ate an ice-lolly instead of a Magnum because she knew she was going to be interviewed about being fat. Dewi states that when she sees delicious food she does not think about being fat and when her mother is asked
to describe her daily life, Dewi answers that she eats too many sweets, although her mother and sister disagree and say that Dewi does not eat too many sweets at all.

Not only the children themselves associate being fat with food and eating; the people and children around them also blame them for eating too much or eating wrong things. Anna tells:

'I brought chocolate flakes (chocolade vlokjes) and then they said: 'so, are you going to eat that; are you nice and fat' and then I only ate a little bit and then later on I was very hungry, since I had only eaten one slice of bread with nothing'.

Denise and Sandra describes the dilemmas they face with food when they are with friends

Denise: ‘When I see someone eating chips then I think, o no don’t ask, because asking ‘can I have this or that’ or when they ask ‘would you like something’, than it is hard for me to say no, than I will take it, and then you see what happens after’

Sandra: ‘when I go with friends to the shopping mall they always go to the Jamin [a Dutch sweetshop] to buy sweets and most of the time I get some sweets from them, but I never buy sweets myself. I just tell them that I have no appetite, while I do have desire for sweets, but then I won’t take anything’.

The majority of children describe the conflicts they have with their parents who try to restrict their children in eating. Dewi and Denise tell their experiences.

Dewi: ‘when I asked can I have a candy, my mother said ‘no, because otherwise you will become fat again’ and then I said ‘boy o boy’ and then I was really angry’.

Denise: ‘then my mother says don’t eat so much and then I did not eat so much that day and then I thought do not interfere, this is my life’.

Being fat and health care system

Linda and Anna are the only ones that bring up medical complaints. Linda minds her pain in her legs and ankles very much and mentions that she feels fat when she is weighted when she visits the paediatrician. Anna tells about her incontinence problems and complaints of pain in her neck and back. Both Sandra and Darrell really realised that they were fat when going to the DVC. Darrell: ‘If I don’t do anything about it now I will always stay like this’.

Being fat and weight

Given their stories weight seems to be an important feature in their daily lives. Children in general exchange their weights with other children. Also the children interviewed knew the weights of most of their friends, while they themselves did not share their weight with their friends although they were asked for theirs frequently. Being weighed also makes them feel bad as Linda and Kim express when they were weighed recently.
Not feeling fat

The children do not feel fat when they are playing (outside) with their friends, when they are making fun or when they are part of a group. Darrell states that he did not feel fat because he was considered normal by his friends. They also do not feel fat when they are doing sports that they are good at, like when they win from someone that is faster or when they do sports they like such as swimming because they feel lighter: ‘when you jump [in the water] then it is just as if you fly or as if you are thin, because then I do a twist and then it feels as if I am a ballerina and then it feels just as if you are always thin’ (Anna) or ‘in the swimming pool I don’t feel fat; I say water bomb and then poof’ (Linda). Anna mentions that when she is able to run fast, she feels thin again. Randy also feels thin when he is concentrating playing darts or power kiting.

Strategies not to feel fat are to make fun or to just not think about being fat. Dewi tries to think that she is content with her body size and tries to feel beautiful, although she also tries to be thin. Some children avoid looking in the mirror. Darrell reminds himself that fat people can become famous too, like Haggrid in the Harry Potter stories.

The children also recognize some advantages of being fat. They feel stronger or look stronger which can be helpful in playing judo or in fights. Linda says: ‘when you have a fight and you punch them they will realise that you are a bit painful and heavy’ and Randy: ‘when they hit you in your belly, you will not feel it’. Darrell tells that children used to be afraid of him because of his size. He also mentions that he had friends that told him that fat people were cosier which he now doubts because of his own experience of losing weight and feeling as cosy as before. Anna agrees with her sister that says that fat people are nicer than thin children, also because she knows some thin children that are really unfriendly.

4.2 Bullying, side effects and strategies

All children mention that they are bullied because of their fatness, but at different stages in the interviews. Dewi and Denise bring it up spontaneously when they describe their daily lives; Randy and Kim bring up bullying when asked whom they dislike in their daily lives. Anna talks about it when she is asked what makes her feel fat. Linda mentions bullying as a bad experience of being fat and Sandra says ‘I would not been bullied any longer’, when asked “what will happen if you would be different”
Words or phrases used by bullies are ‘fatso’ (dikzak), ‘hey, plumpy’ (bolle), ‘what do you want, plumpy’, ‘plump giant’, ‘I can use your underwear to camp in’, ‘big’, ‘fatty’, ‘fat-guts’ (vetzak), ‘fritter’ (oliebol), names of fat animals like ‘cow’ and ‘elephant’, ‘globule’ (bolletje), ‘fat bridge’, ‘fat worm’, ‘sumo-wrestler with tits’. Darrell even describes a bullying game, in which children put candy on the floor for you to pick up, so that they can bully you for eating too many sweets. The children also get dirty looks (Sandra), thoughts ‘so, that one is fat’ (Denise) or whispers ‘if I walk through the corridor they start whispering, because I am too fat’ (Kim).

The children have strong emotions when bullied. They feel sad and sometimes cry at school or at home. They do not like being bullied at all. They often feel very angry and sometimes fight back, like Kim who started a fight when she was called ‘fat worm’. They become irritated of people that bully them all the time. Dewi blames the parents of children that bully her: ‘parents should be more sensible and educate their children better’.

In their descriptions of bullies they make many nuances. Some bullies are boys and girls that they do not know and are often mentioned as older boys or girls. However, the most frequently mentioned bullies are boys or girls from their class or from their neighbourhood. They describe them as nuisances and people they really dislike. Some bullies can also be quite nice too. Dewi describes her classmates that called her ‘sumo wrestler with tits’ as ‘not stupid, and ‘really nice’ since she knew that they meant it as a joke. Some bullies have been old friends. Brothers and sisters can also be bullies, which they dislike even more: ‘it is worse when sisters and brothers bully’ (Anna). Denise whose last name is Groot -which means big in English- was even bullied by her teacher: ‘every time I did not pay attention, [she said]’look lady Big’, but very explicitly ‘big’. Darrell states that bullies are mostly thin and should take children of their own posture to bully instead. He thinks that fat children will not bully because they are afraid of being bullied back and because they know how difficult it is to be fat. Denise thinks that children that are fat themselves should not bully.

Denise: ‘When I had a fight with someone who was somewhat fat, not as fat as me, but he was fat, he called me what do you want, plumpy and then I said, you are also not one of the slimmest, then he stopped immediately’.

Some children are also teased for fun, which they do not mind, like Linda who tells that an old man in the old people’s home in which her grandmother lives called her ‘hey, fatty’: ‘then
I do not mind, then I think ‘hey fatty’ is funny’. All children admit that they themselves bully too, but only when they are bullied first or about other matters like girlfriends and boyfriends.

*Side effects of being bullied*

Some children mention the dilemmas they face when they are bullied. For example Denise finds it hard to reply to the bully.

Denise: ‘then you cannot say anything any longer, because you [the bully] have touched a strong point (read weak spot) and then if you would answer ‘yes, you slimmy’, then they would say, ‘I am happy to be slim and not as fat as you’, you know, so that you cannot answer’.

Kim has the same experience; when she was called ‘fat worm’, she replied: ‘I can still do something about my fatness, but you cannot do anything about your ugly head’. Unfortunately the bully answered back: ‘but then you admit that you are fat’. Most children are also afraid that in fights, the others that they are fighting with will start talking about their fatness.

Bullying often has bad consequences. Anna for example stopped playing judo because of being bullied by two newcomers. She also does not play outside when certain children that bully her are playing outside. Sandra did not participate in physical education for a year because some older girls from the secondary school bullied her. Dewi even states that she does not like school because she is bullied. Worse, bullying can even bring isolation. Linda clearly states:

‘because they bully me, then I think, I will play on my own; then I am just going to sit on the slides and that I don’t mind and then they will ask me will you join is in playing tag and then I will say no I don’t want to and then they will say you are it and then I answer no, that is what they always say to me.

Some children also mention nice experiences, when bullied, like being supported by their friends, children in their neighbourhood or even by others they do not know.

Darrell: ‘a few years ago I was in a playground and then I was bullied and then some people that I did not know at all came to support me’.

*Strategies to deal with bullying*

During their conversations all children mention possible strategies to deal with bullying. Darrell hesitates to tell his effective strategy.

‘It was good on the one hand, but also not really good, as I said before, because I was bigger people were afraid of me and an immigrant started calling me names and I had already warned him a few times and stood in front of him, I was one head taller than him, but he was not afraid of me, and that lasted half a year and then I pushed him to
the ground one time, and then he said ‘sorry, I will never do it again’. I had also told
the teacher and she had told him of a few times but he still continued, but after I had
pushed him he stopped. I did not like doing it this way, but it had to happen just once’.

Sandra after she joined the DVC now laughs at the children that bully her. She does not really
care what they say any longer, because she got used to it and because she learnt to bully back
and to just laugh. Most of the children in their stories bully back. When they counter bully
they use words expressing the external parts of their opponents like ‘nail, steak of a horse,
thin stick or thin leaf’ for their slim body size or words for their skin colour or ethnicity. Often
they use expressions like ‘look at yourself’, ‘look in the mirror’ and ‘say to yourself what you
have just said to me’.

The fake letter of Maaike or Dimitri, their fellow-sufferer proved very helpful in exploring
their strategies. Most children answer that they try to solve being bullied themselves, most
of the time by ignoring it, by walking away or by fighting it, like Kim who tells her bullies: ‘if
you do it again, then I will really hit you, (...) because you have challenged me and made me
angry’. They also tell the teacher whom they expect to do something about it, for example to
punish the bully. They tell their mothers if the bullying takes place outside school or if their
teacher has not been effective. Most children mention that making good friends and becoming
part of a group are also good strategies.

Dewi: ‘find good friends that support you, otherwise you will be nowhere without friends,
you should never be afraid, that someone bullies you, you should never feel left out, if
you feel lonely you should just ask if you can join in a game’.

Denise ‘first tell the teacher and if she does not do anything or she does but they still continue
then I would ignore it and any how find friends that you can be really friends with and
if then they will still continue or if you get tired of it, yet again go to the teacher that
you really do not like it or in case nothing helps tell your mother so that your mother
can still phone school. And if they still continue, I would really do something about it
and I would ask them ‘can you please stop for once, because I really do not like it’.

4.3 Clothing and how to hide being fat

One of the most important experiences that make the children feel fat is when they have to
wear or fit clothes. They do not fit clothes that they see in shops or with their friends because
they are too tight or show their body size, ‘when I wear a very thin T-shirt (...) my belly
comes through’ (Denise). They go to special shops, because for example Cool Cat clothes are

12 these letters can be found in the appendix
too narrow; they buy bigger sizes for adolescents or adults that they have to adjust for their height or wear newly made clothes: 'you have to sew, sew, sew and knit and then you need fat girls clothes'(Anna). They often walk from shop to shop until they at last find something.

Linda: 'When we go and buy cloths we walk quite a bit and then I get painful feet, because clothes are often too tight and then I do not like it because I do not fit it and then I feel sad but then my mothers says: “no, that one is much too tight” and then she looks for one size bigger and then the legs are like this’.

Another problem is that they cannot exchange clothes as many of their friends do, also because they do not want their friends to know what size they have.

Clothes on the contrary can also make them feel proud ‘if I really had problems buying clothes I would not have so many’ (Kim) or thin ‘in this I almost look thin’ (Anna).

*Hiding being fat*

The children try to hide their fatness by wearing clothes that make them look thin, like airy clothes, black clothes, very wide T-shirts and trousers, or on the other hand very tight trousers that fit over their bellies. Darrell remembers that when he once participated in physical education without wearing his T-shirt that normally hid his belly, he felt really fat. Both Darrell and Denise let their mothers buy their clothes, because they do not care about clothes. However, Denise admits that when she is thin she ‘for one time will be crazy about clothes’.

Dewi needs her mother to judge if clothes really suit her, because sometimes she sees something she really likes and desperately wants, while her mum advises her not to buy since suit her. The girls do wear bikinis but make sure the bikinis fit nicely and cross their arms in front of their belly to hide it because ‘when I (…) look down, I see a big bump’ (Kim).

Other ways to hide their fatness instead of clothing are to hold their breath, although this does not work for Anna who says ‘if I hold my breath, my breasts come forward and then you instantly see that I am fat’. Some say they try to loose weight or do sports to hide their fatness. Others hide themselves when changing for physical education, although both Randy and Kim say that they have no problems changing themselves at the gym because other children already know ‘that I am fat’ or ‘that I am like that’ and that there is no need for hiding. Not going to school (Anna) or telling an idle story that you are hiding your slimness with lost of clothes (Linda) are other ways to hide their fatness.
Dik zijn is:

Hebben geen vrienden
is niet leuk
als je niet kunt
Hoef nu nodig
als je dit bent

Sommige kinderen
niet leuk

Ongaafig
Dik zijn is:

Maar dik zijn is soms wel leuk dan He lijf verschil.

En soms wordt het dat dat is niet leuk als de dikke buik op een andere manier dan ook.
Chapter 5: Perceptions on body size

This chapter describes the perceptions of overweight children regarding their own body size and body size in general. The first part starts summing up of all the words that were used throughout the research by the children and their parents to indicate being fat. Furthermore it describes the body images of the children and shows some of the messages the children receive from the people around them. The second part deals with their body dissatisfactions and perceptions of beauty. Part three explores why it is important to have normal body size and why the children feel different.

5.1 Children’s body images and the influence of messages around them

The children use many different words to express being fat. Most of the children used fat (dik); other terms were robust (flink), big (fors), big (groot), broad or wide (breed), firm (stevig), chubby (mollig), heavy (zwaar), plump (bol), round (rond), blubbering (flubberig), overweight (overgewicht) and obese (zwaarlijvig).

Anna, Randy and Darrell seem to have no difficulties using the word fat, while the rest of the children rather use other words instead. Sandra for example uses the word robust instead of fat. Dewi uses many words; she calls herself the broadest, firm, big, fat and blubbering. Linda talks more about being heavy. Darrell is the only child that uses the term overweight. Denise rather likes to be called chubby and she argues that others, like her parents or her general practitioner should not use the word fat; ‘as a GP you are not going to say that there are many fat children, just chubby children, because fat, that doesn’t sound nice.’ When she talks to someone else that is fat, she also uses the word chubby; however, she does not mind using the word fat for herself. Kim does use the word fat, but she actually does not want to talk or think about being fat at all. None of the children used the Dutch word ‘vet’ (fat or greasy) to indicate their body size. They did use this word to describe fatty foods (vet eten) or in their explanation that people are fat (dik), because of having too much fat (vet). They did use the Dutch word ‘vet’ in bullying terms like in ‘vetzak’ (fatso).

Descriptions of themselves

Most children mention their body size when they answer the question “can you describe yourself”. They say: ‘I am fat’ (Randy) or ‘I am chubby, fat, whatever you call it’ (Denise).
Some only name some body parts, like Kim: ‘I have a round face, a bit plump, and for the rest I don’t know’. Linda mentions her fat calves and her belly and Anna her lips and calves. Denise also specifies her fatness: ‘I have fat calves and in my face it is most prominent’ and Dewi shows it by shaking her belly. The belly, the ‘titties’ (tietjes), the head, face and cheeks seem to be the most important body parts that show fatness and are used as indicators to see if someone is fat or not. For example Sandra explains that she is fat because she has ‘a bigger belly than others’.

The children, except Darrell, also described their body image with the help of silhouettes of a chubby, average and thin girl or boy. Randy and Dewi think they look like the chubby one. Kim, Linda and Sandra choose the average one because the chubby one is too fat, ‘I am not that fat’ (Kim), and the thin one is too thin. Linda does not have such fat legs and arms. Denise chooses her body size between the chubby one and the average one and Anna cannot decide between these two because the chubby one is really very fat, while the average one has something ‘skinny-ish’.

Messages from parents

The body image in general is very much constructed by the beliefs and ideas within a particular family, society or culture. These children too receive messages from the people and society around them. In the first place, they receive messages from their parents on their body size, such as ‘My mother thought I was fat’ (Kim.) or ‘My parents mostly tell me, you could loose some weight (Linda)’ and secondly the children’s body image is influenced by what their parents think of their own body size, which have been described in chapter 3.

Some children show that they have internalised their parents messages into their own body image: ‘My mum always says that I am robust, so I’ll say so too’ (Sandra) and ‘Yes, I thought ‘well because my mother said it, I didn’t want to, but later on I felt quite fat myself too’ (Denise). Randy explains that his parents think that he is too fat for his age but that he is also ‘somewhere in between [fat and thin]’ and then he described himself as ‘I feel fat, but also not too fat, but a little bit in the middle.’

To compare these messages to how the parents actual see them, some descriptions by parents are given here. The parents too describe their children as fat, firm or robust. Randy’s parents tell that Randy is fat, although he is getting better; they want him to get rid of his belly and
Dewi’s mother describes Dewi as ‘a round child that will never be slender’ and would like her to lose some of her belly. Kim’s mother portrays her daughter as fat, but well proportioned; ‘she has firm legs, arms, a firm belly and a round face’. Linda’s father calls Linda’s body size normal or a bit heavier while her mother says heavy. The mother of Sandra thinks Sandra is robust and does not really want to call her fat. Sandra’s father thinks she is just robust and really nice in holding (het is gewoon lekker vasthouden allemaal). The mother of Denise describes Denise as firm and a bit fatter than her sister. Anna’s mother says that Anna is obviously too fat, oversized and ‘weighs more then when I got married’. Darrell’s father describes Darrell as someone that had ‘a plump face’ but for the rest did not look fat: ‘only his movements showed that he did not have a normal posture’.

Messages of adults, children and friends around them
Moreover, the body image of the children is also shaped by the body sizes of other people around them, such as classmates, friends or adults they see. Sandra for example says that she feels fat because most of the children in her class are not fat. She judges her body size likewise in her experience in at a swimming pool party and in the supermarket.
Sandra: ‘then there were a lot of very, not really thin, but also not fat, but just normal [children] and then I looked at myself and than I thought what a pity really’

‘I saw a woman at the supermarket who sat in a wheelchair that is how fat she was and then I thought I am not that fat’.

Darrell also says ‘that if you see people around you that are slimmer than you, you actually feel like an outsider’. He did not feel as an outsider when he joined the DVC because ‘the others were all a bit like me’. Dewi shares their feelings in her own experiences: ‘if you see ordinary children and you look at yourself then I am much fatter than other children, however ‘I do not think about being fat when I am in Italy, because then I see a lot of people that are like me, that are a bit firm too.’

In friendships body size is also very important. Most children mention that they have slim or normal friends. They however wonder sometimes why they have slim friends when they are fat themselves:
Denise: ‘sometimes I think it is a bit strange that they want fat children as their friend, I sometimes really think that, because most children that are left out are strange, they have glasses, or have a bracelet or they are fat or wear the wrong clothes.’
Anna clearly states that ‘although thin and fat do not fit for friends’ she has a lot of slim girlfriends. Darrell and Sandra do not mind having fat or slim friends: ‘they are just friends’. When asked “what their friends think of their body size” most children answer that they do not know, or that their friends never told them. Dewi thinks that her classmates will think she is fat, however she does not know what her best friend thinks of her because with her she just wants to have fun. When they talk about fat children themselves they emphasize that these children are nice or friendly too, as if this is not taken for granted, like Denise and Sandra that both add “but” in their descriptions: ‘there is a girl in my class who is very fat, but she is nice and there were some robust children but they were nice’.

Nearly all children do not really want to have the body sizes and shapes of models and other celebrities on television. Denise only wants to look like Britney Spears on the condition that she would be less skinny. Randy only wants to look like people on television because of their skills, like playing darts or being funny. According to Sandra’s mother and Marion Christiaans, children of their age are not so much influenced by the media, but more by what they see in shops or by what their classmates wear. ‘Children want to wear the nice clothes their friends and classmates wear’.

5.2 Body dissatisfaction and perceptions of beauty

In the descriptions of their bodies some children give a judgement of value instantly. Denise says ‘I am fat and I look like nothing’, while Dewi describes herself as ‘I am ugly, I have pretty eyes (...) and I am a bit too blubbering’. Dewi even describes being fat in negative terms using the word blubbering. In Linda’s description of herself she immediately says what she doesn’t like ‘My mum says I have muscular calves and she does not want them to go, but I do and I would like to get rid of this too (points at her belly)’. It is notable that two of the children that have participated in the Dikke Vrienden Club describe themselves in more neutral terms: ‘I am common, just me’ (ik ben gewoon, gewoon mezelf) (Sandra) and ‘now, I am normal’ (Darrell).

When they describe their body size, they often add how they feel about it too. Nearly all state that they are fat and that they don’t like that at all. They also show their fear of becoming fatter and do not want to ‘really fat’.
In their conversations they often show that they are dissatisfied with their body size and that they would rather become normal or thin or want to loose weight. Randy expresses his wish when he says ‘I think that I am too fat, yes, before I was just very thin and that is also what I want to be again’ and Dewi told herself when she felt sad: ‘I am not pretty and I said that I had to change completely, but that I cannot change, because I will never become very thin, so, but for me it is hard to become thin’. Linda uses the metaphor ‘bag’ for her body. She wishes ‘to unpack her pack’ less heavy.

Discussing their ideal body size, they all want to be thin except Darrell whose ideal body size is the one he has at the moment. Randy wants to be thinner because then he can run faster at sports days and Dewi wants to be like her sister, though with her own face and a bit thinner legs. Denise wants to be thin, but not too thin, because she got used to being fat and Sandra wants to look like her grandmother when she is old, because she is not fat. Linda also doesn’t want to be too fat or too skinny, but just normal: ‘Otherwise they will start calling me names because of my slimness like ‘thin stick’.

Using the silhouettes they all choose the thin silhouette as their ideal, although Sandra hesitates and thinks that the thin one might be too thin, since she neither wants to be too fat, nor too thin, but just normal. She definitely does not want to be like a girl in her class who is so skinny that you can see her bones. Kim and Anna wants to be like the thin one because ‘she is slim and pretty’ and ‘fits a lot [of clothes]’. Denise chooses the thin silhouette because she does not want to be like girls that are even thinner. Dewi is still dissatisfied about the waist of the thin girl and admits that she is ‘a bit difficult with these kind of things’. These silhouettes show that some children even employ a slimmer ideal size than the thin silhouette.

The children consider someone beautiful when he/she is normal, slim or average. Linda states that other people also find slim people more beautiful: ‘people would say they are very beautiful, they look pretty’ and Denise when she sees a slim girl also thinks: ‘wow, what a beautiful girl’. They do not consider themselves beautiful although they like certain parts of their body such as their hairs, arms or eyes. They also think that they will become more beautiful when they are slimmer. Sandra indeed feels a bit more beautiful since she lost weight after participating in the DVC.
Being slim is..

Most children use the Dutch word ‘dun’ to indicate a thin or slim body size. For them ‘dun’ has a positive meaning, therefore the word ‘dun’ is translated as slim, which also as a more positive connotation than thin. Sometimes they used the words ‘slank’ (slender) and ‘mager’ (skinny). Skinny was always used in a negative way.

All children consider slim as their ideal body size and believe that the problems they face with their body size in their daily lives will be solved once they are slim. They will not be bullied any longer, are able to fit all clothes they like and can run faster. They also do not want to become too slim, because very thin children are bullied too, also do not fit clothes and become ill sooner since they eat too little. Another reason why they want to be slim is that they believe as mentioned before that slim people are prettier. The following quotes illustrate clearly what being slim means to them.

Anna: ‘when I am slimmer I will watch myself so that I will never grow fat again and when I am slim, I am good in sports and dancing and will be able to go to ballet lessons and you can run really very fast and suddenly you are not hungry again or lethargic after dinner.’

Dewi: ‘when I am slim I am like other children and I will be able to do a double twist from the diving board.’

5.3 The importance of a normal body size

The children have the tendency to divide people into three groups, like Linda that explains that everyone has his ‘own type, because you have thin people, (...) ordinary people and (...) fat people.’ The other children also talk about fat, thin and normal people. In their conversations they show a wish to be normal, like other children. Anna states that she wants to be ‘just normal, a bit thin and a bit fat’. Darrell felt normal when he was still fat, but now when he is just like other people, he feels even ‘more normal’. While he was fat most of his friends saw him as normal, but he noticed that others only saw him as a fat boy. He also admits that when he was treated as a normal child, he also did not think about being fat.

When talking about what is normal a lot of children refer to the DVC, because they have the feeling or expectation that at the DVC they can be normal among the other (fat) children, ‘[fat] children are just different, because then you see just people that are almost the same’
(Dewi). Darrell’s reason to join the DVC was because he wanted to be just normal like his friends:

‘because [if] you are a bit chubby and other children look just normal than you feel a bit strange, since you have many normal children and then [there is] someone besides them that looks very different’.

The parents recognize their desires to be normal and just like other children very much. Denise’s mother thinks that especially when children go to secondary school they want to be just like others; you should not be noticed too much, therefore you should not very skinny and not really very fat, but maybe just ordinary, just like the majority of people. Kim’s mother agrees that children prefer to be the same; they are like small herds, it makes everything easy.

When asked if they feel different most of them reply that they are fatter. They especially feel different when they are confronted with the consequences of their body size. Dewi feels different because she can run less fast and has to wear different clothes; she rather wears things that other children wear. Kim feels different when she walks through the corridors in school and hears other children whisper about her being fat and Anna because she is not cool but a ‘good girl’. Randy feels different when he plays a game in which he has to run and when he is bullied, like Kim and Sandra. Being different means that you are different from the rest, which makes it more difficult to get friends or to be part of a group, especially if you are ‘not cool’ (Denise).

In some cases being different can be nice too. Linda states that then there is more diversity among people and being different gives Denise a nice feeling when she sees other fat children and therefore knows that she is not the only one. Denise also states that every child is different and that is what others should know too: people are different even in their appearances.

Wearing glasses, bracelets, being taller, silly hairs and looking like a boy (as a girl) are other characteristics that make people different; however there seems to be a hierarchy in these characteristics. For example almost all girls think that it is worse to look like a boy. Glasses are seen as the least stigmatising, because more people wear glasses. Some children say they even like them or would like to wear them. This hierarchy is also formed by the idea that if you can do something about it yourself it is a worse stigma. You for example ‘cannot do anything about wearing glasses yourself’ (Denise), but you can control your fatness (Darrell).
Dik zijn is:

- Sporten
- Om af te vallen (marathon)
- Schooten
- Meer vrienden bij de DVC Gekregen.
- Eindelijk je doel bereiken is geweldig.
- Mensen die je helpen
- Mensen die je pesten
- Erno gi voord
- Saken door gingen
- Mensen
Dik zijn is:

Het leuk maar soms ook niet. Om dat soms ook iemand pest en dat vind ik niet leuk! Op school doen ze dat ook!

Bevorderend: "Zeg!Als olifant denk ik dan zeg ik gewoon gewoon hij is een moer.

Je zéén dunnen spiet

Ha ha olifant dikkie

Ha ha hoe olifant dikker

Rijk dunner spiet en bij! Bij! Ha Ha!
Chapter 6: Being fat within the health care system

This chapter describes the experiences and expectations of the children within the health care system and the Dikke Vrienden Club in particular. The first part informs about the help they already received and explains why they seek help from the DVC and what they expect from health professionals. Part two deals with the reasons the children give for their own body size and for overweight in general and describes who or what they account for it. The third part explores the relations between being fat and health from the children’s point of view and what is healthy and unhealthy. Part four describes some of the children’s perceptions on food since they see food as one of the major reasons for being fat and shows some of their strategies to deal with food. In the fifth part the experiences of three participants of the Dikke Vrienden Club are described.

6.1 Medical background and why they want help

All children have been in contact with the health care system such as a general practitioner, a dietician, a paediatrician, or a physiotherapist. All children contacted their general practitioner to get a reference letter for a dietician or the DVC. Only Denise still remembers the content of the conversation with the GP that advised her to eat slowly to become saturated sooner.

All children but Darrell and Dewi have been to a dietician. Only Anna still visits her, while the others stopped because of several reasons. No weight loss or continuing weight gain were the most common reasons. Kim tells her experiences with the dietician:

'a dietician weighs you and takes your height and then she only talks about food. You cannot eat this and you cannot eat that but she does not explain things clearly'.

Kim did not like her mum being present during the consultation with the dietician, because her mother used to tell things to the dietician that Kim did not want to hear. Kim did not explain which things she did not like to hear. Kim’s mother stopped because Kim rebelled against going to the dietician. Randy was also unhappy about the dietician, because 'she really could not do much, she said you have to eat less and she weighted me, but she did not say that I had to exercise'. Denise stopped because she was not allowed to come any longer because of an unpaid cancellation. Denise’s mother explains that they stopped because the dietician did not understand the reasons for Denise’s overweight any longer since Denise gained weight rapidly while she had a healthy diet. Most children cannot recall what they learnt from the
dietician. Their parents, however, state that they within the family changed their eating patterns because of the dietician.

Anna, Linda, Dewi and Randy saw a GP or paediatrician to rule out the medical causes of overweight. Anna and Linda still visit the paediatrician for their weight and medical complaints.

Dewi and Linda do fitness under the guidance of a physiotherapist, which they both like very much, because they have fun and like their therapists.

All children also tried to loose weight on their own. Most of the time their mothers suggested to start dieting, like Linda: ‘when my mother says lets diet then I say okay and then we start dieting’ Most parents already changed to healthier food and restricted their children’s soft drinks, sweets and crisps. They motivate their children with rewards such as visits to the cinema or an ice cream at the end of the week. Some parents also try to involve the rest of the family in dieting. All parents are aware of the importance of exercise and try to stimulate their children to be active.

It is worth mentioning that to the children clothing and the possibility of buying new (smaller size) clothes are important drives to loose weight and are often used by their parents to motivate their children, like Denise: ‘my mother told me lets try to loose weight because then we can buy nice outfits again’.

What children want from health professionals in general
The children want help and support in loosing weight from their health professionals. Most children mention that they want a reference letter to the DVC from their GP. According to Denise the doctor should see if they are really overweight and maybe look for any other reason for being fat than eating too much food. They also want advice where to go to for help. Randy and Kim consider the paediatrician from the DVC as a different doctor than their regular GP because the DVC doctor helps them to loose weight.

Why do children go to the Dikke Vrienden Club and what are their expectations
Randy’s parents suggested him to go to the DVC. He did not want to go, because he thought that the DVC would only forbid eating things he liked. However, now he is participating his
motivation to continue the DVC program is his progress in his physical abilities. Darrell and Sandra were also asked to go to the DVC by their parents. They both did not really like going, but they did want to loose weight. Sandra admits that if she had not been bullied and fitted all clothes she liked, she would only have gone if she really had to. Darrell and Sandra both imagined the DVC as sitting in a small room with a doctor talking about being fat, receiving treatment and advice what to do about it. Darrell’s motivation to participate was that he wanted to become like other children and to become normal. Some other experiences of these three children will be described later in this chapter.

Anna and Kim state that their mothers want them to go to the DVC, though they themselves want to go too. Linda, Denise and Dewi are really looking forward to it. The reason why they want to go is to loose weight because they want to become thinner, don’t want to be bullied any longer and want to fit clothes they like. Linda states: ‘I would very much like to join the DVC, because I would like to wear a tight skirt’. Another important reason is that they want to go is to meet other fat children and make new friends. They want to try to loose weight in a group that supports each other and that shares the same feelings. They expect to make friends quicker, ‘because they are of the same kind and therefore do not bully’ (Linda). Dewi also wants to learn how to stop eating too much and how to do sports well. She feels that ‘it will be difficult in the beginning but if you keep on doing it, or do it more often, it will become easier’. Anna hopes to learn what is healthy and looks forward to a lot of talking, since that is what she likes. They also expect the health professionals at the DVC to be helpful and supportive.

The majority of children does not want to tell others about their participation in the DVC. Most of them are afraid of being bullied. Sandra told her classmates gradually, mostly because her classmates kept on asking her why she left school early on Wednesday afternoons. She was relieved that they reacted in a mild way. Randy only told his teacher and a friend that lives close because he also wondered why Randy left each Wednesday. Darrell did not tell it in the first place, but when he became slimmer he had to answer his peers why he suddenly had become that slim. He only received nice reactions. Dewi already told her teacher and her best friend, but hesitates telling others. Linda wants to keep it a secret and will just tell them that she will go to the hospital. However she is afraid of the children that will continue asking why she has to go to the hospital. Kim, Denise and Anna for now will not tell others.
6.2 Reasons for being fat

All children except Kim and Randy say that they are fat because they eat too much. Most of them are very explicit about it like Denise who says: ‘when I eat too much I instantly will become very fat’ or Sandra and Anna who give a lot of potency to food: ‘when I eat a bag of crisps I will gain 1.5 kilos (Sandra) or Anna thinks she gained again after eating just a small chunk of chocolate during the interview. Kim does not know why she is fat: ‘I used to be a bit fat and I do not eat much at all, but still I get fat; they should know that I cannot do anything about it’. Randy, like his parents states that he became fat after his appendicitis operation. He does not know any other reason. Sandra and Darrell also admit that they did not care so much about eating too much. Darrell says that ‘before the DVC I just liked food, now I may eat it’. Darrell adds that he had an incorrect eating pattern, since he never ate breakfast. Other eating patterns that contribute to their ability to eat much are: ‘when I continue eating so much my stomach will get bigger and bigger and bigger and then more food fits into it too’ (Dewi) and ‘eating too fast like in my family makes me not feel full quick enough. (‘ik zit niet snel vol’)’ (Denise). Some also admit that they eat much because they love food, like Denise:

‘..., I just ate too much, of course I love food and very nice stuff, but I also do not eat that much vegetables, I like spinach and broccoli and butter-beans that I all like, but for example I do not like fruits, I like mandarins, but melon I do not like and lettuce, cucumber and tomato I all do not like, that kind of things. That is really difficult’.

This phrase also shows that the children associate being fat with eating too much but also with eating ‘unhealthy food’ in particular, like eating too much chips (Darrell), too much sugar (Anna) and too many sweets (Sandra). What the children consider healthy and unhealthy will be described in part 6.3.

In addition, half of the mention that they have also gotten their fatness from their family: children. Dewi, Linda, and Anna got it from their father’s side, while Denise states that no one in the family is really slim and that additionally her father has a big belly. Sandra is the only one that says she has too little exercise.

When the children were asked how children in general become fat they, except for Kim who did not know the answer, mention too that those children eat too much and unhealthy food in particular. ‘They eat chips every day’ (Sandra) or ‘they eat too much fat and too many nice stuff (lekkere dingen)’(Denise). Darrell states that parents also contribute to the increase of fat children:
'People just do not pay attention to what their children eat, (...) Parents these days give their children more toys and games and really everything that they like, because they want their children to be happy, but if they become fat they are not really happy, in my opinion.'

Darrell also mentions the sweet factories and their advertisements as possible factors for the increase of overweight children. However, he does not give them full responsibility. They produce sweets and advertise for it, but children eat too much themselves. Denise agrees and says that 'sweet factories only want to make more money, while it is me that eats too much'. Darrell give a clear picture of how sweet advertisements work:

'When children watch them they will say to their parents: 'mum, look, that is nice and the child in the advertisement likes it too, so can you buy it for me' and because parents think: 'oh, it can not hurt if I try it as parents', but then they will buy just more and more'.

For himself when he watched sweets commercials in the past, he used to think: 'hey we do have that at home, I will get it'. Now his strategy to resist is to switch to a different channel when there is an advertisement for sweets.

It is evident that most of these children feel a certain responsibility for their own fatness. They eat too much or have eaten too much. In this way they also blame other fat children like Sandra: 'there is this girl in my class, that is much fatter than I am, but she says she does not need the DVC, because she can do it herself, but she eats nuts three times a week and she always eats crisps'.

When asked if they feel guilty they do not know the answer, but when asked "do you think you could have done something beforehand" most children answer that they should have eaten less or healthier. Denise nuances her feeling of guilt:

'When I have eaten too much I do not say 'oh, stupid, stupid, stupid me', but I do think what have I done, I become fat and fat much quicker, but I do not become slimmer that fast, so then I do think, what did I do.'

Sandra and Dewi also add that they should have exercised more. None of the children blame their parents for being fat or other people or things around them. Sandra explicitly says: 'my parents also cannot do anything about me being fat', although she also feels her mother could have been stricter with food when she was younger. Darrell remarks: 'I cannot blame other people for the delicious taste of chips'. Sandra is the only one that tells that other people around her often blamed her for her fatness, like: 'fatty you eat too much'. Denise and Sandra admit that their feeling of guilt motivates them to eat less, which unfortunately is only for a short period.
Most children agree that they can and should control their body size and loose weight. The strategies they describe for loosing weight or becoming thin are eating less, especially less sweets and crisps and exercise, like sports and dancing. Anna will continue sports until she is thin. Going to the DVC or to the doctor and drinking water and eating healthy are also possible ways to become thin. They all state that support by their parents and other family members such as their grandparents is important. Some children want their mothers to be strict about food and want that they help them in not eating sweets. They also say that it helps when people around restrict their food too, because ‘it is not nice if you have someone next to you eating popcorn’ (Darrell).

6.3 Being fat and health

None of the children see themselves as ill, or see fatness as a disease.

Darrell: ‘being fat is the way you are; some children can eat everything they like and do not gain a single gram, while other children do not eat that much but suddenly gain a kilo, so in a way if it is inborn, you are born fat’.

Randy: ‘I am not ill, because he got used to being fat’.

Most of the children agree that can do something about being fat, ‘unlike glasses that you cannot do any thing about’ (Darrell). Darrell explains that ‘being fat you may be (dik zijn mag); it is not good for you, but you can be fat’.

Although all the children have been in contact with the health care system, only some mention that being fat is bad for their health, like Kim who is taught by her mother that ‘if you eat too many sweets, you can get diabetes’. Randy knows that his parents are worried about his health, because he is too fat for his age, but otherwise he cannot explain the connection between fatness and ill health. Darrell learnt in school that overweight gives you a bigger chance to certain diseases, like fat that clots your vessels and Sandra explains that being fat can be unhealthy, if you ‘continuously eat bad stuff, that is really bad. First you will become fat and then you are bullied and not able to buy any clothes, then you might get ill, because of eating not enough fruits’.
Dik zijn is: Niet leuk en waarom niet. Omdat je haast geen kleding kunt kopen, en omdat je wordt uitgescholden.

Grote maten!

Scheld worden: Vetzak!
Jou onderbroek kan ik wel in dolken! Dit is erd!
Eigenlijk van alles.

Libelle Vakantie 9

Stop met diëten. Start met afvallen.
on Gezond

Goed
What is healthy and what is unhealthy?

All children when asked, "what is healthy" mention food, like vegetables, fruits, brown bread and cheese and not too many sweets or sports. Linda monotonously repeats the health message: 'vegetables and fruits, 2 pieces a day is already okay'. Darrell explains that 'you can do a lot of sports and be healthy but you can also just eat well and be healthy'. Other things mentioned are pills that can make you healthy and washing your hands before dinner. They all feel healthy especially when they eat fruits while other children eat sweets or when they do sports. In her drawing Sandra shows that fruits in some cases are not healthy: 'it looks really very nice, but it is really very bad for you, it does include fruits, but still it is bad for you'.

When they mention the advantages of being healthy it is evident that being healthy is more then just eating healthy food and doing sports: 'you are not different from other children' (Darrell); 'you feel good' (Denise); 'you do not have that need [to pick a lot of sweets], because then you are used to eat healthy food and then you will eat less sweets' (Dewi); 'you can grow taller, always when I eat healthy stuff, then I always grow and then I am always 2-3 cm taller' (Anna); 'you are never ill and then I never have to go to the hospital again' (Linda). Denise and Dewi bring up some disadvantages of a healthy diet, 'you eat almost nothing that is really nice' or 'you should have some nice things in life too, that is part of it too' (Dewi).

Being fit is different from being healthy and refers more to exercise and sports. Most children agree that you cannot be fit if you do not exercise. You can become fit by doing sports, but also by playing outside or by just being active. Sitting behind the computer makes you unfit. None of the children feel 'un-fit'.

What is unhealthy.

They consider someone unhealthy when eats unhealthy food. Unhealthy food consists of too much fat such as chips, too much sugar, like coke and sweets or too much alcohol. Sitting behind the television all day and smoking is also considered unhealthy. They also add that when you are dirty and live in the streets (Kim), 'when you do not do your homework' (Randy) or when you have wounds that can infect (Denise and Sandra) you are unhealthy too. The children feel unhealthy when they eat too many sweets, chocolate or sugar.

Being fat is only considered unhealthy when you are really fat, for example when you have too much fat, when you eat 3 hamburgers in a row or when you cannot walk any longer and
sit in a wheelchair. Sandra feels that ‘a slim person is not unhealthy, because whatever he eats he does not gain weight’ while Linda thinks that ‘slim people are often ill because they are thin and do not eat much’.

The photographic visual exercise contributed to the children’s construction of a healthy, fit and an unhealthy person. As healthy persons most of them took pictures of their parents, because they eat healthy, do exercises or just look healthy. Denise also took a picture from the Internet from Britney Spears, who she considered healthy because of her slimness and healthy diet.

Someone looks fit when he looks sporty, feels good (lekker in je vel), is strong and has muscular arms; on the contrary you look un-fit when you look sleepy. As fit persons they took pictures of their siblings or friends or of other people that were doing sports. Only Kim took pictures of unhealthy persons, like her friend that acted as someone that walked with a stick or a lady in the street that smokes and has unhealthy clothes, and unhealthy and messy hair13.

6.4 Perceptions on food and strategies to resist food
Since most children mention food as the most important reason for their overweight, this part describes some of the most salient perceptions on food. Because of the significance of the subject to them some children brought up food very often in their interviews. In their descriptions their pleasure for food is much present. Some examples are: ‘food is nice, food is delicious’ (Dewi) or ‘food is delicious when if you eat it, you like it so much that you want another one’ (Kim). This does not necessarily mean that they only eat unhealthy food and sweets. Dewi says: ‘I love more food, but my sister eats more sweets’. Food is also important to them: ‘if there is really nothing in the house then you would really starve’ (Sandra), ‘eating is important, because otherwise you will fall ill’ (Dewi) or ‘food helps you when you are hungry’.

Being hungry is the only reason given by the children to explain why they eat. They first feel hungry and then they start eating. Some reasons why they eat too much are because they are big and have no break (Anna), because they did not care (Darrell) or because ‘the food is so

13 the picture of a this ‘unhealthy’ person is shown on the next page together was other example of the exercise.
nice that I cannot resist it and then I forget that I am fat and that have to watch what I eat' (Dewi). Denise therefore is very happy when she is not hungry, because then she does not eat.

If they want to eat something they all ask their parents first. They are very good in asking. Dewi admits that she does not ask, but whines or food. Linda begs for food and just keeps on asking, again and again and again, while she her brother. Randy also keeps on asking 'please'. Some other tactics they use to get food, they really want, are the following:

Dewi: ‘after I have asked it very often and continuously, my mum says “please stop it” and then I say ‘please’ and sometimes it does work or I ask ‘why can I not have it? I did not eat well before; can I not have a tiny bit, only a tiny winy bit?

Kim: ‘if I get a candy now, I will eat my vegetables for dinner.’

Linda: ‘sometimes we have not had something for a long time and then I ask my mother can I have it and then I see another pack of cookies that I have not eaten for a long time’

They also sometimes take food without asking, which is mainly when they are home alone. ‘Sometimes I eat when my mother is not there, but that is not secretly. If I think she won’t mind, I’ll take it’ (Dewi). Some children admit they eat secretly or buy sweets or food by themselves. Sandra does not do it, because ‘why buy it yourself when it is already at home’.

Because eating less or healthy food is a way to fight their body size, the children also come up with a lot of food rules that are present in their daily lives. Dewi cannot eat ice cream:

‘since we have a promise between me and my mum, that if I won’t eat ice cream all week I will get 1 euro’;

Kim also has her rule for taking sweets, however she also makes new rules when necessary:

‘if I have not had any sweets that day I can take it; I only have to say no when I already had one, but if I get a second one I will keep it for the following day’.

According to the children mothers also have certain rules. Sandra tells when she asks for crisps, her mother will answer: ‘yes, but then you won’t get any during the weekend’, Kim can only eat sugar free sweets, Denise can only eat an apple or something healthy when she asks for something and Anna can only eat ice cream, if it does not contain chocolate. These rules can also be broken for example when your mother is not there, like Dewi that knows that if she is in Italy with her aunt, she can just take what she likes. Rules can also be hard to comply with, like Denise who admits: ‘when I am thirsty, I have to take water, but then I do take Fanta again. I cannot do it myself’. In some places it is more difficult to follow the rules and resist food, like being home alone and at school when children give treats (Dewi) or when
the teacher rewards with sweets (Kim). Denise feels that losing weight only makes her think about food more.

**Changed eating patterns**

Randy, Sandra and Darrell state that they have changed some of their eating habits because of their participation in the Dikke Vrienden club. Sandra eats less and eats fruits instead of sweets. She learnt to resist sweets and how to say no to it. In the past she used to just take sweets and now she first thinks about it. She never eats in secret any longer and she drinks a lot of water. She does not like to always watch what she eats. Randy eats less fatty foods and more fruits, because fruits give you vitamins. He also takes ice-lollies instead of ice cream. He does not bother eating less, because he can still eat what he wants, but less fat. Randy admits that when his mother says no: ‘I do not like it, but I won’t keep on trying’. Darrell changed his eating pattern to every day breakfast, lunch, dinner and 3 ‘in betweens’ of less than 100 calories. He also eats less sweets and less chips. He still eats chips but in smaller portions with curry instead of mayonnaise. He used to buy chips every time he passed by it, but now he knows how to pass it without buying. For Darrell it is not difficult to continue this pattern of eating. He experienced ‘that when you continue doing it, it will soon bring results’.

**Strategies not to eat**

Most children have ways to forget their desire for food. They go play outside, walk the dog, do nice things, watch television and visit friends, because then they forget to think about food or they just try not to think about it. Some also say words to themselves to be able to resist food they like: ‘you cannot eat now, you really cannot eat now’ (Denise) or ‘that is unhealthy, that you should not take’ (Kim). Kim also closes her eyes when she sees sweets. Sandra tells herself when she is offered sweets ‘it is better to say no’ and when she sees candy she looks at it for a while and then leaves it, while she says to herself: ‘don’t do it, don’t do it’. Randy learnt at the DVC to talk to his stomach, because the stomach tries to trick you: ‘stop it, I won’t listen to you’. He also learnt to drink water when he feels like eating and to leave when people offer him some food and do not stop offering.

Darrell and Sandra reveal that they avoid certain things. Sandra does not go to the sweetshops any longer and Darrell avoids visiting his grandparents on market days when the chips booth is present. He can resist chips now, but he still does not like it when his sister and mother take chips, while he cannot. They also both try to avoid sitting next to food on birthday parties.
When Darrell was participating in the DVC, he also used a strategy that he invented himself to resist food that was offered by others. He used to wear a coat with a chocolate bar in one of the pockets and if people offered him something he already had something. In this way he resisted sweets for one week and then as a reward he could finish the chocolate from his pocket at the end of the week. He proudly states that once he kept it in his pocket for two entire weeks.

6.5 Experiences with the Dikke Vrienden Club

Sandra, Randy and Darrell participated in the DVC. They all like joining the DVC, although Sandra did not like exercising and Darrell did not like the theoretical parts about healthy food very much. They all liked being with other children. Randy and Darrell made new friends. Darrell explains that the name Dikke Vrienden Club actually has two meanings. ‘First I only knew that I would meet fat (dikke) friends, but now I know I have made good (dikke) friends’.

The way they were treated or supported by the leaders of the group, but also by children in the group was of great significance to them. The children of the group supported each other, because they shared similar experiences and as Darrell says: ‘if you see other children loose weight, then you really think that you want it too and then you continue doing it and in that way, if someone had gained weight, we would all support him or her.’ Sandra and Darrell think that they could not have lost weight on their own and that other children also need the support of the DVC: ‘on my own it would have been much more difficult, because there are moments that you should be able to talk’ (Darrell).

The most important things Sandra learnt at the DVC are to say no to sweets: ‘I learnt to think more of myself than of a particular candy’ as well as to exercise more. She was also taught to ignore bullies or to bully back when bullied. The DVC changed her health—although she cannot explain what she really means by that— and she feels ‘healthier and fitter’ than before the DVC. Randy learnt to eat less fat food and do more exercises. Randy now walks to school instead of going by car and loves active activities with his parents during the weekends. The DVC means a lot to him, ‘because of the DVC I exercise more and I lost weight’. The DVC made Darrell ‘realise’ that he really had to loose weight and that he was exactly in the right age group, since he still grows in height. He also learnt to accept other fat children, since he
now judges chubby girls wearing short skirts and tight shirts as brave, while he does not really find them attractive. The DVC also made him realize that loosing weight is really possible with the help of the DVC and not by taking pills. 'It only works if you do something about it yourself. Darrell's biggest motivation to continue the DVC was that he lost weight: 'I remember that I was in the second session and then I saw that I lost weight and then I thought now go for it' and that he was supported by his father. For him being fat and the DVC mean: 'to finally reach your goal' which feels marvellous.'
Dik zijn is: niet leuk want

ik schaam me soms.

ze pesten ze soms.

veel kleding (leuke)
 Pas ik niet.

met rennen ben ik

minder

snel (komt omdat je veel zware buik moet mee dragen)

denk ik

mensen kijken soms gek naar me

Veel lekker mag ik dan niet aan

maar dat hoort erbij.

Was het

10/7
Dik zijn is:

IK WIL DU N ZIJN

heel erg stom
Discussion

This chapter describes and discusses the themes that are most salient in the every day lives of overweight children. First, it looks into the idea that child overweight is a social problem rather than a health problem. Secondly, it briefly introduces the subject of stigma that is attached to overweight and obesity in our society. Then, it examines the concept of overweight from the child perspective and goes into the causality of overweight from the child point of view. Furthermore it describes the overweight children in this study in relation to the present health messages and it discusses the importance of friends and being part of a group in the every day lives of children.

7.1 Being fat: a social problem or a health problem

All children that participated in this research perceive themselves as fat. Being fat from their point of view means that they are bullied mainly by other children or receive remarks from other people around them. Moreover, they have difficulties buying clothes and looking good; they experience problems with physical activities; they find it harder to make friends or worse to get boy or girlfriends. They feel different and sometimes jealous of thin or normal children and they often have a problematic relationship with food because they cannot eat too many sweets or as many sweets as their friends and because they always feel hungry. These experiences make them feel ashamed, unhappy and sometimes even isolated.

The children do not by themselves mention health in their experiences of being fat and do not consider themselves unhealthy or ill. They sometimes feel unhealthy when they eat unhealthy food, but they believe that only really fat people are unhealthy or ‘bad’ and they for sure do not consider themselves really fat. Some do have medical complaints that they relate to their body size, for example when they are physically active and feel pain in their legs, feet and backs. However, their desire to become thinner and loose weight derives from the problems they face in their social interactions with other children and people around them. The problems with their health are of lesser importance and additionally most of the children do not seem to be aware of the health consequences of being fat. These findings are consistent with results from a study done in the United Kingdom where school children aged 9-11 years old seemed not to be too concerned about the health consequences of overweight, but foremost had ‘social concerns not to be seen as fat’. In their views they expresse that it was
important to be thin, and that fat children would be bullied and unpopular (Dixey et al. 2001: 77).

Thus, the children experience being fat as a social problem and not as a medical or health problem and in this way, worry more about their social well-being than about their health.

In contrast to the children, the parents of the children interviewed, primarily worry about the health status of their children, sometimes because they have family members that have diseases that are associated with overweight or because they feel the pressure of the messages they receive from people around them, health workers and the media. They also experience increasing medical complaints in their children who gain more weight. Nevertheless, all parents are very much aware of the psychosocial problems their children are confronted with. Their motivation to seek treatment is to prevent further medical problems, but also to make their children more secure and resistant against the negative messages around them.

The health workers working at the DVC or in the field of child overweight also know that overweight children in this age group face many problems and that they seek help because of these everyday confrontations with their body size. They know that children view being fat as a social problem, while their parents seek help mainly for the medical consequences. They themselves feel that on the one hand obesity is a major health problem because of the consequences for the health system in the future, but on the other hand they emphasize that it is also a social problem that should be taken care of outside the health system in order to prevent the problem at an earlier stage.

Neumark-Sztainer (2003) an expert in the field (child) overweight wonders if the problems that overweight children face in their daily lives are not primarily due to the society's reaction to overweight in stead of to overweight itself. From this point of view society should maybe alter its reactions towards fat children in order to prevent further problems.

7.2 The stigma of being fat

The term stigma conventionally refers to any attribute, trait, or disorder that marks an individual as being unacceptably different from the “normal” people with whom he or she routinely interacts” (Goffman cited in Scambler 1998: 1054).
Research literature shows that hatred of fat children starts at an early age. Lerner and Gellert (cited in Cash & Roy 1999: 213) found that five and six year old children reacted with aversion to photographs of ‘chubby’ children, with 86 percent of children reporting that they did not want to look like such children. Caskey and Felker (cited in Cash & Roy 1999: 213) found that girls in the first through fifth grades attribute favourable characteristics to a thin silhouette, describing it as honest, happy, pretty, smart, kind and helpful, while in contrast, they perceive the fat body as lazy, sloppy, ugly, mean, dirty and stupid. Fraser (cited in Joanisse & Synnott 1999: 53-54) described children that saw ‘getting fat’ as their greatest fear.

The ‘non-overweight’ children in the focus group discussion in this study also view fat children as less favourable than slim children and even the overweight children themselves attribute more positive characteristics to a slimmer body size. Overweight and obesity are thus generally regarded as stigmatizing and a larger body size as a form of deviance.

Scambler (1998) states that in contemporary developed cultures more stigma is attached to conditions for which people are considered culpable (ie, achieved rather than ascribed stigma) such as overweight and obesity and that stigmatizing diseases can be further distinguished by their visibility and intrusiveness. Scambler (1998) also differentiates ‘enacted stigma’ which ‘refers to actual discrimination or unacceptability’, from ‘felt stigma’, which refers to on the one hand the shame associated with a certain condition and on the other hand the fear of encountering enacted stigma. (Scambler 1998: 1054).

The overweight children feel stigmatised because of the actual discrimination, because they are bullied and get remarks and looks from people around them (enacted stigma). However they also feel ashamed of being fat and fear further discrimination (felt stigma). The children feel ashamed for being fat because fat people in general are considered persons that have unhealthy food and exercise patterns, but also lack self-control, which is intolerable in our society.

Because of their fear of encountering further discrimination the overweight children use a number of strategies such as hiding their body size, avoiding fights and trying to make friends and become part of a group. This felt stigma also constitutes their wish to become normal like other children. Burgard (2004) states that ‘fat children are well aware of the message that “fat is bad” and see themselves as “being fat” rather than “having fat”’—that is, there is something
intrinsically wrong with them if they are fat'. (Burgard 2004:22). She wonders if we can expect fat children to feel and act differently while children and other people around them, as the children of the FDG clearly illustrate, ‘harass’ them, ‘spotlight their weight’, and ‘drum into them the insistent message that fat is bad’ (Burgard 2004:22).

All overweight children in this study had a history of ‘treatment’ within the medical domain and therefore had been ‘diagnosed’ with overweight. The application of a diagnostic label can “spoil” the identity of a person and can make him or her more vulnerable to stigmatization (Scambler 1998: 1054). However, in this study the overweight children were relieved to receive the diagnostic label “overweight”, because the label meant that they were going to receive help and support from experts: that is from people that were trained to help fat children but also from other fat children that shared the same experiences. The children already felt ‘abnormal’ or ‘deviant’ even before they were diagnosed with a disease because of the problems they faced in their daily lives. However, some overweight children disapproved of going to the DVC in the first place, because of their fear of encountering discriminations and unacceptability. This felt stigma also hinders the children to talk to their peers about their ‘diagnosis’ or their participation in the DVC.

7.3 Causality from a child perspective

Most children in this study feel responsible for their own body size and blame themselves for eating too much (unhealthy) food, unlike their parents who place predisposition as the first reason for their children’s body size. The children do mention that they are predisposed to being fat, but they foremost blame themselves for being fat. The ideas of the children oppose the belief of most health workers that think that the overweight children themselves cannot be blamed for their body size. The health workers do not attribute any role to the children in the causality of their overweight and obesity or the prevention of overweight. They primarily hold responsible the child’s predisposition and the changing society in which we live.

They do give children an active and very responsible role in changing their body size and therefore changing their eating and exercises patterns. They even feel that treating children and their parents is more effective than treating overweight adults. They also attribute an important role to the parents in teaching their children to deal with the changing society, but they clearly state that blaming the parents exclusively for the body size of their children obscures the complexity of the causality of child overweight. As mentioned before this
opinion differs from the dominant notion in the medical discourse that parents are accountable for the body size of their children. However, also because of this dominant notion, some parents do feel guilty that their children are too fat and that they have not watched their children’s eating and exercise behaviours close enough or have not been strict enough at an earlier age.

Some of the overweight children indirectly blame parents in general and not their own parents for the increase of child overweight. They feel that parents nowadays are not strict enough and give their children everything they like just to make them happy. None of the children accuses the society like the food industries or food advertisements. They do feel their pressure, but blame themselves for eating too much.

Most of the school children in the FGD’s blame fat children for their body size. Some mention predisposition as a reason while a few say that fat children cannot help it. They agree that fatness is something that you should act upon yourself and give many possible strategies fat children should undertake to become thin. The majority of the overweight children too agree that they should control their weight and also know many ways to become thin.

7.4 The internalisation of ‘health’ messages

The experiences in their daily lives and the descriptions of their body images clearly illustrate that both the overweight children and the ‘non-overweight’ children are very well aware of the present health messages in the medical and popular discourses. They are both aware of the dominant notions that overweight is caused by too much food and too little exercise and that to attain well being they have to strive to be healthy and fit. They also know that too many sweets, too much sugar such as in soft drinks, too much fat and too many crisps and chips are bad and that watching television and playing computer games are less important than playing outside and being active.

However, their perceptions on being fat and being unhealthy or healthy differ. The non-overweight children regard chubby children as unhealthy because of their unhealthy diets, while the fat children do not consider themselves unhealthy. The overweight children however do consider thin children healthier. Both groups of children link being slim very much too being fit and healthy and believe that fat children have the ability to become slim if they make an effort to eat less and exercise more.
Burgard (2004) states that on the one hand ‘we assume that thin people are “making better choices”, “eating more healthful foods,” or “being more physically active” whereas on the other hand fat children on the contrary make unhealthy choices and are less physically active. Most of the children that participated in this study were physically active and according to their parents had more or less healthy diets. However, all children attributed too much unhealthy food to their continuing weight gain. Burgard (2004) asks herself if we can expect fat children to make their own choices, when children and people around expect them to make healthy food choices and to be physically active. And when they do make healthy choices ‘the fatter children who are making an effort never see those efforts being recognized because they are not thin enough to be seen as succeeding’, whereas at the same time ‘thin children must be doing something right by definition’ (Burgard 2004: 23).

This study shows that the overweight children interpret and construct ‘health’ in their own way. They interpret messages they foremost receive from their parents, but also from their peers and other people around them. They associate being healthy primarily with food, physical activity and never being ill, but also relate it to feeling good and not being different from other children. These results show that these children attribute a wider meaning to being healthy and that they assign immediate benefits to being healthy.

This study also shows that the overweight children cannot resist the powerful health messages that too much unhealthy food and not enough exercise makes them fat. Most of their actions in daily life are influenced by these powerful messages. They feel responsible for their own body size and view it as a condition that can be controlled. Research also shows that children in general attribute ‘the fictional character’s weight gain to poor eating habits, implying a conception of obesity as controllable’ (Lowes&Tiggerman 2003:144).

One also has to keep in mind that the overweight children in this study have a history of ‘treatment’ in the medical domain, which also influences their ideas and interpretations on overweight. Their concept of overweight is thus constructed through the shared medical, cultural and social ideas that are present in their personal world and context they live in. Therefore, overweight children that have not been in contact with the health system may use different concepts of overweight and hold different ideas and practices.

The overweight children in this study who all see their body size as controllable also have the
desire to become thin and associate being slim with being beautiful. They themselves as their parents contest the idea that they are influenced by the media and its culture of slender. On the one hand the overweight children state that they only want to have a normal body size like other children, but on the other hand they all choose the thin silhouette as their ideal body size. This shows that they are certainly influenced by the cultural obsession with slender.

Dixey (2001) is concerned that messages that promote healthy eating, and the importance of not being overweight, also ‘may increase pressures on girls and boys to conform to an ideal body shape as presented by media images, or to the increase in eating disorders’ (Dixey et al 2001: 77). Loewy also warns that ‘the more pressure we put on children to conform to the ideal body type, the more we perpetuate the myth that this ideal can be achieved by everyone (Loewy 1998: 6). In this study it is not clear if this obsession with slender is created by the ‘treatment’ children received or already existed before ‘treatment’.

### 7.5 The importance of friends and being part of a group

In this study the themes friendships and being part of a group are very important. Kuik (1999) says that children in our society ‘are able to develop a peer culture’ since they are sent to school (Kuik 1999: 54). Yet, beside the peer culture at school there may also be a different peer culture when children play outside without the supervision of parents or teachers. The children in this study make friends at school, but they make different friends in their direct environment with whom they do different things. Being part of a group is as important at school as it is when playing outside. Some children did not play outside because they did not belong to a group and were bullied. The children mention that having good friends or being part of a group is a useful strategy to deal with bullying. In the aforementioned study in the United Kingdom schoolgirls aged 9-11 years old also suggested that fat children should ‘start a diet so she can get thin . . . and make friends’ (Dixey et al 2001: 76). The most important feature of being part of a group is that it becomes harder to be seen as different and therefore the chance of being bullied becomes less. The English study states that ‘any person who is different is bullied’ (Dixey et al 2001: 76). Kuik (1999) also states that ‘the popular children tease the less popular ones and that the visibility of physical imperfections makes it easier for children to punish rowdiness and lack of social skills’ (Kuik 1999: 56-57).

Some children admit that they sometimes find it difficult to make friends, because of their body size. This is understandable since research shows that ‘fat children are less likely than
other children to receive "best friend" ratings from their classmates and when shown silhouettes of fat and thin males and females, 9-year-old children rated the fat figures as having significantly fewer friends (Rothblum and Hill&Silver cited in Loewy 1998: 2).

According to Dixey (2001) ‘friends did not emerge as a perceived influence on eating habits’, apart from sharing sweets and eating at each other’s houses. However, ‘there may not have been an awareness of overt peer pressure’ (Dixey et al 2001: 76).

In this study the overweight children do mention that their eating habits are influenced by their peers, although it may be indirectly. On the one hand when among friends, they forget their hunger and eat less, while on the other hand they feel tempted to eat when their friends eat sweets or crisps they cannot have or feel pressured to eat when their friends keep on offering food, while saying ‘no’ is so hard. They face these dilemmas every day, especially since most of the overweight children have normal or thin friends and therefore this will influence their eating habits. Finally, it is likely that the present obsession with weight in our society as it is also described in this study will influence the peer culture and eating habits among peers.

The overweight children in this study also experience that it is more difficult for them to make friends and to be part of a group. They feel less physically competent than their friends because of their body size. Peers influence their perceptions on physical competence and therefore their perceptions on exercise. Not being able to keep up with their friends, feeling tired quicker and chosen last in games might lead to more difficulties in getting friends and loss of popularity, which again may lead to avoidance of exercising at all. Kuik (1999) in her research among Dutch school children aged 10-11 years old describes the importance of physical skills among children. ‘By comparing their physical skills, [the children] discovered differences between themselves’ and ‘were able to find and value their mutual differences easier than in speech’. These children ‘investigated who was the strongest, who could jump the furthest, dance the best’ and ‘compared their capacities in concrete competencies’ (Kuik 1999: 64). The health workers working in the field of child overweight are very much aware of the importance of peer pressure in relation to exercise.
7.6 Concluding remarks

Gender

Gender so far has not been described, although it is an important theme considering the concepts of body image, body dissatisfaction and the culture of slender. Gender issues were discussed during the interviews but being a boy or a girl did not seem to influence the perceptions and experiences of the children, their parents and the health workers. They did not feel that girls or boys faced different experiences in their daily lives or had different perceptions on their body size. They also did not feel that their strategies depended on being a girl or a boy. The only times the gender issue was raised was when the mother of Randy thought that it would be worse for a girl than for a boy not being able to fit fashionable clothes; when Dewi mentioned that she found it more easy to change clothes among girls, since girls would better understand how hard it is to be fat and when Anna concluded that girls become fat more easily because of the number of fat girls at school. On the other hand, research has shown that girls and boys feel that girls are more pressured than boys by the culture of slender (Dixey et al. 2001), which might mean that fat girls face more difficulties buying clothes and containing a positive body image, which was not the case in this study. However, one has to keep in mind though that most of the children that participated in this study were female, which may influence the results.

Influence of siblings

In this study most overweight children had normal weight siblings. These siblings were of great importance to the children interviewed and also to their parents. The overweight children feel that their siblings on the one hand are of great support to them, while on the other hand they feel worse when bullied for their body size by their siblings and sometimes feel jealous of what their siblings can eat, can wear and can do with their normal size bodies. Some see their siblings as role models and as motivation to lose weight.

Parents feel relieved that they also have normal size children since it lessens their worries, but more important it lessens the stigma of the family. Their normal weight siblings show that they as parents are able to nurture their children correctly and do not just stuff their children.

Some parents mention that they experienced difficulties feeding the sibling at a younger age, which may have influenced the eating pattern of the overweight child since for mothers and others involved in the upbringing it is a pleasure to feed a child that for once loves food.
Conclusion and recommendations

Conclusion
This thesis has been an attempt to explore the broader social and cultural context of overweight children in the Netherlands and to uncover the meaning of 'being fat' for children with overweight from their point of view. It presents the experiences of overweight children in their daily lives and their perceptions on body size.

It has also been set out to gain insight in the strategies overweight children use in their daily lives and how they, since they have been 'diagnosed' with overweight, perceive the medical discourse that indirectly blames the 'overweight victims' for their unhealthy lifestyle and lack of attempts to avoid the causes.

Overweight children in this study experience being fat as a social problem and not as a medical or health problem. They feel stigmatised by their encountered discrimination but also because of the shame of being fat and fear of additional discrimination and unacceptability. Their concept of overweight is influenced by the beliefs that are present in the world around them and by the problems they face in their social interactions with parents, friends, other children, teachers and other actors in their daily lives. The children internalised the health beliefs that overweight is due to eating too much and therefore predominantly blame themselves for being fat. In this way, they see overweight as a controllable condition. This notion may be influenced by their experiences in the health system, although the dominant belief that being fat is controllable was also present in the focus group discussions with 'normal weight' children. All overweight children see themselves as fat and are dissatisfied with their body size. They share the desire to become thin and be like other children around them and attribute positive notions to their ideal body size, which in all the participating children is slim. In this way, they are also influenced by the present culture of slenderness.

Making friends and being part of a group are extremely important themes in the daily lives of these children and help them preserve a positive identity and cope with the stigma of being fat. It also helps them to control their body size.
Recommendations

As mentioned before overweight children view child overweight more as a social problem than a health problem and are more interested to attain social well-being.

Parents, friends, teachers, health workers and policy makers should pay more attention to the problems faced by overweight children in their daily lives and should learn how these experiences and the social interactions they have with others influence their perceptions on their body size and their practices in dealing with their body size. It is also important to be aware of the possible effects, of being stereotyped and bullied at such a young age, in their later lives even if they have succeeded in loosing weight.

Health workers and policy makers should therefore realise that a medical solution to treat and prevent child overweight is not sufficient. One should also look for social solutions such as information and education on the psychosocial consequences of being fat, on the effects of bullying, on the consequences of the culture of slender and the culture of being healthy and fit, on the power of the food industries and their advertisements on television, on the upbringing of children in a changing society in which for example both parents work etc. Parents, schools, food industries, advertising and marketing companies, politicians and health workers should all work together to find effective and lasting solutions to treat overweight children and to prevent more children to become overweight. To only teach children health education is not satisfactory, firstly because children are already well aware of the present health messages and secondly because the reasons for overweight are much more complex than just incorrect food and exercise patterns.

Multi-disciplinary treatment-programs like the Dikke Vrienden Club that help overweight children to stabilize their weight gain and more important help them cope with their body size in their everyday life are good examples of combining medical care with social support. The children in this study felt relieved to receive treatment, but also felt stigmatised because they needed treatment for a condition that is seen as controllable. In this way, health workers should also be aware of the social implications of overweight itself, and of the social consequences of their treatment (programs). Health workers should be aware that these overweight children blame themselves for their body size and feel responsible to control it. They should also be aware that overweight children idealise the slender body size and that they desire to be slim.
Another step forward might be to increase the overall acceptance of fat children by their peers, especially because having friends and being part of a group is considered an important strategy to attain a positive identity. Acceptance by their peers might alleviate the problems overweight children face in their everyday lives and may contribute to an improvement of their quality of life. Considering this, one should be aware of the existing peer culture at school and also of the existence of the cultural beliefs and practices when children play outside. However one should keep in mind that ‘children even when they feel empathy for the bullied children, do not easily restrain from teasing and bullying: by teasing time and again the same children, the bullies evoke rules and norms for behaviour’ (Kuik 1999: 67). For example, fat children are not only bullied for their body size or for their unhealthy behaviour. They are also bullied because being fat also means lack of self-control, which goes against the rules and norms present in our society.

Recommendations of the children themselves
The recommendations stated by the children themselves relate very much to their notion that overweight is a social problem. It is noticeable that their recommendations deal with the detrimental experiences they face in their daily lives and are directed towards their peers mostly.

All of them want to teach others that fat children should not be bullied. Anna stresses that sisters and brothers especially should not bully. Denise emphasizes that others should not bully you for what you are, since everyone is somewhat different, also in their looks. Darrell thinks bullies are sad since they do not know how difficult it is to be heavier and Kim states that fat children might even be more enjoyable than thin children. She wants to be treated as a normal person. Dewi just wants to teach others how fat children feel which for her is the reason to participate in this study and Linda wants to teach children to just play together irrespective of what size you are.

Randy wants to teach other fat children that they should not take notice of bullying. Darrell wants to show other fat children pictures of himself from before and after the DVC to motivate others to join the Dikke Vrienden Club.
References

Borra, S.T., L. Kelly, M.B. Shirreffs, K. Neville & C.J. Geiger

Bouckaert J. & D. Matthys

Braet, C.

Braet, C.

Burgard, D.
2004 Protecting Children from the “War on Obesity”. *Health at every size*, (2) 22-24

Caputo, V

Cash, T.F. & R.E. Roy

Chang V. & N. Christakis

Christensen, P.H.

Counihan, C
Cramer, Ph & T. Steinwert

Dixey, R., P. Sahota, S. Atwal & A. Turner

Evans J., R. Evans, C. Evans & J.E. Evans


Greenhalgh, T
1997 How to read a paper. The basics of evidence based medicine. London: BMJ publishing group

Goethals, A, T. Hak & P. ten Have
1997 Kwalitatieve medische sociologie. Amsterdam: SISWO.

Grogan, S. & N. Wainwright

Hahn, R.A.

Hammersley&Atkinson

2001 Applied Health research; Anthropology of health and health care. Amsterdam: Askant

Helman, C.G.
2001 Culture, Health and Illness. London etc.: Arnold

Jeurissen E. & M. van Spanje
Joanisse, L & A. Synnott

Kohl H.W. & K. E. Hobbs

Kuik, S
1999 The magical Power of Words: About Children, Their Conflicts and Their Bodies. Etnofoor: 53-69

Loewy, M.I.
1998 Suggestions for working with fat children in the schools. Professional School Counseling 1(4)

Lowes, J. & M. Tiggemann

Moag-Stahlberg et al.

Neumark-Sztainer, D.
1999 The Weight Dilemma. International journal of obesity 23 (supplement 2) S31-S37

Paquette, M.C. & K. Raine

Renders, C.M., J.C. Seidell, W. van Mechelen & R.A. Hirasing

Rich, E

Rous, T & A. Hunt

Sands, E.R. & J. Wardle

Scambler, G
Schepper

Smolak L, M.P. Levine & F. Schermer

Sobal, J


Strauss, R. S., D. Rodzilsky, G. Borack & M. Colin
2001  Psychosocial Correlates of Physical Activity in Healthy Childen. Archives of Adolescents Medicine 155: 897-902

Streefland P.H.

Trakas, D & R. Wirsing

Van Dongen, E
1997  Eten, controleren, kicken en verzet, een zoektocht naar de betekenis van anorexia. Medische antropologie 9(2):322-341

van Winckel, M. A. & E. van Mil

Wilkinson, R

World Health Organisation

Zijlstra, H
Appendix 1  *team members of the DVC*

Marion Christiaans - JGZ, bijna klinisch psychologe
Marisca Renzen - diëtiste
Astrid van Meggelen - assistente psychologisch onderzoek
Karen Meiners - Fysiotherapeute
Anne Clair Nuyens - Fysiotherapeute
Jolande Bloem - secretaresse
Erica van den Akker - kinderarts
Micke Groen - psychologe en project leidster

Appendix 2  *General questions for parents*

| Beroep vader: | fulltime/parttime | ....uur |
| Beroep moeder: | fulltime/parttime | ....uur |
| School groep broer/ zus | groep: |

| Gewicht en lengte vader: | kg | cm |
| Gewicht en lengte moeder | kg | cm |
| Gewicht en lengte broer/zus | kg | cm |

Gewicht en lengte deelnemer

| Nu | kg | cm |
| Voor DVC | kg | cm |
| Datum deelname DVC: |

Appendix 3  *Questions accompanying the photographic visuals exercise*

**Lichaamsbeeld**

De kinderen zullen een aantal foto’s maken van:

1. jezelf hoe jezelf het liefste op een foto wil staan
   (met hulp van vader, moeder of iemand anders)
2. van mensen die je lief vindt (mag ook jezelf zijn!)
3. van mensen die je goed vindt (mag ook jezelf zijn!)
4. van mensen die je mooi vindt (mag ook jezelf zijn!)
5. van mensen die je normaal vindt (mag ook jezelf zijn!)
6. van mensen die je gezond vindt (mag ook jezelf zijn!)
7. van mensen die je fit vindt (mag ook jezelf zijn!)
Als je het leuk vindt mag je ook de tegenovergestelde dingen fotograferen of uitknippen. Je mag ook onbekende fotograferen.

1. zoals je nooit op een foto zou willen staan (mag je ook vertellen)
2. wie je onaardig, stom of vervelend vindt
3. wie je slecht vindt
4. wie je lelijk vindt
5. wie je abnormaal vindt
6. wie je ongezond vindt
7. wie je niet fit vindt

Appendix 4 Questions game

Wat is gezond?
Wat is ongezond?
Wat is ziek zijn?
Wat is bewegen?
Wat is snoep?
Wat is lekker?
Wat is eten?
Wat is fit?
Wat is zweten?
Wat is erbij horen?

Noem 2 manieren hoe je je trek in eten of lekkers kunt vergeten
Noem 3 dingen die de Dikke Vrienden Club voor jou kan doen
Noem 3 voordelen van gezond zijn. Weet je ook nadelen
Noem 3 manieren hoe je aan je ouders iets lekkers kan vragen
Noem 2 nadelen van dik zijn en nadelen van dun zijn
Noem 3 manieren hoe dikke kinderen hun dik zijn kunnen verbergen
Noem 2 manieren hoeje je dik zijn kan vergeten
Noem 2 dingen waarom sommige dikke kinderen naar de dokter moeten
Noem 2 dingen waarom sommige dikke kinderen zich schamen voor hun dik zijn
Wat wil je dat anderen moeten leren van dikke kinderen

Laat zien waar bij jullie in huis lekkere dingen te vinden zijn
Laat een fotoalbum of foto's van jezelf zien toen je jonger was dan nu
Waar staat de weegschaal bij jullie in huis
Laat je mooiste kleren zien en schoenen!
Appendix 5  Questions focus group discussion children at school
(also used during interviews with children)

Dagelijks leven
Alle kinderen krijgen een half uur om een cirkel te ‘vullen’ met de dingen die ze doen in hun
dagelijks leven. Daarna mogen ze de verschillende activiteiten markeren met rode stickers
voor belangrijkheid en gele stickers met een lachend of sip gezicht erop om te laten zien wat
stom en leuk is. Hierna komen we bij elkaar en zullen we gezamenlijk naar hun tekeningen
kijken.

Lichaamsbeeld

“Er komt een nieuw meisje bij jullie in de klas, jullie weten nog niets van haar, maar kunnen
haar alleen ‘bekijken’” Wat vinden jullie van haar? (abnormaal, mooi, gezond en ongezond)
Verandert het als er een nieuwe jongen in de klas komt?

We lezen een briefje:

Hallo ik ben Maaike/ Dimitri Ik ga volgend jaar naar een nieuwe school, maar
ben bang dat ik gepest zal worden omdat ik dik ben. Wat moet ik doen?
Maaike/Dimitri

We lezen een briefje:

Hallo ik ben Jordy/ Mirella en ik moet van mijn moeder naar de dokter om af te
vallen? Ik ben wel dik maar ik voel me verder prima. Is er iemand die hetzelfde
probleem heeft? Jordy/ Mirella

Wat is waar en niet waar?:

Als mij moeder zegt dat ik niet mag snoepen, snoep ik niet
Sporten is altijd leuk
Mc Donalds eten is alleen maar lekker
Als je dik bent ben je ziek.
Mijn gezondheid is het allerbelangrijkst.
Appendix 6: Silhouettes