Starting the conversation: A phenomenological study exploring Registered Dietitian’s lived experience counseling children living with obesity and their families

By

Brittany Roberts

A Thesis Submitted in Partial Fulfillment of the requirements for the Degree of

Master of Health Science

In

The Faculty of Health Science

Program

University of Ontario Institute of Technology

August 2014

© Brittany Roberts, 2014
Abstract

This study was completed in order to gain an understanding of Registered Dietitian’s lived experiences counseling children living with obesity and their families.

Between November 2013 and March 2014, 8 Registered Dietitians participated in a telephone interview or online survey where they reflected upon their lived experience counseling children living with obesity and their families. A phenomenology of practice design was used to collect and analyze the data in order to determine the lived experience of Registered Dietitians who counsel children living with obesity and their families, and what resources and education prepare them to counsel this population. The findings confirm that Registered Dietitians’ goal is to provide the necessary knowledge and resources to the families so they are able to make sustainable healthy lifestyle changes. To better their practice they would like a physical activity component in their education, more resources in family counseling, and motivational interviewing training.

Key words: Registered Dietitians, lived experience, childhood obesity, family, phenomenology
Dedication

I dedicate my thesis to my superhero up in heaven, my papa, *Dennis Roberts*.

Education has always been a large part of my life, ever since I was young. When nearing the end of my high school career, there was no question about continuing on to university and obtaining a degree. Although my ideas for career paths changed a time or two… or three… and I went through a stage of wanting to give up and drop out altogether, there is one person who never stopped believing in me – my papa. He was a very proud grandfather of all of his grandchildren for achieving post-secondary education.

After finishing my undergraduate degree, I decided to take it one step further and go to graduate school to get my Masters. This was an even bigger deal to my papa, as I am the very first Roberts (his side of the family) to go this far with my education. Not only was he happy that I was furthering my education even more, but he was so excited that I would finally be closer to home after being away for 4 years.

Unfortunately in the first few months of my MHSc program, my papa fell ill. November 1st 2012, heaven received another angel. The rest of my first semester at UOIT was very hard to get through, as I experienced an abundance of grief from my papa’s passing. However, I used the strength of knowing how proud of me he was for being there to work even harder and do the best that I was capable of.

I know that if my papa were still here today, he would be bragging and telling everyone he knew about my achievements and how far I have come. Because of this, it is my honour to dedicate all of my hard work to a man that always believed in me, never gave up on me, and encouraged me to be the best that I could be.
Acknowledgements

My journey the past two years at UOIT has provided me with an opportunity not only to enhance my academic career and gain valuable experiences, but also to grow as an individual. I would like to take this opportunity to thank everyone who has made an impact on this journey and has helped me along the way.

First, I would like to send a huge thank you to my thesis supervisor, Dr. Gail Lindsay. Thank you for taking your time to help me, mentor me, and guide me though the last two years. Without your understanding, patience, and assistance I would not have made it to where I am today. Although there were times throughout my research process that were more challenging than others, I am grateful for your motivation and valuable insights that helped me overcome these hurdles. Thank you for all of your help and knowledge, for encouraging me, and for standing by me every step of the way.

I would also like to the thank the other members of my committee, Dr. Meghann Lloyd, and Dr. Ellen Vogel, for all of the time and assistance you have provided me throughout my research process. Your constant support, guidance, comments and suggestions have been appreciated beyond words. Finally, I would like to thank Dr. Isolde Daiski for taking the time out of her busy schedule to serve as my external examiner.

I am grateful for the entire faculty in the Department of Health Science at UOIT, as well as my colleagues, for their support and for sharing their knowledge with me over the past couple of years. I would like to personally thank Sarah Prosser; we have spent the last two years working hard on our theses and you have put up with a lot of my venting. I
greatly appreciate your patience and I would like to congratulate you on all of your hard work and the completion of your degree!

Last but not least, I would like to thank all of my friends and family back at home for their continued encouragement. In particular I owe my deepest gratitude to my parents. You have stuck by my side through thick and thin. You provided me with a loving home growing up and created an environment that encouraged academic thinking and learning. You have shown unconditional support, both financially and emotionally throughout my degree, and you have had continuous faith in me. This alone has helped to get me where I am today and I know I would not have made it through without you.
## Table of Contents

### Chapter One
1.0 Introduction ........................................................................................................ 1  
1.1 Evolution of the Study .......................................................................................... 2  
1.2 Researcher’s Background ..................................................................................... 2  
1.3 Background ......................................................................................................... 2  
  1.3.1 Childhood Obesity ......................................................................................... 3  
  1.3.2 Defining Childhood Obesity ........................................................................... 4  
  1.3.3 Registered Dietitians and Childhood Obesity ................................................. 6  
1.4 Rationale ............................................................................................................. 6  
1.5 Research Questions ............................................................................................. 7  
1.6 Summary ............................................................................................................ 8  

### Chapter Two
2.0 Review of the Literature ....................................................................................... 9  
2.1 Childhood Obesity ............................................................................................... 9  
  2.1.1 Familial Influences on Childhood Obesity ...................................................... 9  
  2.1.2 Other Factors Influencing Childhood Obesity ................................................. 11  
  2.1.3 Health Consequences of Childhood Obesity ............................................... 14  
  2.1.4 Barriers to Treatment .................................................................................... 16  
2.2 Registered Dietitians ........................................................................................... 18  
  2.2.1 Registered Dietitians Attitudes Toward Obesity ............................................ 19  
2.3 Filling the Gaps ................................................................................................... 21  
2.4 Theoretical Framework ....................................................................................... 22  
  2.4.1 Qualitative Research .................................................................................... 23  
  2.4.2 Phenomenology ............................................................................................ 23  
2.5 Summary ............................................................................................................ 25  

### Chapter Three
3.0 Methodology ....................................................................................................... 26  
3.1 Ethical Considerations ......................................................................................... 26  
3.2 Sample and Recruitment ..................................................................................... 27
### Chapter Four

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0 Presentation of the Findings</td>
<td>31</td>
</tr>
<tr>
<td>4.1 Pertinent Characteristics of the Participants</td>
<td>31</td>
</tr>
<tr>
<td>4.2 RDs Lived Experience Working with Children Living with Obesity and Their Family</td>
<td>32</td>
</tr>
<tr>
<td>4.3 Defining Obesity</td>
<td>35</td>
</tr>
<tr>
<td>4.4 Practice Changed</td>
<td>37</td>
</tr>
<tr>
<td>4.5 Strategies Used to Help Children Living with Obesity and Their Families</td>
<td>37</td>
</tr>
<tr>
<td>4.6 Successful Intervention</td>
<td>39</td>
</tr>
<tr>
<td>4.7 Resources</td>
<td>41</td>
</tr>
<tr>
<td>4.8 Family</td>
<td>42</td>
</tr>
<tr>
<td>4.8.1 Assessing Family’s Roles</td>
<td>42</td>
</tr>
<tr>
<td>4.8.2 Motivating the Family</td>
<td>43</td>
</tr>
<tr>
<td>4.9 Issues That Do Not Involve Food</td>
<td>44</td>
</tr>
<tr>
<td>4.10 Physical Activity and Motivating Family to Become Active</td>
<td>45</td>
</tr>
<tr>
<td>4.11 RD Education</td>
<td>46</td>
</tr>
<tr>
<td>4.11.1 Prepared by Education</td>
<td>46</td>
</tr>
<tr>
<td>4.11.2 How Should Schools Prepare RDs</td>
<td>47</td>
</tr>
<tr>
<td>4.12 Life Experience</td>
<td>48</td>
</tr>
<tr>
<td>4.13 Summary</td>
<td>49</td>
</tr>
</tbody>
</table>

### Chapter Five

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.0 Discussion of Findings</td>
<td>50</td>
</tr>
<tr>
<td>5.1 Overview</td>
<td>50</td>
</tr>
<tr>
<td>5.1.1 Theme One: Registered Dietitian’s Lived Experience With Children Living With Obesity and Their Families</td>
<td>50</td>
</tr>
</tbody>
</table>
5.1.2 Theme Two: Family Roles.................................................................51
5.1.3 Theme Three: Measuring Success..................................................54
5.1.4 Theme Four: Registered Dietitian Education.................................55
  5.1.4.1 Motivational Interviewing.......................................................58
5.2 Practical Implications and Recommendations.....................................60
  5.2.1 Recommendations for Those Who Educate RDs............................61
    5.2.1.1 Physical Activity...............................................................61
    5.2.1.2 Resources........................................................................62
    5.2.1.3 Motivational Interviewing..................................................62
  5.2.2 Recommendations for Future Research.........................................63
5.3 Closing Thoughts..............................................................................65

6.0 References.........................................................................................67

7.0 Appendices.........................................................................................I
List of Appendices

Appendix A:  Initial Letter of Invitation.............................................................I
Appendix B:  Revised Letter of Invitation.........................................................III
Appendix C:  Initial Consent to Participate – Telephone Interview......................V
Appendix D:  Revised Consent to Participate – Telephone Interview...................X
Appendix E:  Consent to Participate – Survey....................................................XV
Appendix F:  Interview Guide........................................................................XVIII
Appendix G:  Timeline..................................................................................XXI
Appendix H:  REB Letter of Approval..............................................................XXIII
Appendix I:  REB Amendment Letter of Approval...........................................XXIV
Appendix J:  Demographics.........................................................................XXV
Chapter 1

1.0 Introduction

This thesis explores Registered Dietitian’s lived experience counseling children living with obesity and their families. In approximately 30 years the rates of childhood obesity have tripled (Roberts, Shields, deGrah, Azis & Gilbert, 2012). This is a public health concern as childhood obesity has both immediate and long-term effects on a child’s health and well-being. Registered Dietitians are educated to provide clients with knowledge on proper nutrition in order to guide them in making food choices (Dietitians of Canada, 2009).

Chapter one provides the evolution of study, the researcher’s background on the issue under study, an overview of childhood obesity and Registered Dietitians, as well as the rationale for the study, and the primary research questions.

Chapter two reviews the published literature and highlights the current body of knowledge for childhood obesity and Registered Dietitians, and it notes the gap within this literature. This chapter also provides the theoretical framework that is adopted for the study.

Chapter three describes the study’s methodology. The participants, sample selection, and recruitment methods are explained, along with the data collection and the data analysis methods.

Chapter four presents the findings of the study. This chapter describes the study’s participant characteristics followed by a detailed description of the results.
Chapter five provides a discussion of the findings. It also outlines practical implications and recommendations, recommendations for future research, as well as the study’s closing thoughts.

1.1 Evolution of the Study

This chapter provides the researcher’s background on the issue, an overview on childhood obesity and how it is defined, as well as Registered Dietitians and their relation to childhood obesity. A rationale for the study is given followed by the study’s main research questions.

1.2 Researcher’s Background

I have been interested in the childhood obesity epidemic for some time now. Throughout my undergraduate degree I took many courses that dealt with health and the health of populations. My interest in childhood obesity stemmed from a course that I took in my fourth year, Health in the Family. I completed a research paper on this topic and looked at different factors that play a role in childhood obesity.

Growing up, being active was always a big part of my life. I participated in house league soccer during the summer and had swimming lessons in the winter. In addition to that, I was always outside running, biking, and playing with the other children in my neighbourhood. Everyday when I got home from school I would finish my homework as fast as I could so I could go out and play. I stayed outside until dusk with the exception coming in for dinner.

I recognize there are many factors in a child’s life that may influence their health and weight, but seeing children being as sedentary as they are today and with the obesity
epidemic, I want to contribute to the literature in order to help current and future
generations. Taken together, this is one of the main reasons childhood obesity sparked
my interest and influenced my area of research.

1.3 Background

1.3.1 Childhood Obesity

Adults and children are both affected by obesity (LeBlanc, Irving, & Tremblay, 2007; Lau et al., 2007; Kuhle, Kirk, Ohinmaa, Yasui, Allen, & Veugekers, 2011). Obese children and adolescents have more of a risk of growing up to be obese in adulthood (LeBlanc, Irving, & Tremblay, 2007; Lau et al., 2007; Kuhle et al., 2011; Roberts et al., 2012). The older the child is when they become obese, the more likely they are to be obese at 35 (Daniels, 2006). Obesity is present in both the developed and developing world, and obesity among children has become a global epidemic (Flynn, McNeil, Maloff, Mutasingwa, Wu, Ford, & Tough 2006). Over the past two decades, the prevalence of childhood obesity has risen in Canada (LeBlanc, Irving, & Tremblay, 2007; Lau et al., 2007; Ball & McCarger, 2003; Barlow, Trowbridge, Klishand, & Dietz, 2002; PHAC, 2012; Ewing, Cluss, Goldstrohm, Ulrich, Colburn, Cipriani, & Wald, 2009; Roblin, 2007) due to environmental and cultural influences (Kumanyika, 2008; Lau et al., 2007) and now is causing a serious public health concern (Raj & Kumar, 2010; Daniels, 2006; Roblin, 2007). Between the 1970’s and the 1990’s, the prevalence of childhood obesity in Canada tripled (Wang & Lobstein 2006). The 2009 to 2011 Canadian Health Measures Survey determined that 24.8 per cent of Canadian children and adolescents ages five to seventeen were overweight or obese (Roberts et al., 2012). Obesity alone
accounts for 9.5 per cent of boys and 7.1 per cent of girls, which is triple of the rates from 1979 (Roberts et al., 2012; Roblin, 2007).

Obesity in children is influenced by many factors (Flynn et al., 2006). Studies have concluded that based on the substantial increase of obesity rates during the past two decades, genetics cannot be the main cause, therefore changes in the environment must play a larger part (Barlow et al., 2002). Children who have a genetic susceptibility and live in an environment where their physical activity levels are low, and they consume energy-dense diets, are placed in a position where they become more susceptible to obesity and increased health risks (Ball & McCarger, 2003). Children who become obese during their childhood find themselves in a situation where they are more likely to suffer health problems in adulthood, such as diabetes, high blood pressure and heart disease (Roblin, 2007).

There are complex factors that are associated with obesity (Roberts et al., 2012), therefore it is strongly correlated with long-term effects on the child’s mortality and morbidity (Wang & Lobstein 2006). A child’s health behaviour is influenced by social, environmental, and biological determinants that affect their daily eating habits and physical activity levels (Roberts et al., 2012). Therefore, attempting to prevent and treat childhood obesity is an urgent public health priority (Wang & Lobstein 2006) because at this rate, children today may live less healthy and shorter lives than their parents (Daniels, 2006).

1.3.2 Defining Childhood Obesity

In 2007, the World Health Organization (WHO) released growth charts for school age (5-19 years) children and adolescents (Collaborative Statement, 2010). These growth
standards are based on an international longitudinal sample of healthy children and they reflect how a child should grow if health is well maintained (Dietitians of Canada, 2013b). Measuring a child’s body mass index (BMI) is the most common method used to classify weight status (Roberts et al., 2012; Raj & Kumar, 2010). The BMI calculates a person’s weight relative to their height, in order to get an approximation of their adiposity (Roberts et al., 2012). However, looking at the BMI for children is only useful when it is plotted against the child’s age (Dietitians of Canada, 2013b). Since adiposity varies with both age and gender during an individual’s childhood, the Dietitians of Canada feel that the BMI–for–age calculation per gender is a good assessment of childhood obesity (Dietitians of Canada, 2013b; Flynn et al., 2006; Roberts et al., 2012). Once a child’s measurements are plotted, percentile curves are used in order to determine the child’s rank compared to other children of the same age and gender (Dietitians of Canada, 2013b). Children who fall within the 85th percentile are considered to be overweight, those in the 97th percentile are obese, and children in the 99.9th percentile are seen as being severely obese (Dietitians of Canada, 2013b). For example, if a child’s age and BMI are plotted on the growth curve and they fall within the 97th percentile curve, it means that 97 out of 100 children of the same age and gender weigh less than that child, or 3 out of 100 children of the same age and gender weigh more than that child (Dietitians of Canada, 2013b). In order for a child to maintain a normal health pattern, they must follow the same growth curve over time, they must fall between the 3rd and 85th percentile, and their BMI must be proportional with respect to their weight and height (Dietitians of Canada, 2013b).
### 1.3.3 Registered Dietitians and Childhood Obesity

Chronic disease prevalence has increased in Canada creating a burden on the health care system, and these chronic issues are intensified by Canada’s high obesity and childhood obesity rates that can often be affected by dietary practices, physical activity and sedentary habits (Dietitians of Canada, 2009). Registered Dietitians in Canada are health care providers who have specialized training in informing clients on proper nutrition, food, and diet (Dietitians of Canada, 2009). It is important for dietitians to be a part of the health care team in dealing with childhood obesity because they work with clients and their families and provide information about nutrition in order to influence them to make healthy food choices (Dietitians of Canada, 2009). This study looks at the RDs lived experience of counseling children living with obesity and their families within the scope of their practice.

### 1.4 Rationale

The objective of this study is to develop an understanding of the lived experience of Registered Dietitians who counsel children who are living with obesity and their families. It is important to capture the lived experience of RDs, working with this population; therefore a phenomenological approach (VanManen, 1984) will provide insightful descriptions.

Phenomenology of practice attempts to discover unique aspects of human existence within practitioner’s everyday lives and takes concerns of professional practices into consideration (VanManen, 2014). This approach is relevant to the study as
Registered Dietitian’s lived experience is explored; clarifying and deepening our understanding of these RDs in their field of practice.

Experience according to VanManen (2014) is described as the lived experience. The origin of the word experience in German is *erlebnis*, which includes the word *leben*, which means ‘to live’ (VanManen, 2014). Lived experience “aims to provide concrete insights into qualitative meaning of phenomena in people’s lives” (VanManen, 2014, p.40).

Findings from this phenomenological inquiry will have practical and scholarly implications. Since the late 1970’s, childhood obesity prevalence has risen, however it has not increased further within the past decade (Roberts et al., 2012). Although the prevalence has reached a plateau, it still remains a public health concern (Roberts et al., 2012; de Onis, Onyango, Borghi, Siyam, Nishida, & Siekmann, 2007) and it is important to recognize and understand the different patterns of practice used by practitioners who are treating this population. This research investigates the lived experience of Registered Dietitians who are engaged with this population. It contributes to the people in practice themselves, the RDs, those who educate the RDs, as well as organizations that employ the RDs.

**1.5 Research Questions**

This study is guided by the following research questions:

1) What is the lived experience of Registered Dietitians who counsel children that are living with obesity and their families? And,
2) What resources and education prepare Registered Dietitians to counsel children living with obesity and their families?

This study’s interview guide and survey provides questions that are related to the overall research questions and can be found in Appendices E & F.

1.6 Summary

In summary, it is clear that childhood obesity is a major concern in Canada (Raj & Kumar, 2010; Daniels, 2006; Roblin, 2007). Since an individual’s change in diet and everyday behaviours influences their likelihood of obesity, it establishes the need for Registered Dietitians to be a part of the process in counseling children living with obesity and their families. Gaining an understanding of the RDs lived experience in counseling children living with obesity and their families provide guidance and direction for the development of professional and continuing education for RDs. By increasing the knowledge and understanding of RDs lived experience with counseling children with obesity and their families, it allows the RD themselves and their colleagues to affirm and extend their practice. Chapter 2 provides a review of the published literature around this issue, how this study fills the research gaps, and what theoretical framework was adopted for the study.
Chapter 2

2.0 Review of the Literature

This literature review looks at themes concerned with childhood obesity related to the topic of the study, Registered Dietitians and their lived experience. The following themes are reviewed: familial influences on childhood obesity, other factors influencing childhood obesity, health consequences of childhood obesity, barriers to treatment, Registered Dietitians, as well as Registered Dietitians’ attitudes toward obesity. The theoretical framework that guided the study is also explored.

2.1 Childhood Obesity

2.1.1 Familial Influences on Childhood Obesity

Families are role models for shaping their children’s perceptions, behaviours, and attitudes, as they have the greatest impact on their children’s lives. Parents are the primary providers of food for their children and they have a strong impact on how their children view nutrition (Anzman, Rollins, & Birch, 2010; Sothern & Gordon, 2003; Davison & Birch, 2001). It is the parents’ responsibility to create a “home environment that fosters healthful eating and physical activity among children and adolescents” (Lindsay, Sussner, Kim, & Gortmaker, 2006, p. 170). Many believe that unsatisfactory nutrition and low levels of physical activity are contributors to childhood obesity (Sothern & Gordon, 2003; Roblin, 2007). This is especially true when the individual has a family history of obesity (Anzman et al., 2010; Sothern & Gordon, 2003). Children who grow up in an environment where the parents are inactive, are more likely to be inactive themselves (Sothern & Gordon, 2003; Davison & Birch, 2001). The results from
the 2004 Canadian Community Health Survey suggests that there are numerous children who are not consuming a balanced diet when comparing their food choices to the Canada’s Food Guide to Healthy Eating (Roblin, 2007). Approximately 59 per cent of children in Canada consume fewer than five servings of fruits and vegetables in a day, and these are the children that are more likely to be obese when compared to children who ate fruits and vegetables regularly (Roblin, 2007). Children who are older than 4 years consume more than 40 per cent of their daily snack calories on energy-dense snacks such as, chips, chocolate bars, soda, and fruit drinks (Roblin, 2007). Families and caregivers, friends, marketing, and the media all influence a child’s food choices (Roblin, 2007).

It is important to look at nutritional literacy when looking at the contributors to childhood obesity. Parents’ knowledge of nutrition influences the way they emphasize the importance of eating healthy and maintaining a healthy lifestyle to their children (Anzman et al., 2010; Lindsay et al., 2006; Davison & Birch, 2001). Parent’s food preferences greatly affect children’s eating patterns (Anzman et al., 2010; Sothern & Gordon, 2003), as parents are the main contributors to their children’s dietary practices through food selection, meal structure, and home eating patterns (Lindsay et al., 2006). Children learn through exposure and repeated experience, so it is important for parents to provide opportunities that encourage their children to control their own food intake (Anzman et al., 2010; Lindsay et al., 2006). Children under the age of three are capable to self-regulate and they eat until they feel full regardless of how much food they are given (Ramsay, Branen, Fletcher, Price, Johnson, & Sigman-Grant, 2010; Schmidt, 2003). However, children are often encouraged to ‘clean their plate’ as they get older
A child’s ability to regulate their calories decline as parents’ control during meal times increase, which puts them at a greater risk of obesity (Anzman et al., 2010; Gable & Luta, 2000).

Families with school-age children may have a greater struggle with ensuring their children are following a healthy lifestyle because the children are more likely to “spend increasingly more time away from the home, become more exposed to environments that encourage obesity, and have greater choices in their own diet and physical activities” (Lindsay et al., 2006, p. 173). Having healthy foods readily available in the home and eating together as a family helps parents encourage healthy eating patterns (Lindsay et al., 2006; Roblin, 2007). Gillman et al. (2000) concludes that families who eat meals together at least three times a week lowers the risk of becoming obese because they are more likely to eat an overall healthier diet, consisting of more fruits and vegetables, more fiber and essential nutrients, and less fried, fatty foods (Roblin, 2007). Eating together as a family also decreases the likelihood of eating while watching television (Roblin, 2007). It is possible for parents to maintain a home environment that encourages healthy lifestyles by being positive role models for their children through the preparation of healthy meals, eating together as a family, and allowing ample opportunity for physical activity (Roblin, 2007). Taken together, these factors demonstrate the importance of including the family in counseling of children living with obesity.

2.1.2 Other Factors Influencing Childhood Obesity

The determinants of obesity are complex (Raine et al., 2013). In addition to familial influences on childhood obesity, there are also strong associations between
environmental factors and childhood obesity (Raine et al., 2013; Flynn at al., 2006). Some of these factors include physical, economic, and social environments, as well as the media (Raine et al., 2013).

If a child lives in a physical environment that encourages inactive forms of leisure and transportation, it can be correlated to childhood obesity (Dunton, Wolch, Jerrett, & Reynolds, 2009). Factors such as the availability of recreational facilities, proportion of green space, safety of the community, the presence of sidewalks, the number of cars, controlled intersections, and access to public transportation are all associated with activity in children (Dunton et al., 2009; de Vris, Bakker, van Mechelen, & Hopman-Rock, 2007; Frank, Kerr, Chapman, & Sallis, 2007; Alton, Adab, Roberts, & Barrett, 2005). This issue is also connected to the child’s economic environment. Many economically deprived communities consist of built environments that promote a sedentary lifestyle (Wakefield, 2004). Low-income areas sometimes have minimal access to public and private recreation facilities (Sallis & Glanz, 2009). Individuals are more likely to be active if they live close to gyms, walking trails, and public swimming pools (Schmidt, 2003). A study by Schmidt (2003) shows that the activity levels among four-year olds “correlated highly with the amount of time they spent outdoors and their access to recreational areas such as playgrounds, parks, and yards” (p.703) and those who live in poorer areas are less likely to have these within a reasonable distance (Schmidt, 2003). Community designs have a large impact on a child’s physical activity levels. The overall walk-ability within the community, through the presence of sidewalks and trails, is associated with activity levels, and these levels increase based on residential density and street connectivity (Schmidt, 2003).
The child’s social and school environment also plays an important role. Schools play a vital role in the prevention of childhood obesity by promoting proper nutrition and physical activity through health and physical educational programming (Story, Kaphingst & French, 2006). School curriculums have comprehensive programs that contain health and physical education programs, recess in elementary schools, and intramural activities in secondary schools (Story et al., 2006). However, this programming is not necessarily implemented. Physical activity in schools has been replaced with more academic time in the classroom (Anderson & Butcher, 2006). The Center for Disease Control and Prevention recommends health education for every grade, as they strongly believe that it is a crucial part of school’s health and physical education programming (Story et al., 2006). Physical education teaches students the “knowledge, skills and confidence to be physically active both in and out of school throughout their life” (Story et al., 2006, p. 118). It also encourages children to reach their health, skills, and fitness goals through physical activity (Story et al., 2006). Health and physical education teaches children the importance of eating healthy and staying active, in hope that they will use this knowledge to create and maintain healthy lifestyles (Story et al., 2006).

Media can also play a factor in influencing childhood obesity rates. Children who eat in front of the television are more likely to become obese, as they have a higher intake of energy-dense foods, such as pizza, snack foods, and soda, and a lower intake of healthy snacks, such as fruits and vegetables (Roblin, 2007). Both the media and food marketers play a role in children’s eating habits (Roblin, 2007). Media has a large effect on childhood obesity, as the marketing tactics that are used greatly influence family choice. The goal of many food marketers is to directly market toward children (Brescoll,
Kersh, & Brownell, 2008). Targeting this age group can easily be done through advertisements on television during child-focused programming (Trasande et al., 2009). Studies show that a child is in contact with over twenty television ads for food every day (Brescoll et al., 2008). These advertisements are negative influences as they attempt to persuade the consumption of high fat and high sugar content foods (Trasande et al., 2009). Both the World Health Organization (WHO) and the International Obesity Task Force (IOTF) have published statements and put forth strong recommendations in regards to placing restrictions on the marketing of unhealthy food and beverages to children (WHO, 2010; IOTF, 2007). Therefore, it is clear that childhood obesity is a complex problem and in order to reduce the prevalence of childhood obesity, all multi-factorial issues must be addressed.

2.1.3 Health Consequences of Childhood Obesity

Regardless of age, the risk of chronic illness is intensified among individuals who are obese (Wang & Lobstein, 2006). However, the health consequences are particularly concerning for obese children (Wang & Lobstein, 2006), as many of these conditions that are now being seen in children were once only applicable to adults (Daniels, 2006). Studies have shown that even if the child does not show any symptoms until they are older (Daniels, 2006), their long-term health can be affected (Anzman et al., 2010; Ball & McCarger, 2003), and they are still at a greater risk of symptoms appearing earlier than they usually would (Daniels, 2006). A child who is obese is susceptible to additional health complications since their body is developing and growing (Daniels, 2006), such as increased blood pressure and blood glucose (Dietitians of Canada, 2012). The childhood obesity epidemic will continue to grow as the children age and will lead to health
epidemics, such as diabetes, hypertension, and cardiovascular disease (Frieden, Dietz, & Collins, 2010; Barlow et al., 2002). Morbidity and mortality are increased if these health problems develop early on and continue throughout the individual’s life (de Onis, Blossner, & Borghi, 2010; Ball & McCarger, 2003). Excess weight in children is associated with many risk factors for cardiovascular disease (Flynn et al., 2006; Roberts et al., 2012), type 2 diabetes (Roberts et al., 2012; Flynn et al., 2006; Sothern & Gordon, 2003; Lobstein, Baur & Uney, 2004; Kuhle et al., 2011), hypertension (Flynn et al., 2006; Lobstein et al., 2004; Kuhle et al., 2011), asthma (Daniels, 2006), poor emotional and psychosocial health (Roberts et al., 2012; Sothern & Gordon, 2003; Daniels, 2006), as well as many other co-morbidities that may present themselves before or during early adulthood (Lobstein et al., 2004). Obesity is related to various personal health consequences and is a problem for our health care system (Kuhle et al., 2011; Ball & McCarger, 2003). It is also important to understand the social stigma attached to children with obesity, as it may affect the child’s emotional and physical health. These negative attitudes may come from peers, educators, or even the child’s parents (Puhl & Latner, 2007). Negative social and emotional consequences of childhood obesity may create adverse medical outcomes (Puhl & Latner, 2007). Consequences for children include psychosocial issues, such as poor body image and self-esteem, and interference with academic progress, as well as physical health consequences, as children who are obese are more likely to engage in disordered eating behaviours (Puhl & Latner, 2007).

Numerous risk factors, psychosocial factors, as well as adverse effects are implicated with obesity in children (Flynn et al., 2006). A child’s genetics, physical environment, fitness and activity levels, as well as their eating habits, greatly influence
their likelihood of developing obesity which in turn may lead to anxiety and depression, and low self-esteem (Flynn et al., 2006). Children and adolescents who are obese and have low self-esteem may resort to smoking to control their weight or may develop an eating disorder to try and reverse their weight (Flynn et al., 2006). It is important for health care providers to identify, evaluate, and treat obesity as soon as possible to prevent these behaviours from occurring (Barlow et al., 2002).

It is difficult and costly to treat obesity once it has developed (Wang & Lobstein, 2006). Obesity-related health problems in children are continuously increasing and as a consequence. Children living with obesity use the health care system more frequently than their peers due to the health implications that are related to excess weight, resulting in higher overall health care costs in the population (Kuhle et al., 2011; Lobstein et al., 2004). Daniels (2006) conducted a study to show that medical expenses are higher among obese individuals. This study focused solely on obese adults and found that compared to non-obese individuals, medical expenses are 36 per cent higher among the obese population due to health implications that are a result of being overweight (Daniels, 2006). This is significant because it demonstrates the importance of resolving and preventing the issue of childhood obesity as it greatly affects the health care system not only at that point in time, but also as the child becomes an adult as well (Daniels, 2006).

2.1.4 Barriers to Treatment

Many challenges arise when treating obese children (Flynn et al., 2006). A significant barrier related to intervention and prevention of childhood obesity is the lack of training physicians have received in terms of treatment for obese patients (Ewing et al.,
2009; Barlow et al., 2002). This causes physicians to not feel confident in counseling these patients and their families (Ewing et al., 2009; Barlow et al., 2002). Physicians may also defer addressing obesity within their practice because it is a complex issue and they do not feel they have the time to address it within the context of one visit (Ewing et al., 2009; Barlow et al., 2002). Treatment and intervention for children who are obese require more time in addition to other health care providers such as a dietitian, psychologist, and exercise physiologist (Lobstein et al., 2004). Children who are obese need both clinical management and one-on-one treatment, with continual monitoring in order to be effective, however those who use follow up support frequently may overwhelm resources for prevention strategies (Flynn et al., 2006).

I recognized from the beginning that income of the family and ability to pay per service might be one barrier to treatment that arises in my study. RD services under Ontario Health Insurance Plan (OHIP) cover visits to those who work in a hospital, community health, or family health team setting (Dietitians of Canada, 2013a). If a client sees an RD that has his/her own private practice, this is not covered by OHIP and the client must pay “out of pocket for the service” (Dietitians of Canada, 2013a). RDs in private practice create their own service rates depending on the variety of services they offer to their clients and on their number of years of practice (Dietitians of Canada, 2013a). This is something for me, as the researcher, to be aware of when analyzing the data, as it is important to keep in mind that those families from lower socioeconomic status may be unable to afford private practice services.
2.2 Registered Dietitians

Registered Dietitians (RDs) are food and nutrition experts who have earned a bachelors degree in human nutrition at an accredited university within the country (Dietitians of Canada, 2012). They must also complete an internship in a supervised clinical setting in order to gain practical experience and to be eligible for their registration examination (Dietitians of Canada, 2012). RDs may work in public health or community centres where they educate health professionals, policy makers, and the public on nutrition, or they may have a more specific focus of work, such as their own clinical practice where they counsel patients and focus on nutrition, health promotion, and disease prevention (Dietitians of Canada, 2012). Registered dietitians are educated to inform clients about diet, food, and nutrition to support them in making healthy food choices, and to explain the science of nutrition in more practical terms (Dietitians of Canada, 2012). RDs are qualified to encourage behaviour change through food choices and eating behaviour (Dietitians of Canada, 2012). Therefore, it is important for RDs to use their knowledge of health determinants when developing a plan of action for the client, while still encouraging the client to be involved in the decision making (Dietitians of Canada, 2012). All Registered Dietitians adhere to established standards of practice that have been created nationally, but are monitored provincially. According to the standards of practice, Registered Dietitians are to use a client-centered approach (College of Dietitians of Ontario, 1997). This produces an environment to help clients to achieve their nutritional goals (College of Dietitians of Ontario, 1997). Registered Dietitians share their skills and knowledge with their clients, but also take into consideration their client’s knowledge and experiences (College of Dietitians of Ontario, 1997). They collaborate
with their clients to develop an action plan, where they can monitor and modify it as required (College of Dietitians of Ontario, 1997). It is important that they follow these standards within their practice.

The clinical practice guidelines on the management and prevention of obesity in adults and children states that RDs are to provide the children and adolescents living with obesity with individualized diets that are to be based on principles of healthy eating, and it is the RDs role to inform them of the nutritional value and energy context of different food (Dent, Vallis, Hramiak, & Francis, 2007). It is also important for the RD to encourage both the child living with obesity, as well as their family, to practice portion control and monitor their food intake (Dent et al., 2007). In addition, the clinical practice guidelines recommends health care professionals to make use of Canada’s physical activity guide for children and adolescents and to encourage the elimination of ‘screen time’ to their clients and increasing their activity time (Bar-Or, O, 2007). The Canadian physical activity guidelines state that children should be participating in a minimum of 60 minutes of moderate to vigorous –intensity of physical activity per day, where three or more days a week must include vigorous-intensity activities, as well as muscle strengthening activities, on top of the incidental daily physical activity (Lipnowski & LeBlanc, 2012; Tremblay, Warburton, Janssen, Paterson, Latimer, Rhodes, Kho, Hicks, LeBlanc, Zehr, Murumets, & Duggan, 2011).

2.2.1 Registered Dietitians’ Attitudes Towards Obesity

It is crucial that as a society we concentrate on determining beneficial intervention and prevention programs to decrease the negative health consequences that are associated
with obesity, as health care costs are significant and quality of life is extremely important (Barr, Yarker, Levy-Milne, & Chapman 2004). Barr et al. (2004) conducted a study to recognize Canadian dietitians’ attitudes and practices with regard to obesity and weight management. This study was a cross sectional mail survey with a random sample of members of Canadian dietetic associations (Barr et al., 2004). Over half of the RDs who responded actively counseled obese clients, and it was found that dietitians frequently followed a lifestyle approach in terms of weight management, and suggested to their obese patients to increase physical activity and eat in accordance to the Canada Food Guide (Barr et al., 2004). The study concluded that dietitians believe that they are the professionals who are best trained to work with this population and manage obesity (Barr et al., 2004). A study done by Barlow, Trowbridge, Klish, & Dietz (2002) supports these findings, as their study also shows that Registered Dietitians are most likely to suggest eating interventions that involve the maintenance of a healthy, well balanced diet. Barlow et al. (2002) conducted their study to recognize what interventions are being used in treating children with weight problems, and determine the provider’s educational needs. The study focused on RDs, pediatricians, as well as pediatric nurse practitioners (Barlow et al., 2002). A random sample of RDs, pediatricians, and pediatric nurse practitioner received questionnaires about their diet, physical activity, and medication recommendations for overweight and obese clients (Barlow et al., 2002). Pediatricians and pediatric nurse practitioners reported not having any obesity specialists available to them, but most had RDs available to refer their patients to; suggesting strongly that RDs are an important resource in regards to treatment and intervention when it comes to obese patients (Barlow et al., 2002). Registered dietitians feel that they are more prepared to
deal with obese patients, when compared to pediatricians and pediatric nurse practitioners, as RDs did not report lack of time as being an issue and they are well trained and knowledgeable when it comes to diet evaluation and healthy lifestyles (Barlow et al., 2002).

These studies both focus on adulthood obesity, as opposed to childhood obesity. There is sparse available literature focusing on RD’s lived experience with obesity in adults, let alone in children. Both Barr et al. (2004) and Barlow et al. (2002) explore the attitudes, not the lived experience, of the RDs when counseling clients who are obese, therefore this is another way in which this current study attempts to fill this gap in the literature.

2.3 Filling the gaps

This literature review summarizes all of the areas of research that relate to the study. All of the published and accessible literature proves that there is a lot of research done on childhood obesity in Canada, however there is a lack of published research available looking at the lived experience of health care professionals, such as Registered Dietitians, when working with and counseling this population. The literature shows that families can greatly influence a child’s eating patterns and activity levels, therefore counseling needs to not only be directed at the child, but to the family as well. This study attempts to fill some of these gaps by exploring the lived experience of Registered Dietitians who counsel children living with obesity and their families, and attempt to provide knowledge for future research in this area.
It is evident that childhood obesity is a complex issue (Han, Lawlor, & Kimm, 2010). The high prevalence of childhood obesity in Canada is concerning since the negative health consequences stemming from obesity are very likely for many children (Barlow & Dietz, 2002). There are many professionals who provide care to these children on a daily basis, such as pediatricians, pediatric nurse practitioners, and social workers (Barlow & Dietz, 2002). However, there are barriers to the care they are able to provide because educating the client and their family is challenging and it takes time (Barlow & Dietz, 2002). Therefore, addressing these issues within the context of a visit within a busy practice is easily deferred (Barlow & Dietz, 2002). Given the scope of practice of RDs, it suggests that they are educated and regulated to provide such care, therefore this study is exploring what RDs say about how prepared they are for this area of practice. Registered Dietitians by virtue of their practice field have a critical piece in childhood obesity treatment. Registered Dietitians are well positioned to counsel children living with obesity and their families, as they are educated to teach their clients about food and nutrition, in addition to encouraging behaviour change through food choices and eating behaviours (Dietitians of Canada, 2012). There is currently no published, accessible literature available looking at the lived experience of RDs who counsel children living with obesity and their families. This study attempts to fill this gap within the literature.

2.4 Theoretical Framework

This exploratory study examined the lived experience of Registered Dietitians who counsel children living with obesity and their families. Therefore, a
phenomenological framework was adapted in order to gain a better understanding of their lived experience.

2.4.1 Qualitative Research

Qualitative research stems from multiple origins and has developed over time. Classical social theorist, Max Weber, was one of the founders of qualitative research (Scott and Garner, 2013). Weber’s well-known term Verstehen, translates to understanding (Scott and Garner, 2013). He uses this term when talking about qualitative research because he feels that it is important for the researcher to “understand the ideas, thoughts, and meanings of the people they study” (Scott and Garner, 2013 p.15). The purpose of qualitative research is to not just document the opinions and behaviours of the participants, but the ultimate goal is to really understand the participants’ lived experience (Scott and Garner, 2013). There are many methods of qualitative research inquiry, such as grounded theory, ethnographic, case study, narrative, as well as phenomenology (Creswell, 2013). The goal of this study is to understand the lived experience of Registered Dietitians who counsel children living with obesity and their families, therefore a phenomenological approach was taken.

2.4.2 Phenomenology

Phenomenology is a philosophy that emerged in the first decade of the 20th century through the work of a German philosopher, Emund Husserl (Shosa, 2012). Phenomenology aims to explore and understand individual’s lived experiences (Shosa, 2012; VanManen, 2014). The concept of ‘lived experience’ comes from the German word Erlebnis, and its aim is to provide a solid understanding of the meanings of
phenomena in people’s lives (VanManen, 2014). Husserl believed it was important to create an unbiased approach to reach an understanding of these experiences (Shosha, 2012). One of Husserl’s students, Heidegger, modified his work into interpretive/hermeneutic research (Shosha, 2012). This approach attempts to provide rich descriptions of the subject’s lived experiences though their life stories (Kafle, 2011). Major concepts and meanings that evolve from the narratives come from within the lived experience of the individual (Shosha, 2012).

Phenomenological research takes an in-depth approach to exploring lived experience in order to understand the way we know the world (VanManen, 1984). Researcher’s interpretive skills are needed for qualitative methodology, and phenomenological research can be difficult since it is a method of inquiry that is always changing, therefore there is not an established set of strategies or research techniques (VanManen, 2014). Philosopher Gadamer said it best when he “pointed out that once we make an experience into an object (as happens when employing a method), then the truth of the lived meaning of the experience will remain beyond reach” (VanManen, 2014, p. 42).

In-depth interviewing is a common research approach in phenomenological research, as it does not try to evaluate a test or a hypothesis, but rather strives to gain a deeper understanding of people’s lived experiences, as well as the meaning they make of these situations (Seidman, 1998). The interviewer asks open-ended questions and it is the interviewers’ responsibility to build on and explore the participant’s responses to the questions, in order to guide the participant in reconstructing their lived experience (VanManen, 1984; Seidman, 1998). The overall goal of this process is to understand and
articulate the meaning of the participants’ lived experience (Seidman, 1998). As this study’s aim was to explore the lived experience of Registered Dietitians who counsel obese children and their families, a phenomenological framework was used and will be more fully described in the next chapter.

2.5 Summary

This chapter outlines the current literature related to the topic of study and how the current study will fill the gap within the literature. Themes that are concerned with Registered Dietitians and their lived experience with children living with obesity and their families are reviewed. These include: familial influences on childhood obesity, other factors influencing childhood obesity, health consequences of childhood obesity, barriers to treatment, Registered Dietitians, as well as Registered Dietitian’s attitudes toward obesity. The importance of using a phenomenological framework for this study was also expressed. Chapter 3 describes the methods used for the study, including participants, sample selection, and recruitment, the data collection design, as well as data analysis methods.
Chapter 3

3.0 Methodology

In order to gain a better understanding of Registered Dietitian’s lived experience counseling children living with obesity and their families, a phenomenological study was conducted. The data collection process, as well as an overview of the data analysis procedures is expanded on in this chapter. A timeline of the data collection and analysis for the study can be found in Appendix G

3.1 Ethical Considerations

The ethics review process involved completing UOIT’s Research Ethics Board application in order to gain approval for the study to take place. All REB documents can be found in Appendix H & I. Once approval was obtained, individual RDs who have a self-described private practice with a focus on children and obesity, and have been located on the Dietitians of Canada public access website were contacted (http://www.dietitians.ca). Since all RDs were coming from private practices, no additional institutional ethics approval was required. With a low response rate from the first round of recruitment, an ethics amendment was completed to offer other options for completion of the interview questions. The amendment allowed online question completion and snowball recruiting. More detail will be provided in section 3.2 Sample and Recruitment. All participants read and gave consent before the interview/survey took place.
3.2 Sample and Recruitment

The phenomena under study influences the type of participants included in the study (Groenewald, 2004). The participant sample is based on the purpose of the study (Babbie, 2013; Greig, Taylor, & MacKay, 2007; Groenewald, 2004) and those chosen are meant to have related experience to the phenomena being looked at (Groenewald, 2004). Registered Dietitians were accessed through the Dietitians of Canada public website (http://www.dietitians.ca) who have identified their practice focus to include children living with obesity. The RDs were contacted by email inviting them to participate in this study. The invitation provided the purpose and a description of the study, it informed the participants on how their confidentiality and anonymity will be safeguarded, and included further instruction for those interested in participating. The first round of recruitment emails were sent to 23 Registered Dietitians on November 1, 2013. A reminder was sent out a week following the first email invitation. If interested, a consent package was promptly emailed to them. This recruitment round had 2 responses agreeing to participate, 9 responses declining participation and 12 did not respond. A common theme among those who declined participation was their lack of time due to their busy schedules. An REB amendment then took place in order to offer an online survey version of the interview questions, hoping that this method would interest those who did not have the time to set aside for a telephone interview. A snowball effect took place as other Registered Dietitians were suggested to contact for the study. Using the snowball effect, one participant was referred by someone else, as this individual had a lot of experience in this area. However this individual was not registered with Dietitians of Canada but was still able to be accessed on the provincial public registry, therefore an amendment was
made and it was approved to allow this individual to participate in the study. On January 22, 2014, a second round of recruitment emails were sent out and 20 more RDs were contacted. From this round, 6 responded agreeing to participate, 3 declining participation and 11 did not respond. According to Guest, Bunce, & Johnson (2006), key themes in phenomenological work emerge after 6 interviews, therefore the goal of this study was to have five–to-ten participants. A total of 8 Registered Dietitians participated in the study.

3.3 Data Collection

After two rounds of recruitment emails sent, a total of 8 participants agreed to participate. Four of the participants took part in telephone interviews at a time that was convenient for them and their verbal consent was given at the beginning of each interview. Each interview lasted approximately 25-35 minutes in length, and was digitally recorded using an Olympus WS-802 voice recorder. These interviews were subsequently transcribed by the researcher and were sent back within 48 hours to the participant in order for them to complete a member check, and finalize the transcript. The member check allowed the participants to comment on anything inaccurate or add anything they wished to enlarge on. Only one of the four participants interviewed made changes to their interview before they finalized it. All participants returned the finalized transcripts within one week of receiving it. The interview was semi-structured and consisted of open-ended questions to help guide the interview, yet it still allowed for free expression. The other four participants decided on the online survey option. Registered Dietitians gave their consent for this option by completing the survey. Participants were able to complete the questions at their own pace and submit their responses via email.
once completed. All participants and locations were given pseudonyms in order to adhere to the confidentiality agreement.

3.4 Data Analysis

3.4.1 Thematic Analysis

Transcripts were entered into a qualitative data analysis program called Nvivo (version 10) and organized by question. I also analyzed the data manually. With 8 participants, this hands-on analysis deepened my immersion in the data. A phenomenological reflection and analysis of the given data was completed. It is a complex process in order to analyze the thematic meanings of a lived experience (VanManen, 2014). Formulating a thematic understanding must be done at the level of the whole story, at the level of separate paragraphs, and at the level of single sentences, phrases and words (VanManen, 2014). The analysis began with a holistic read of the transcripts. The selective reading approach was used next in order to isolate thematic statements (VanManen, 1984; VanManen, 2014). This approach requires the researcher to read the transcripts several times in order to determine what statements and phrases are exhibited through the lived experience being described (VanManen, 1984; VanManen, 2014). These statements and phrases are then highlighted. The line-by-line detailed reading approach required the researcher to look at each individual sentence in order to determine how that particular sentence reveals the lived experience (VanManen, 1984; VanManen, 2014). All highlighted phrases and sentences were categorized into overall themes in order to emphasize the main issues that are discussed by the participants (VanManen, 1984). Direct quotations from the participants will be included in the presentation of findings in order to illustrate and substantiate each thematic finding.
3.4.2 Credibility, Transferability, Dependability, and Confirmability

As Denzin & Lincoln (2005) state, common terms such as, internal and external validity, reliability, and objectivity, are replaced in qualitative research with credibility, transferability, dependability, and confirmability. Credibility ensures an authentic representation of the lived experience, therefore the researcher must make sure the interpretations presented in the study are true to the participant’s lived experiences (Reid & Gough, 2000). In my study, credibility was ensured through the member check of the transcripts, where the participants were able to comment on anything inaccurate or add to anything they wished to enlarge on. Transferability represents whether or not the findings hold true in other situations, or in the same context at a different time (Reid & Gough, 2000). This criterion is satisfied in my study by using thick descriptions, which are rich, detailed illustrations of the participant’s lived experiences that provides a database for others to assess the transferability of findings to other populations. Dependability, or honesty, is the record of how all phases of the research process are kept, such as participant selection, interview transcripts, data analysis etc., and confirmability is the extent to which research bias influences the interpretations (Reid & Gough, 2000). In order to make sure both of these criteria were met, the researcher produced an audit trail. The audit trail demonstrates how theme identification arises from the transcripts and surveys, to show how categories were derived within the findings. My supervisor, who is also a qualitative researcher, reviewed the theme identification from the finalized transcripts as a part of the data audit trail.
Chapter 4

4.0 Presentation of the Findings

This study explores the lived experience of eight Registered Dietitians who counsel children living with obesity and their families. This chapter provides a brief description of the participants, the results from the interview/survey questions, and thematic descriptions. A description of the study’s major themes will be presented. Pseudonyms are used throughout the study for people and places, with the exception of educational institutions. Unnecessary repetitions within direct quotations from participants are omitted in order to increase readability, however any edits to these quotes were very minor so their integrity was upheld.

4.1 Pertinent Characteristics of the Participants

Eight Registered Dietitians who counsel children living with obesity and their families participated in this study. All eight of these participants were female. Seven resided and worked in Ontario, one in Alberta. Two participants were in their 20’s, one was in their 30’s, four were in their 40’s, and one was in their 50’s. The RDs graduated from a variety of Canadian university nutrition programs, including Ryerson University, the University of Guelph, McGill University, and the University of Alberta. All participants completed their education and internships for their programs in hospital settings throughout Alberta, Ontario and Quebec. RDs years of practice ranged anywhere from 2 years to over 20 years with an average of 12 years. Approximately half of the participants started counseling children living with obesity and their families upon graduation, while the other half started working with this population later on in their
career. The range of years RDs started working with this population ranges from immediately after graduation to 12 years after already practicing as a RD. Participants have counseled children as young as one year old up to 18 years old and their families. Most of the participants report that the majority of the children they counsel who are above the 97th percentile are over the age of 10. The majority of participants agreed that seeing children living with obesity and their families is currently, or has been, central within their practice. Five out of eight of the participants have taken continuing education courses relating to counseling children living with obesity and their families since they have graduated. Examples of these continuing education courses include: cognitive behaviour training, motivational interviewing training, individual and family therapy training, as well as behavioural modification conferences. A summary of participant characteristics can be found in Appendix J.

4.2 RDs lived experience working with children living with obesity and their family

When participants were asked about their lived experience working with children living with obesity and their families, the responses were similar between all RDs. Two common topics were addressed among all participants; the role of the child’s family, as well as social consequences of obesity.

Half of the participant RDs mentioned how family dynamics play a role in the child’s weight. What is happening within the family environment can greatly impact the child’s eating behaviours. Lucy comments, “the most frustrating piece is the parents. They often model unhealthy behaviours at home and then they wonder why their children
eat so poorly”. Ann adds, “the parents sometimes need [counseling] more than the child”. Small things, such as not having standards in place at meal times, such as eating meals as a family at the table and not in front of the television, and parents not modeling appropriate food-related behaviours, or family difficulties of one form or another can all impact on the child’s eating patterns, therefore affecting their overall weight.

When participants were asked to share a story that really stands out for them, a common theme across these stories was about the family dynamics, the break down of families, and how this affected the child and their weight. Leah shared,

“these days many children have two families likely due to increasing rates of divorce/separation. Going from one parent to another causes much difficulty in trying to achieve goals or follow recommendations when both parties might not be on the same page”

Danielle also talked about a situation of how the breakdown of a family and food scarcity has impacted the weight of the child. This story was about a 10-year-old boy, David. In David’s family there are 6 children, 4 of them being biological siblings and he is the youngest of these is 4. His mother has now remarried and has created a blended family, where she has had 2 more children. Danielle continued,

“when the first marriage broke up and that family broke up, mom would say there was a real period where there was food scarcity and she noticed then that [David] started to have these behaviours of…sneaking food, and hiding food or getting up at night to eat, those kinds of things. And now that she is in this new relationship, and it is a stable relationship…[David] continues to have these behaviours of worrying about having enough food…he would ask all of the time, what are we going to have for supper, he eats really fast and he tries to protect his food. So, that…is an example of…how he lived that trauma when he was quite young, maybe 4 years old or so of getting into a situation of food scarcity and the breakdown of the family and how that’s impacted him”

Danielle and Lucy both mention social consequences they have come across with their lived experience counseling children living with obesity. Lucy mentioned how
parents sometimes objectify their child as they use terms such as ‘fat’, ‘chubby’ and ‘belly’ during their sessions, or pinch fattier parts of their child’s body and she said “you can see the child shrink into their seat…they are mortified to think that others see their bodies as ‘a problem’”. Lucy also shared a story.

“A mother and 4-year old child were in the consult room together. The mother described a diet that was out of control: extremely oversized portions for a child, very starch heavy meals, no vegetables, many treats, no activity, juice with all meals, and no boundaries in place when the child asked for food. The mother during the session kept using the terms fat, chubby and belly, and reassured me that her child who was playing would not hear. At one point in the session, the child turned to me and he asked “do you think I’m fat?” That was extremely heartbreaking for me. It also angered me that the mother spoke in front of her child like this routinely. I explained to him that I don’t tell children they are fat; rather, I talk about them being healthy and unhealthy. I explained that he needs to grow up healthy, but he was growing too fast and was not very healthy. He seemed to feel comfortable with that response and went back to playing.”

Not only do the children get objectified by their families, but Danielle and Lucy have had children tell them stories about how they are struggling because they have been teased and bullied by other children at school. Lucy stated that hearing the child’s own negative self-talk is heartbreaking. These findings are consistent with the published literature, as Puhl & Latner (2007) talk about how the child’s emotional health is affected when other children at school, as well as the child’s parents themselves convey negative attitudes about their weight. In turn, this creates low self-esteem for the child resulting in psychosocial issues, as well as hindered academic progress (Puhl & Latner, 2007).

Studies have suggested that parent’s perceptions of being overweight is linked to low self esteem in their children, as a mother who is dissatisfied with her own body conveys this message to her child, therefore influencing the child’s own body
dissatisfaction (Golan and Crow 2004; Schwartz and Puhl, 2003). A story that Lucy
shared about her experience that really stood out was when she

“recently had a mother ask if we thought it would be okay for her morbidly obese
daughter to wear a two-piece bathing suit on a cruise. She was concerned that
other guests on the cruise would point and tease. The team noted that this mother,
who was obese, was very considerate but also projected some of her own body
image issues and weight bias onto her daughter. The answer we gave her was
yes. Providing that the bathing suit was age appropriate and not overly
sexualized, there was no reason this child could not be proud and comfortable in
her own skin. The daughter was thrilled when she heard this news; she is only 5.”

Overall, the RDs lived experience working with children living with obesity and
their families can be frustrating, in the sense of parents modeling unhealthy behaviours
and then wondering why their child eats so poorly and is overweight, as well as
heartbreaking as they see the children socially struggling due to their weight. A common
theme from all of the RDs lived experience is that there may be feelings of guilt and
shame from the family, but as Mallory pointed out, in the end “it is about everybody, and
it has to be a group effort”. Parents greatly influence their child’s dietary practices,
physical activity, as well as their sedentary habits by the way they model healthy
behaviours and emphasize the significance of healthy eating and maintaining a healthy
lifestyle, therefore this highlights the significance of including parents in the counseling
(Anzman et al., 2010; Lindsay et al., 2006; Golan and Crow, 2004).

4.3 Defining Obesity

Childhood obesity can be defined in many ways; therefore the RDs who work
with this population on a regular basis were asked how they would define it to a family
member. The majority of the participants report that they do not use the word ‘obesity’
and they use other terms within their practice instead. When children living with obesity
and their families go to see an RD about their weight issues, they already recognize that there is a problem and it is not necessary to classify the child. Leah comments that “focusing so much on the word weight, overweight, or obesity is not something positive for the child who is often present when I counsel”. Similar responses were provided by four of the other participants.

With that being said, only three RDs use Body Mass Index (BMI), plotted on the World Health Organization (WHO) growth curve as a way of measuring and defining obesity in children. However, this response is consistent with the literature and RD best practice guidelines. Measuring the child’s BMI is most commonly used to rank the child’s weight (Roberts et al., 2012; Raj & Kumar, 2010), and is only used when plotted against the child’s age on the WHO growth curve (Dietitians of Canada, 2013b). Alice talked about how she uses the child’s BMI to define obesity. She plots the BMI on the WHO growth chart and makes sure that the parents understand what that measurement means. She mentions that there is a range for 2 to 5 year olds and a range for 5 to 19 year olds. If the child’s BMI is greater than the 85th percentile once plotted on the curve, then it suggests that the child is overweight, greater than the 97th percentile the child is considered obese, and greater than the 99.9th percentile is severely obese. Danielle likes to determine the child’s velocity of growth by looking at their history and trying to figure out where their growth took place and what factors could have influenced the growth at this time.
4.4 Practice remained the same or changed

When participants were asked if their practice has remained the same or changed from the first time they counseled a child living with obesity and their family, the majority agreed that their practice has definitely changed from that first time. The most common response was that it was constantly changing, after each family they see, and they feel more comfortable dealing with the issues that arise the more experience they have. Lucy says, “you start to get a sense of reoccurring and common issues”. Leah adds that she “often learn[s] a lot in terms of what works, what doesn’t, and also gain[s] new insights from [the] families themselves” and she also admits that due to her lack of experience, she “was quite rigid on recommendations [when she first started counseling children living with obesity and their families] without realizing many circumstances come into play”. Mallory agrees as she feels that her practice has definitely changed in the sense she has three children of her own. She feels that life experience is very important and “it is one thing counseling a child when you don’t have kids yourself, and for a parent you don’t know the true demands that parents have”.

4.5 Strategies used to help children living with obesity and their families

When RDs were asked what kind of strategies they use to help children living with obesity and their families, they responded by stressing that sharing basic nutrition education with the child and their families was of utmost importance, but they also reported that they provide recommendations and set realistic nutrition goals for the families as well.
Alice talked about how one of the very first things that she does with the child and their family is to go through their meal plan and compare it to Canada’s food guide, where she will then provide the family with feedback and some strategies for how to fill any gaps. She said, “recommendations may include a look at what are appropriate child size servings, what is a serving per Canada’s food guide…[and] looking at what families are preparing in terms of sometimes foods: snacks and sweets”. Mallory agrees that meal planning is important among the family. She works with the children and their families to teach them how to meal plan. Rather than her just telling them what to eat, she provides them with ideas and they work together to come up with a plan.

Both Danielle and Grace mentioned incorporating an interactive education component to provide nutrition education. Danielle likes to offer “good knowledge around how to read labels, what portion sizes look like of different food groups, [and] look at foods that are tasty but may be less dense in energy”, whereas Grace uses “sugar, fat, [and] salt models of food [and encourages clients to] learn…by counting sugar cubes and reading labels”. Danielle works in a childhood obesity clinic and this clinic is collaborating with a large grocery store’s cooking school in order to provide a practical portion to their educational component. The families get to participate in hands-on cooking and learn about easy meals they can make, simple but healthy after school snacks, as well as fun foods to make while entertaining friends.

Half of the participants mentioned realistic goal setting as being an important aspect of things they do to help these children and their families. Emily encourages patient-led nutrition goals within her practice. She motivates families to “give up making diet changes unless they can realistically sustain them for the rest of their lives”. She
stressed the importance of good eating hygiene within the family unit, such as “not eating in front of the television, eating all meals, no skipping meals…eating together at the table for meals etc”. Alice suggests setting “goals in terms of what families can do to be less sedentary, increase physical activity, modifying their meal plan”, and Leah encourages “family discussion and child participation on meal planning and preparation”. Lucy believes that as long as the family mindset has changed and they are able to focus on healthy behaviours, then the weight loss will be sure to follow.

Although all of the RDs have the same ultimate end goal, to help the children living with obesity and their families, they all have their own unique ways of helping their clients reach this goal. The most common ways described by participants were by providing their clients with education on nutrition, giving them recommendations, as well as setting realistic nutrition goals.

4.6 Successful Interventions

When RDs were asked what they would consider a successful intervention, there were various ideas given. Leah believes a successful intervention “is one that both the child and the parent/caregiver are agreeable to and are able to follow through”. Lucy mentioned that if “they feel more content, supported, and find the strategies are helpful, [she has] been successful”. Both Alice and Danielle saw a successful intervention as being one where a healthy lifestyle change has been made. Danielle went on to explain a situation where she knew this change has been made and both the child and the parents were on board. When talking to the parents, they told Danielle how they have seen changes in their child’s behaviour. This might be things like “Bobby doesn’t look for
juice anymore at every meal, we have…made the change to drinking water with our meals and he has milk sometimes but … before he would always go for juice”. Danielle sees her goal “is really to help these families make changes in their lifestyle but more than that, it is also to increase their confidence and their knowledge [so] that they are able to sustain change”. Mallory feels successful when they return and they provide her with positive feedback. She says that “success might not be a tangible weight on a scale, but it is that…they are feeling better”. Ann disagrees with this as she considers weight loss to be a successful intervention. However, the most common response for how success is measured is not by measuring lost weight in the child. Alice believes that for children, the goal is not always to focus on weight loss, it is to make sure they avoid further weight gain/or maintain their weight as they are continuing to grow”. Lucy agrees that she “also measure[s] success clinically to see if weight is stabilized [and] in pre-pubescent children, the goal is always weight maintenance”. Danielle not only measures success by looking at weight maintenance, but adds that she looks for any slowing down in weight velocity, any kind of shift in weight, as well as physical measures such as, “blood pressure, waist circumference, height and weight…lipids, insulin levels, blood sugar and that kind of stuff”.

Half of the participants mentioned that seeing change within the family’s behaviour or the family’s dynamic is an indicator of success. Changes within the family included feedback that they are feeling “more content, supported, and find the strategies are helpful” (Lucy), therefore the “family and the child have made a healthy lifestyle change…[such as] scheduling of meals and snacks, eating per Canada’s food guide, increasing level of physical play or activity, [and] reducing sedentary time” (Alice), to an
overall improvement in both the child and the family’s behaviours. For instance, a family told Danielle “we have really changed how often we buy…the high fat snack foods now in our house…we don’t buy it every week”. It is noted by Danielle that these behaviour changes “increase [the family’s] confidence in their ability to sustain change”.

None of the RDs mentioned if they ask the child and the family what they would consider ‘success’ to be.

4.7 Resources

When participants were asked about the resources they have available that relate to counseling children living with obesity and their families, the majority of participants commented on how resources are key in counseling these families. However, there are no standard resources and the RDs have to go searching on their own in order to find them. Some resources that were mentioned by participants that they feel are useful within their practice are; professional sites, such as Dietitians of Canada, Health Canada, the Hospital for Sick Children, the Dairy Farmers of Canada, and Pen – a practice based evidence based nutrition website for Dietitians. Lucy added,

“I can’t say that there are any standard resources that I receive, nor do I necessarily have criteria or expectations. Based on my experiences, I think that what would be helpful in future for RDs are resources on how to manage the counseling and/or psychological component of childhood obesity. The healthy eating behaviours are easy to teach - less juice, more walking etc. - but the challenge becomes when you have to answer patient when they ask you if they’re fat, or how to restructure parents’ conversations at home, etc.”
4.8 Family

4.8.1 Assessing Family’s Roles

Lucy and Mallory both mentioned that if possible, they like to talk to both the parents and the child separately. Leah feels that by doing this, “you can really get more about ‘home life’”. Mallory added that she likes the child to “feel safe with what they are telling [her] and...[she] like[s] [the parents] to know that if [she] is ever concerned about safety or there is something that should be told to them, they will be aware”. Obesity is a complex issue, and perhaps obesity itself is a symptom and not the primary problem. It is more than the child’s weight, and more about the family dynamics and what is happening in the home. Alice talked about how the child’s issue with obesity often starts with the family dynamics and in order for the child to be successful; the parents have to commit to the recommended strategies. She believes that

“For younger children it is easier for families to help organize the schedules, the meal plan, activity plan to be supportive. For older children we encourage families to do the same but the older child also has to be ready and willing to accept the lifestyle change for success”.

The literature suggests that adolescents spend more time away from their homes, are less likely to eat meals with their families and have a greater independence when it comes to decision making and behaviour, in terms of their diet and physical activities (Lindsay et al. 2000; Golan and Crow, 2004). Eating meals together as a family has a positive association with an overall healthier diet that includes more fruits, vegetables, grains, and essential nutrients (Golan and Crow, 2004; Gillman et al., 2000; Roblin, 2007). Therefore, parents modeling and promoting healthy meal times encourages positive dietary intake in their children.
Both Leah and Lucy mention that they assess the family’s roles and practices through their initial assessment interview process, as well as through observation. Lucy explains that she looks

“at verbal and non-verbal cues, as well as the parent/child dynamics in the consultation. Is the child involved in the conversation or is the parent blaming them for poor self-control? Does the child make eye contact or are they shut off? Do they feel embarrassed that their parents are talking about them in this way?”

4.8.2 Motivating the family

RDs were asked how they motivated the families to eat better and the most common response was how motivation is individualized and decided per child and family. With that being said, the majority also stressed that the main avenue for motivation was through realistic and achievable nutritional goal setting in order for the child and the family to comply with the goals and for them to be successful. Emily says that “the nutrition goals we make are ‘baby steps’…and the families need to be able to tell me that they could sustain the goal for the rest of their lives before we write it down”. Mallory follows the same idea as she mentions that she is big on self-efficacy and that the family’s motivation comes from within through “their confidence that they can sustain a behaviour”, therefore she works with the family to “make [a] plan together, not [her] delegating out what [the family] need[s], it is [everyone] coming up with it together”. In most cases, Alice said she does not necessarily have to motivate them to eat better, as they are already ready to make changes when they go for their initial visit. However, she
“encourage[s] families to eat better by structuring family meals at the table, away from the TV, computer. Everything has to be individualized per the family. Trying to make sure goals set are realistic and achievable will be for good success and compliance. The best measure of success is to get initial goals organized and achieved in order to then move onto other goals and provide opportunity for further lifestyle change.”

4.9 Issues that do not involve food

Participants were asked if the family every talked to them about issues that do not involve food; all RDs agreed that families do bring this up in their sessions. Leah believes these issues may ultimately affect the child’s eating behaviours. Some of the issues that the RDs have had come up in their practice include social, financial, family, mental health, and other issues. Social issues that RDs mentioned they have come across in their practice are school related, extended family pressure issues, neighbours, bullying/teasing, work, and stress at work. Financial issues are the family’s low-income limitations. Family issues include family conflict, divorce, work/life balance, stress and the dynamic of one parent being overbearing at a meal. Families talk about mental health issues, like body image and emotional issues, and they also bring up other issues that do not involve food, such as sleep and medications.

It is not uncommon for issues that are not related to food be brought up during the counseling session with the Registered Dietitian. It is important for the RD to get a sense of the ‘whole’ picture while assessing the situation and coming up with a treatment plan. More than half of the RDs noted that it is important to listen to the client and empathize then, as Leah points out “reflect on how these issues may be affecting eating behaviours at home” and, as Ann does, “take them into consideration when making your own
recommendations”. Danielle believes it is crucial to “listen…and then bring it back to food”. So for example, “if they are telling that their…neighbour’s child has been nasty to their kid…I would do my piece around that…so did that impact on how he ate, did that impact on what choices you offered him…”

All but one of the participants mentioned that if they believe the issue is out of their scope of practice, they would refer the child and their family to another professional and/or suggest finding additional resources, services and supports. Danielle and Emily commented on how fortunate they are to be a part of a multidisciplinary team. They are able to refer the situation to another team member and if they want to address it within their work, they can.

4.10 Physical Activity and Motivating the Family to Become More Active

The majority of the participants are aware of the physical activity guidelines for children (Lipnowski & LeBlanc, 2012; Tremblay et al., 2011). These participant RDs use them in their practice and make their clients aware of them. Most participants mentioned that they talk about the basics with their clients, how to be more active, and they mention recommendations from Health Canada, however they do not get into designing a fitness plan for them. Lucy said

“I am moderately comfortable counseling physical activity, in the sense that I know how to look up guidelines and can provide resources to the family (eg. Participaction). I am not able to recommend specific exercises if they ask; I acknowledge that this is beyond my scope of practice”
She adds that she tries

“to get the family involved as a unit because most kids won’t be active on their own. I convince parents to either go for family walks, or schedule Sunday play days. I’ve routinely recommended them to visit the Participaction website where they have established the campaign “Bring Back Play”; there are plenty of ideas to choose from. I often recommend parents don’t force children onto a treadmill, and rather encourage the child to pick things they like. It could even be things like dancing, house league sports at school, a yoga You Tube video, or their own little routine they’ve put together.”

One participant admitted that she is not comfortable counseling on physical activity as she is unaware of the specifics of the guidelines. Therefore she does not use them in her practice but makes her clients aware of them. However, this participant has the advantage of being a part of a multidisciplinary team, therefore there is another practitioner who specifically deals with this area with the child and their family.

4.11 RD Education

4.11.1 Prepared by Education

Both Ann and Mallory felt prepared by their education to work with children living with obesity and their families. Interestingly, Ann and Emily both went to the same university, but they do not agree on how prepared they were by their education they received. Childhood obesity counseling is only marginal in Ann’s practice, and she felt “quite prepared from internship”. Whereas, counseling children living with obesity and their families is a very central part of Emily’s practice and she did not feel prepared by her education to work with this population. Emily says, “I was prepared to do general nutrition assessments but everything I learned in school re: weight management goes against my current practice. It’s not as simple as calories in/calories out”.

Alice, Danielle, Emily, Grace, Leah, and Lucy did not feel prepared by their education to counsel children living with obesity and their families.

Alice, Leah, Lucy, and Mallory all attended the same university. Mallory is the only one out of these four who counsels children living with obesity and their families marginally within her practice. She is also the only one to report feeling as though she was prepared by her education to counsel this population. However, the other three participants who attended the same university as Mallory have childhood obesity as a central part of their practice and they did not feel prepared at all. Alice said “as my practice and experience has grown, the opportunity for me to be more involved with these children has presented itself. I wouldn’t say my education specifically focused on it”. Lucy agreed by saying “without the experience I gained in that pediatric clinic, I would know very little about childhood obesity, growth chart measurements and assessments, and even counseling styles”.

4.11.2 How should schools prepare RDs

Since most participants admitted to not being well prepared by their schooling to work with children living with obesity and their families, it is interesting to see what they feel is important in terms of how schools should prepare RDs in educating them to deal with this population.

One of the most talked about issues was counseling techniques taught in the classroom. Alice feels “it is a very specific counseling component that comes with overweight children and their families”. Ann agrees and adds that she would like to see “educational strategies on…how to deal with parents when it’s the health of the
child…[as] it is more about what the parents are providing”. Danielle and Lucy emphasize the importance of cognitive behaviour therapy courses and strategies to use in counseling as RDs are going to be dealing with people and behaviours. Ann and Leah both agree that motivational interviewing is of great importance when it comes to counseling strategies, and it should be included within the RDs education. Motivational interviewing as a counseling technique will be further explored in the discussion chapter (Gance-Cleveland & Oetzel, 2010; Resnicow, Davis, & Rollinick, 2006; Davis, Gance-Cleveland, Hassink, Johnson, Paradis & Resnicow, 2007; Barlow & Dietz, 2002; Barr, Yarker, Levy-Milne & Chapman, 2004).

Grace and Leah would like to see more hands-on experience when it comes to child nutrition, and in other settings other than hospitals. Grace feels “hospital[s] teach the diagnosed population, but [are] not usually [involved] in illness prevention”. Since most of the participants have their own private practice, they are not always going to just get the diagnosed population, as it is not realistic outside of the hospital setting.

Alice and Lucy feel that future RDs will benefit from the involvement of current RDs in the classroom. Alice suggests including a module within the program where a practicing RD who deals with, or has dealt with, childhood obesity teaches a class. Lucy proposes the idea to “tape live sessions in pediatric practice and view these in class to identify strengths/weaknesses of the session and common topics of conversation”

4.12 Life experience

Registered Dietitians were asked to comment on if any of their own life experiences comes in play within their practice. Emily commented on how she struggled
with her weight in her late teenage years and early twenties. She added that once she “learned to stop dieting…and accept [her] body’s set-point and focus on health rather than weight, it all fell into place”. She sometimes shares this experience with the families she counsels in order to build a rapport. Danielle agrees with this as she feels that “the definition of having [a] healthy lifestyle will provide you with a healthy body”. Alice talked about how her home life experiences have an influence on her practice. She says, “I am a believer in being active and having fun and play. This does not necessarily mean making sure that your child is signed up for all kinds of sport classes that cost money, but just being less sedentary, less tv time, less video game time, less sedentary time in general…My husband and I live and raise our children that for the most part we eat well, play well, get enough sleep, stay active, and I take these experiences into my practice”.

As mentioned previously, Mallory said that her life experience is a very important part of her practice, as it helps her connect with her clients in ways she would not be able to if she did not have children for herself and understand the true demands of parenting.

4.13 Summary

This chapter summarizes the findings from the study. The experience of eight Registered Dietitians was explored throughout the chapter. Study participants, the results from data collection, as well as thematic descriptions were provided. Chapter five discusses the findings, provides practical implications and recommendations, recommendations for future research, as well as the researcher’s overall impression of the study.
Chapter 5

5.0 Discussion of Findings

It is clear from the data that Registered Dietitians who counsel children living with obesity and their families are professionals whose goal is to help the children and their families make changes in their lifestyle by providing them with the necessary resources in order to increase their confidence and knowledge so they are able to sustain change. It is also evident that the RDs consistently try to better their service by learning from each family and evaluating their practice to improve their skills for future clients.

This study used a phenomenological approach in order to gain an understanding of Registered Dietitian’s lived experience counseling children living with obesity and their families. Data was organized and synthesized in order to thematically analyze the participant’s stories of practice to understand their lived experience. This chapter presents an overview of the findings where four main themes emerged throughout the research data. These themes include: the Registered Dietitian’s lived experience with children living with obesity and their family, the family’s roles, measuring success, as well as Registered Dietitians education. This chapter also provides practical implications and recommendations, as well as recommendations for future research.

5.1 Overview

5.1.1 Theme One: Registered Dietitian’s Lived Experience With Children Living With Obesity and Their Families

It is clear that Registered Dietitians find counseling children living with obesity and their families rewarding, however they find it heartbreaking and frustrating at the same time. It is rewarding in the sense that they are able to “see the little ones eyes light
up because somebody is…listening to them” (Mallory). They enjoy helping the children understand that it is not about their weight and the number the scale, and they are delighted to support the children and their family in a way to build their confidence and make them feel more comfortable in their own skin. The heartbreaking piece is when the children have negative self talk, or when they tell stories about getting teased and bullied at school, or even being objectified by their own parents as they convey negative attitudes or pinch fattier parts of their child’s body. The most frustrating part is the parents. The child is a product of the parents and what is happening in the home greatly impacts the child’s eating behaviours. If the parents are modeling unhealthy behaviours or fail to implement healthy behaviours, such as not setting mealtime or physical activity standards, then we cannot blame the child. Emily mentions that although counseling children living with obesity and their families is “often frustrating work, [it is] rewarding when families are able to embrace HAES (health at every size)”. Lucy adds that even though counseling children living with obesity and their families can be challenging, there is a huge need for this type of counseling and “without appropriately trained dietitians, families are leaving these children unsupported, or sending them to commercial weight loss programs [or] using over the counter weight loss products”. Registered Dieticians negotiate the paradox of feeling rewarded and heart-broken with frustration in counselling children living with obesity and their families.

5.1.2 Theme Two: Family Roles

The data shows the importance of including the family in the counseling process when working with children living with obesity, as the family plays such an influential role within the child’s life. These findings are consistent with the published literature, as
Lindsay et al. (2006) suggests that parents can encourage healthy eating habits at home by providing healthful foods and reduce the amount of sugar-sweetened beverages in the house. It is also noted that a child’s food preferences and eating behaviours begin at a very young age, therefore it is important for parents to take the responsibility to impact these early food environments (Anzman, Rollins, & Birch, 2007; Davison & Birch, 2001) through early exposure and repeated experience, as well as modeling healthful eating habits themselves (Lindsay et al., 2006). Furthermore, the availability of healthy foods within the home helps parents to encourage healthy eating patterns (Lindsay et al., 2006; Roblin, 2007; Davison & Birch, 2001). Because of this, it is evident that the family plays a vital role in the child’s dietary intake, and in turn the child’s weight status, and shows the need for the family to be included in the counseling process. This relationship dynamic is the basis of the paradox Registered Dieticians describe about their practice.

Emily and Danielle both mentioned how they recommend the use of the Satter Eating Competence Model (ecSatter) within their practice. This is an evidence-based, practice-based model that “outlines an inclusive definition of the interrelated spectrum of eating attitudes and behaviors” (Satter, 2007 p. S142). The main idea of this model within this context is about the division of responsibility, where the parents are responsible for what, when and where the family eats, and the children are responsible for whether or not they eat and how much they eat. Emily expressed that she really tries to encourage the parents to lead by example. The ecSatter approach recognizes that children, who are exposed to a variety of different food options, learn to like a variety of foods, even when they are given the independence to choose to eat it or not eat it (Satter, 2007). No matter how much food children under the age of three are given, they are able
self-regulate their own food intake until they feel full, whereas once the child gets older, it is common for parents to encourage their children to finish all of the food on their plate (Ramsay et al., 2010; Schmidt, 2003; Davison & Birch, 2001). The parents increasing control during meal times affect the child’s ability to self-regulate their food intake and calories, therefore putting the child at a greater risk of weight gain, leading to obesity (Anzman et al., 2010; Gable & Luta, 2000; Davison & Birch, 2001). The ecSatter approach is one resource that has been recommended by RDs to assist children living with obesity and their families within their practice.

RDs identified various non-food related issues that are mentioned during their counseling sessions with the children and their families. The main issues brought up are social, financial, family, and mental health. All of these issues may play a role in affecting the child’s eating behaviours at home. Most of the participants agreed that if an issue came up that was outside of their scope of practice, they would suggest additional services, resources and supports. The data shows that the RDs are interested in more counseling education in order to improve their skills at doing what is within their scope of practice.

The ecological systems theory looks at human development in the context of their relationships that form their environment (Davison & Birch, 2001). It suggests that when it comes to children living with obesity, the family’s characteristics and parenting styles play a role in the development of obesity in their children (Davison & Birch, 2001). The food that parents provide and make available to their children is greatly influenced by their socioeconomic status and their nutritional knowledge. Children from lower socioeconomic status groups are not only more likely to consume a less diverse diet than
children from a higher socioeconomic group, but parents may overfeed their children if they are unaware and lack the knowledge of the importance of eating healthy and the appropriate child serving sizes (Davison & Birch, 2001; Anzman et al., 2010; Lindsay et al., 2006).

Overall, it is evident that the family plays a vital role in the child’s dietary intake, and in turn the child’s weight status, and shows the need for the family to be included in the counseling process.

5.1.3 Theme Three: Measuring Success

Overall, the participant RDs were clear that successful interventions are not all about the numbers on the scale, as weight loss is not necessarily their primary focus. Many children are still growing, so if they are able to maintain their weight as they continue to grow, then that is seen as success. It is about the children and their families making healthy changes in their life, in terms of food choices and less sedentary time. The RDs like to see an improvement in their client’s behaviours and attitudes. They also like to see the children and their families feeling good about it, providing positive feedback, and feeling like it is becoming a part of their new habits. The RDs feel that if their clients are able to make these improvements, then they will be able to sustain the changes throughout their lives. However, none of the RDs mentioned if they ask the child and the family what they would consider ‘success’ to be. This leads to further research ideas. It is important for the RD to know what the child and their family considers ‘success’ to be, as learning about the families definition of success and goals may help the RD to establish a context for their counseling.
RDs agreed that their practice is constantly changing and they are continually learning after seeing each child and their family. Not only does the RD begin to feel more comfortable dealing with issues that may arise with the more experience they have, but it also helps them to weed out what is not working and fine-tune what does work. RDs education provides them with the knowledge to deliver basic nutrition education, explain the Canada food guide, describe appropriate serving sizes, and educate the families how to read labels. RDs encourage patient led nutrition goals and they motivate and work with the family to do goal setting and set realistic goals that can be maintained within their life. They teach basic nutrition education and provide strategies to help the families follow through with their goals. In order to improve the success of RDs, Alice suggested that it might be worth having an RD who is experienced in this field to be a part of a university education where they teach a class. The general nutritional background taught in dietetic programs helps to give some support, but there is a specific counseling component that comes with working with children who are obese and their families. The following theme goes into more detail on the education of RDs.

5.1.4 Theme Four: Registered Dietitian Education

Registered Dietitians are trained to educate their clients about nutrition and encourage them to make behaviour changes through their food choices and eating behaviours (Dietitians of Canada, 2012), and because of this RDs should be one of the key professionals educated to work with this population and manage obesity (Bar et al., 2004). However, it is evident throughout the data that RDs did not feel prepared from their education to work with children living with obesity and their families. Given this is an epidemic within society today, it is a serious concern. Lucy says that “theoretical
education on childhood obesity is very limited”, and most of the other participants would agree that schools need to be doing more in order to prepare future RDs to deal with some of the issues that will arise with this clientele. Lucy also mentions that dealing with these children and families are not as easy as just teaching and encouraging healthy eating behaviours, such as less high energy dense foods, less sugar-sweetened beverages, and more physical activity. Children and families are more challenging and require a “very specific counseling component that comes with overweight children and their families” (Alice). Many suggest that obesity counseling with families requires specialized training and skill development as they are dealing with people’s behaviours. RD participants from the study suggested that it would be helpful in the future for more access to resources; specifically resources on the energy balance in children and how to assess their diet, or how to manage the counseling and psychological aspect of childhood obesity. The RDs talked about how it is not just about the child but it is more about what the parents are providing for their children, therefore they feel that it would be beneficial to have education on how to deal with the parents. The family dynamics play a large role in the child’s eating behaviours and any difficulties within the family can affect the child’s eating patterns. Children may have two families due to the rate of divorce and separation; therefore there may be inconsistency within their environments as their parents may have different parenting styles. All of these areas are important as the study shows how influential the family is when it comes to the child’s eating behaviours and the RD will be dealing with not only the child’s behaviour, but the family as a whole. These additions to their education would assist RDs to manage the paradox that, in the context of family dynamics, their practice is rewarding and heart-breaking.
Participants voiced their concerns about the need for RD education and continuing education to be more on top of the current trends in childhood obesity management. In an online search, I could find useful education and continuing education courses for future and current RDs offered at Ryerson University as well as through Dietitians of Canada. Ryerson University offers a continuing education Certificate in Food Security, as well as a Certificate in Physical Activity: Assessment and Promotion. Ryerson’s Certificate in Food Security focuses on concepts and policies regarding food security within Canada. It is important for RDs to have this background as Dietitians of Canada feels that food security is a necessity and a basic right for all Canadians. The Certificate in Physical Activity: Assessment and Promotion is also offered, providing RDs with a broader skill set. This matters as more RDs are choosing to work in primary care, which presents them with an opportunity for a more enhanced role where they must be able to assess and implement physical activity interventions. Dietitians of Canada offers e-learning courses to its members at a small fee. One course that the organization offers is a behaviour change course. It is an evidence-based course that provides counseling strategies to support behaviour change (Dietitians of Canada, 2014). This course may be beneficial for RDs as they acknowledged the need for behaviour training since they are dealing with people and their behaviours when they are counseling children living with obesity and their families.

Continuing education is important for RDs, as professionals, as it not only maintains their knowledge and skill area, but it helps to enhance and provide new knowledge and skills to their current practice. The other universities where participants
completed their degrees do not offer any continuing education courses related to counseling children living with obesity and their families.

5.1.4.1 Motivational interviewing. Ann and Leah both mentioned motivational interviewing and how it is an important counseling strategy. In the past, motivational interviewing was used mainly within the addiction field (Resnicow, Davis, & Rollinick, 2006) as an alternative strategy in addressing and dealing with substance abuse (Gance-Cleveland & Oetzel, 2010). There have been many studies done to show its clinical efficacy for addictive behaviours (Resnicow, Davis, & Rollinick, 2006). Within the past decade, public health practitioners have adopted this framework in order to deal with various chronic disease behaviours (Resnicow, Davis, & Rollinick, 2006).

Motivational interviewing is a form of guiding (Resnicow, Davis, & Rollinick, 2006) and is used to encourage patients to express their “thoughts, feelings, and ambivalence, so that they reach a decisional balance” (Brug, Spikmans, Aartsen, Breedveld, Bes & Fereira, 2007, p.8). This method is used to help the patient come to a realization of their behaviour, choose what they think needs to change, and develop a strategic plan in order to make those changes (Brug et al., 2007). Practitioners who use this framework use open-ended questions throughout the interview (Gance-Cleveland & Oetzel, 2010) and focus on reflective listening (Resnicow, Davis, & Rollinick, 2006). It is important for motivational interviewers to assure their patients feel comfortable, so they are certain to use a non-judgmental and encouraging tone so that their patient does not feel vulnerable when talking about their behaviour (Davis, Gance-Cleveland, Hassink, Johnson, Paradis & Resnicow, 2007). This counseling approach is client-centered; therefore practitioners collaborate with the individual and their family (Gance-Cleveland & Oetzel, 2010), guide
patients to talk about how their health status may be affecting them to achieve any goals within their life (Reshicow, Davis, & Rollinick, 2006; Davis et al., 2007), and work with the patient and their family on a plan of care (Gance-Cleveland & Oetzel, 2010). The whole idea of motivational interviewing is to allow the patient and/or family talk about their behaviours and how they believe they need to change, because if they voice these concerns themselves, they are more likely to accept it and commit to these changes (Reshicow, Davis, & Rollinick, 2006; Davis et al., 2007). Interestingly, this method also ensures the patient’s goals are explicitly part of the planning and interventions.

Motivational interviewing is a framework for counselors to refer to when working with patients and/or families (Davis et al., 2007) and can easily be applied when dealing with weight control (Barlow & Dietz, 2002). The motivational interviewer helps their patients realize the issue of excess weight, help them recognize that eating and activity changes would be beneficial, and they help them build a plan of action in order to take steps to tackle the problem (Barlow & Dietz, 2002). In response to the childhood obesity epidemic, many organizations have responded by recommending the use of motivational interviewing, a family centered approach, to encourage healthy eating and exercise among families (Gance-Cleveland & Oetzel, 2010). This approach also recognizes that the problem of childhood obesity is multi-factorial and requires attention to the child, their family, school and broader environment.

It has been recommended that providers use motivational interviewing within their practice, however they have not been trained in the use of it (Gance-Cleveland & Oetzel, 2010). Many health care providers who deal with children do not feel confident, or qualified in counseling obese children and their families (Resnicow, Davis & Rollinick,
This is where the role of the education of Registered Dietitians comes into play. Registered Dietitians would benefit most from motivational interviewing training, as they are already trained professionals in dealing with obesity (Barr, Yarker, Levy-Milne & Chapman, 2004), and they are experienced with counseling patients about diet and activity changes (Barlow & Dietz, 2002). Motivational interviewers could work with the child and their family to pinpoint the actions that may be contributing to the child’s weight and try and come to an agreement on interventions (Resnicow et al., 2006). If the child is older, it is important for the intervention to take place with the child themselves, as studies have shown that older children do not benefit as much as younger children with the involvement of their parents (Resnicow et al., 2006). An introduction to motivational interviewing as a counseling technique for behaviour change can be found in module 5 of the knowledge center through the Dietitians of Canada website (Dietitians of Canada, 2013c). It is clear that motivational interviewing is an important counseling technique for Registered Dietitians to use within their practice to encourage behaviour change in their clients. It will be discussed further in section 5.2 Practical Implications and Recommendations.

5.2 Practical Implications and Recommendations

As previously mentioned, the goal of phenomenological research is to better understand the phenomenon under study. Therefore, it is not possible to provide generalizations or recommendations to a larger or pronounced population. However, this study has practical use in contributing to greater awareness of the lived experiences of Registered Dietitians who counsel children living with obesity and their families and is transferable to other situations. Listening to the lived experience of the RDs who
participated in the study may provide both future and current RDs with insight into their own practice, as well as those who educate RDs as they are able to recognize and understand what is actually happening when the RDs are counseling this population and what educational resources are needed in order to better their practice.

The recommendations provided from this study are important because the suggestions given come directly from the participants themselves. The focus of the recommendations is on how to better support RDs who counsel children living with obesity and their families, as most participants expressed that they were not prepared to counsel this population.

5.2.1 Recommendations for Those Who Educate Registered Dietitians

5.2.1.1 Physical activity. It is recognized that physical activity counseling is not an area of expertise for Registered Dietitians and it goes beyond their scope of practice. However, the number of RDs who are working within primary care settings is increasing. Therefore, RDs are now given an opportunity for a more enhanced role where they must be able to combine their nutrition expertise with a physical activity component where they assess and implement not only food-related interventions, but physical activity interventions as well. If many RDs are graduating and working within primary care, then a course in physical activity assessment and promotion needs to be included at the undergraduate level when students are completing their degree so they are prepared upon graduation. RDs already in practice could take such a course through continuing education.
5.2.1.2 **Resources.** Most RDs stated that they believe resources are key within their practice; however no standard resources are provided and they have to research on their own in order to find documents that would be useful in their practice. The RDs agree that realistic healthy eating and good eating hygiene are easy to teach, but their work becomes more difficult when dealing with people and behaviours. Also, there are issues that are not related to food that are brought up in counseling sessions with the RD, the child, and their family, and they are not taught how to deal with these aspects of counseling within their nutritional education. Therefore, resources need to be provided to RDs in the areas of family counseling, family psychology, cognitive behaviour strategies to use in counseling, and appropriate assessment forms and counseling tips to use when working with children living with obesity and their families. These suggestions from the RDs are of importance because it helps them to get a bigger picture of what is going on in the child’s life and how other factors within their family dynamics may be affecting the child’s eating behaviours at home. Dietitians of Canada should include an area within their website that only members can access, where colleagues can go and talk to others who are working with the same population and share tips and ideas that they have found worked and/or did not work within their practice.

5.2.1.3 **Motivational interviewing.** The importance of motivational interviewing was mentioned by a couple of participants within the study. Motivational interviewing is a family centered approach to encourage healthy eating and exercise among families, as it helps the children and their families recognize the issue of obesity, how eating and activity changes would benefit them, and help the family make a plan of change. Motivational Interviewing meets the Dietitians of Canada’s standards for
patient-centered care and for including the child and family’s definitions of quality of life, and of success in the care planning (Dietitians of Canada, 2009). Providing motivational interview training to current and future RDs would greatly benefit their practice and strengthen their counseling skills when working with children living with obesity and their families. It is recommended for dietetic programs to include an introduction to motivational interviewing as an approach to support behaviour change, which would aid in counseling children living with obesity and their families. Dietitians of Canada offer a learning on demand module on “Counseling to Promote Healthy Growth and Development” that not only introduces motivational interviewing, but it establishes useful strategies that would be beneficial to RDs when beginning to talk to the parents about their child who is obese (Dietitians of Canada, 2013c). Therefore, it is also recommended that RDs already practicing take part in this module, as it will benefit them within their practice.

5.2.2 Recommendations for Future Research

It is suggested by my study participants that using motivational interviewing as a counseling technique can benefit RDs in their practice. Therefore in the future, an evaluation of the effectiveness of Registered Dietitians using motivational interviewing as a counseling technique when working with children living with obesity and their families should be done.

Also, Registered Dietitians described that they see a successful intervention as being where the child and the family have made a healthy lifestyle change; they are content and find the strategies helpful. In the future it would be interesting to investigate
how Registered Dietitians, as professionals, view successful interventions and what their clients see as being a successful intervention and whether or not they are on the same page.

Social determinants of health, particularly income, may affect the nutrition of the child and their family (Veugelers & Fitzgerald, 2005; Mark, Lambert, O’Loughlin, & Gray-Donald, 2012). This was not a prominent theme in the interviews by the participant RDs probably because the families do not have an issue with the accessibility and affordability of healthy foods. This claim is based on the assumption that those seeing these RDs can afford to pay out of pocket for a private practice services. Since this study focused on Registered Dietitians who work in their own private practices, future research could not only look at comparing Registered Dietitians who work in a public setting with Registered Dietitians who work in a private setting to see whether or not they are experiencing the same situations with children living with obesity and their families, but it could also determine how social determinants of health, specifically income, affect a child’s nutrition, and in turn, their weight status.

Another issue that did not arise in the interviews was prevention of obesity in children. Perhaps this is because the child already is suffering with weight issues by the time a family brings them to an RD. The work of RDs in public health and with healthy eating to ensure proper nutrition and body weight could be the subject of further research.

Furthermore, cultural eating practices and health beliefs related to food can greatly affect a family’s eating behaviours and how they view nutrition (Kumanyika, 2008; Caprio et al., 2008). It was surprising that nothing related to this was talked about
within the interviews with the participant Registered Dietitians, as Canada is a multicultural nation. Therefore, it is recommended that future research looks at how different cultural eating practices and cultural health beliefs affects families’ dietary practices, and how does it affect the weight of the child.

5.3 Closing Thoughts

This study used a phenomenology of practice approach in order to determine Registered Dietitian’s lived experience counseling children living with obesity and their families, as well as what education and resources prepared them to counsel this population. In summary, the participant RDs made it clear that family dynamics and what is happening within the child’s environment plays a large role in their eating behaviours. The RDs indicate that the way in which the child’s family models healthy behaviours and emphasizes the significance of eating healthy and being active has a large influence on the child’s dietary practices, physical activity and sedentary habits. Because of this, RDs feel that the parents sometimes need the counseling more than the children. The RDs know that they have been successful when they receive positive feedback from the child and their family, and that have made a healthy lifestyle change they are able to maintain.

Registered Dietitians are educated to deliver basic nutrition education to their clients, as well as to provide recommendations regarding the Canada Food Guide, appropriate serving sizes and education on how to read food labels. RDs aim to work with the children and their families to set realistic goals that will be maintained for the rest of their lives, but the participants make it clear that there is a specific counseling
component that comes with counseling children living with obesity and their family. Therefore, the RDs suggest that more counseling techniques and behaviour change courses would build their knowledge to enhance their practice.

As VanManen (2014) suggests, the lived experience of Registered Dietitians can be explored by phenomenological thematization and description. The RDs keep on living their daily lives and re-interpret the meaning of that experience. In that sense, phenomenological exploration of practice is never finished or complete. This is important to RDs as they can reflect on and continuously develop their practice. The participants agree that their practice is constantly changing and they are always trying to improve. A phenomenology of practice matters to RDs and to those who educate them as the need for education and resources is expressed as well as being a way to help RDs to improve their practice.
6.0 References


website
http://www.worldobesity.org/iotf/obesity/childhoodobesity/sydneyprinciples/

Interdisciplinary Journal*, 5.

cost of health services among overweight and obese Canadian children.


of pediatric obesity using physical activity. *Canadian Medical Association

Lindsay, A., Sussner, K., Kim, J., & Gortmaker, S. (2006). The role of parents in
preventing childhood obesity. *Childhood Obesity*, 16(1), 169-186.


Lobstein, T., Baur, L., & Uaway, R. (2004). Obesity in children and young people:


7.0 Appendices

Appendix A

Initial Letter of Invitation

November 11, 2013

Dear Participant,

I am conducting research with Registered Dietitians (RDs), who are included on the Registered Dietitians of Canada register, to help gain a better understanding of RDs’ lived experiences counseling children living with obesity and their families.

Because you identified a clinical focus of both children and obesity on the register, you are invited to participate in this research study. The purpose of the study is to explore the lived experience of Registered Dietitians who counsel children living with obesity and their families. Due to the high prevalence of childhood obesity, it is important to recognize the different lived experiences of practitioners who are treating this population. This study sets out to investigate the lived experience of RDs who are engaged with this population. It will contribute to intervention literature about how to help RDs help children who are living with obesity and their families. Gaining an understanding of the RDs lived experience in counseling children living with obesity and their families will aid in developing appropriate education and training support and continuing education for RDs. Finally, by increasing the knowledge and understanding of RDs lived experience with counseling children with obesity and their families, it allows the RD to learn what their colleagues are doing when working with this population, which helps to affirm and extend their practice.

This study consists of a 45-60 minute interview by telephone in order to understand your lived experience. The interview will be composed of open-ended questions such as: What is the lived experience of Registered Dietitians in Canada who counsel children that are living with obesity and their families? As well as, what resources and education prepare Registered Dietitians to counsel children living with obesity and their families?

While you will be asked a few demographic questions, there is no individually identifying information collected. Your replies are anonymous and confidential. Should sharing stories bring forward uncomfortable feelings, you would have the option to stop the research process temporarily or permanently without any consequences or penalties to you. You may refuse to answer any particular question, or stop participation altogether. If you withdraw from the study, your informed consent and any recordings or transcripts will be destroyed and will not be used in the data analysis. If you find you are upset at or after the research appointment, please speak with the researcher to explore how you wish to proceed with assistance and available resources.

Once the data is analyzed, a summary of the study will be sent to the participants and the findings will be available through presentations and publications.
Please read the attached consent and indicate your willingness to participate in this research by emailing me at brittany.roberts@uoit.ca

Thank you for your consideration,

*Brittany Roberts MHSc Candidate, BA*
University of Ontario Institute of Technology
[brittany.roberts@uoit.ca](mailto:brittany.roberts@uoit.ca)
613-827-0959
Appendix B

Revised Letter of Invitation

Dear Participant,

I am conducting research with Registered Dietitians (RDs), who are included on the Registered Dietitians of Canada register, to help gain a better understanding of RDs’ lived experiences counseling children living with obesity and their families.

I have spoken with Andrea Miller, and she has suggested that I get in touch with you.

The purpose of the study is to explore the lived experience of Registered Dietitians who counsel children living with obesity and their families. Due to the high prevalence of childhood obesity, it is important to recognize the different lived experiences of practitioners who are treating this population. This study sets out to investigate the lived experience of RDs who are engaged with this population. It will contribute to intervention literature about how to help RDs help children who are living with obesity and their families. Gaining an understanding of the RDs lived experience in counseling children living with obesity and their families will aid in developing appropriate education and training support and continuing education for RDs. Finally, by increasing the knowledge and understanding of RDs lived experience with counseling children with obesity and their families, it allows the RD to learn what their colleagues are doing when working with this population, which helps to affirm and extend their practice.

This study consists of a survey, via email, OR a 30-minute interview by telephone in order to understand your lived experience. The interview will be composed of open-ended questions.

While you will be asked a few demographic questions, there is no individually identifying information collected. Your replies are anonymous and confidential. Should sharing stories bring forward uncomfortable feelings, you would have the option to stop the research process temporarily or permanently without any consequences or penalties to you. You may refuse to answer any particular question, or stop participation altogether. If you withdraw from the study, your informed consent and any recordings or transcripts will be destroyed and will not be used in the data analysis. If you find you are upset at or after the research appointment, please speak with the researcher to explore how you wish to proceed with assistance and available resources.

Once the data is analyzed, a summary of the study will be sent to the participants and the findings will be available through presentations and publications.

Please read the attached consent and indicate your willingness to participate in this research by emailing me at brittany.roberts@uoit.ca
Thank you for your consideration,

_Brittany Roberts MHSc Candidate, BA_
University of Ontario Institute of Technology
brittany.roberts@uoit.ca
613-827-0959
Appendix C

Initial Consent to Participate – Telephone Interview

CONSENT TO PARTICIPATE IN RESEARCH STUDY

Exploring Registered Dietitians’ lived experiences counseling children living with obesity and their families

Principal Investigator:
Brittany Roberts BA, MHSc Candidate
University of Ontario Institute of Technology
brittany.roberts@uoit.ca
613-827-0959

Thesis supervisor:
Gail Lindsay, RN, PhD
Associate Professor
University of Ontario Institute of Technology
gail.lindsay@uoit.ca
905.721.8668 ext. 2175

Introduction:
Before agreeing to take part in this research study, it is important that you read the information in this research consent form. It includes details you need to know in order to decide whether or not you want to take part in the study. You should not agree to participate in the study until you are sure you understand the information. All research participation is voluntary.

If you have any questions, please ask/contact the principle researcher, Brittany Roberts (Tel: 613-827-0959 or email: brittany.roberts@uoit.ca).

Purpose of the Study
You are invited to participate in a research study. The purpose of the study is to explore the lived experience of Registered Dietitians who counsel children living with obesity and their families. Due to the high prevalence of childhood obesity, it is important to
recognize the different lived experiences of practitioners who are treating this population. This study sets out to investigate the lived experience of RDs who are engaged with this population. It will contribute to intervention literature about how to help RDs help children who are living with obesity and their families. Gaining an understanding of the RDs lived experience in counseling children living with obesity and their families will aid in developing appropriate education and training support and continuing education for RDs. Finally, by increasing the knowledge and understanding of RDs lived experience with counseling children with obesity and their families, it allows the RD to learn what their colleagues are doing when working with this population, which helps to affirm and extend their practice.

Description of the Study

This research project consists of one 45-60 minute interview facilitated by Brittany Roberts. The interview will take place at a time of your choice by telephone. You will participate in a conversation about your lived experience counseling children with obesity and their families and answer questions about your lived experience.

What is experimental in this study?

The Researcher is facilitating participants to explore:

- What is the lived experience of Registered Dietitians who are counseling children living with obesity and their families?
- What resources and education prepares Registered Dietitian to counsel children living with obesity and their families?

Risks and Discomforts

There is very little foreseeable harm and thus the risk of participating in this study is minimal. Should sharing stories bring forward uncomfortable feelings you would have the option to stop the research process temporarily or permanently without any consequences or penalties to you. You may refuse to answer any particular question, or stop participation altogether. If you withdraw from the study, your informed consent and any recordings or transcripts will be destroyed and will not be used in the data analysis. If you find you are upset at or after the research appointment, please speak with the researcher to explore how you wish to proceed with assistance and available resources.

This research has been reviewed by the Research Ethics Board at University of Ontario Institute of Technology and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines

Benefits of the Study

It is the researchers’ intention that this study will be beneficial to you as a source of personal and professional growth. Anonymized findings from the interviews will be
shared with participants. Otherwise, there is no other direct benefit to you from participating in this study. However, the findings of this study may contribute to understanding the lived experience of RDs with potential for informing Registered Dietitian education and continuing education.

Confidentiality

The importance of confidentiality will be reviewed at the beginning of the interview. The interview will be audio taped and will not include any identifying information. These tapes will be destroyed at the end of the research. To protect your privacy, no actual names of the Registered Dietitians will be used within the transcription, and/or any other method of dissemination. Pseudonyms will be used in transcriptions and in dissemination methods. NVivo files, used in anonymized data analysis, will be deleted upon completion of the study.

Incentives to Participate

The satisfaction of contributing to personal and professional development and to generate new Registered Dietitian knowledge.

Voluntary Nature of Participation

Participation in this study is strictly voluntary and you may withdraw from the study at any time without negative consequences to you. At any point in this study, you may refuse to answer any particular question or stop participation altogether. If you withdraw from the study, any recordings or transcripts will be destroyed and will not be used in the data analysis.

Questions about the Study

For any questions about the research study now or at a later date, please ask or contact the researcher:

Brittany Roberts MHSc Candidate, BA
University of Ontario Institute of Technology
brittany.roberts@uoit.ca
613-827-0959

Any questions regarding rights as a human subject and participant in this study please contact the following:
Agreement

Dear Participant:
I have read the information in the consent document. I agree to a telephone interview. I will ask any questions I have about the study, *Exploring the lived experience of Registered Dietitians counseling children living with obesity and their families*, conducted by Brittany Roberts, BA, MHSc Candidate, of University of Ontario Institute of Technology, at the time of the interview. My agreement indicates that I voluntarily agree to be in the study and have been told that I can change my mind and withdraw my consent to participate at any time. I am not giving up any of my legal rights by agreeing to participate in this study.

Audio-taping

By agreeing to participate in this study, I consent to being audio-taped, and my words and comments transcribed, without any identifying names and/or attributes, included in future publications by the researcher.

Member Check and Follow up

I consent to having the transcription of my interview sent to me in order to comment on anything inaccurate or add anything I wish to enlarge on. I also consent to having the researcher contact me via telephone or email one week after I receive the transcript to see if there is anything I wish to change or enlarge on prior to finalizing the transcription.

Preferred Telephone number(s)

Preferred Email Address
Summary of Study

By providing an email address or mailing address below, I consent to having the summary of the completed study sent to me. I wish to have this document sent to me via:

Email : ________________________________________

Or

Mail: __________________________________________

__________________________________________
Appendix D

Revised Consent to Participate – Telephone Interview

CONSENT TO PARTICIPATE IN RESEARCH STUDY

Exploring Registered Dietitians’ lived experiences counseling children living with obesity and their families

Principal Investigator:
Brittany Roberts BA, MHSc Candidate
University of Ontario Institute of Technology
brittany.roberts@uoit.ca
613-827-0959

Thesis supervisor:
Gail Lindsay, RN, PhD
Associate Professor
University of Ontario Institute of Technology
gail.lindsay@uoit.ca
905.721.8668 ext. 2175

Introduction:
Before agreeing to take part in this research study, it is important that you read the information in this research consent form. It includes details you need to know in order to decide whether or not you want to take part in the study. You should not agree to participate in the study until you are sure you understand the information. All research participation is voluntary.

If you have any questions, please ask/contact the principle researcher, Brittany Roberts (Tel: 613-827-0959 or email: brittany.roberts@uoit.ca).
Purpose of the Study

You are invited to participate in a research study. The purpose of the study is to explore the lived experience of Registered Dietitians who counsel children living with obesity and their families. Due to the high prevalence of childhood obesity, it is important to recognize the different lived experiences of practitioners who are treating this population. This study sets out to investigate the lived experience of RDs who are engaged with this population. It will contribute to intervention literature about how to help RDs help children who are living with obesity and their families. Gaining an understanding of the RDs lived experience in counseling children living with obesity and their families will aid in developing appropriate education and training support and continuing education for RDs. Finally, by increasing the knowledge and understanding of RDs lived experience with counseling children with obesity and their families, it allows the RD to learn what their colleagues are doing when working with this population, which helps to affirm and extend their practice.

Description of the Study

This research project consists of a survey, via email, OR one 30-minute interview facilitated by Brittany Roberts. The interview will take place at a time of your choice by telephone. You will participate in a conversation about your lived experience counseling children with obesity and their families and answer questions about your lived experience.

What is experimental in this study?

The Researcher is facilitating participants to explore:

- What is the lived experience of Registered Dietitians who are counseling children living with obesity and their families?
- What resources and education prepares Registered Dietitian to counsel children living with obesity and their families?

Risks and Discomforts

There is very little foreseeable harm and thus the risk of participating in this study is minimal. Should sharing stories bring forward uncomfortable feelings you would have the option to stop the research process temporarily or permanently without any consequences or penalties to you. You may refuse to answer any particular question, or stop participation altogether. If you withdraw from the study, your informed consent and any recordings or transcripts will be destroyed and will not be used in the data analysis. If you find you are upset at or after the research appointment, please speak with the researcher to explore how you wish to proceed with assistance and available resources.

This research has been reviewed by the Research Ethics Board at University of Ontario Institute of Technology and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.
Benefits of the Study

It is the researchers’ intention that this study will be beneficial to you as a source of personal and professional growth. Anonymized findings from the interviews will be shared with participants. Otherwise, there is no other direct benefit to you from participating in this study. However, the findings of this study may contribute to understanding the lived experience of RDs with potential for informing Registered Dietitian education and continuing education.

Confidentiality

The importance of confidentiality will be reviewed at the beginning of the interview. The interview will be audio taped and will not include any identifying information. These tapes will be destroyed at the end of the research. To protect your privacy, no actual names of the Registered Dietitians will be used within the transcription, and/or any other method of dissemination. Pseudonyms will be used in transcriptions and in dissemination methods. NVivo files, used in anonymized data analysis, will be deleted upon completion of the study.

Incentives to Participate

The satisfaction of contributing to personal and professional development and to generate new Registered Dietitian knowledge.

Voluntary Nature of Participation

Participation in this study is strictly voluntary and you may withdraw from the study at any time without negative consequences to you. At any point in this study, you may refuse to answer any particular question or stop participation altogether. If you withdraw from the study, any recordings or transcripts will be destroyed and will not be used in the data analysis.

Questions about the Study

For any questions about the research study now or at a later date, please ask or contact the researcher:

Brittany Roberts MHSc Candidate, BA
University of Ontario Institute of Technology
brittany.roberts@uoit.ca
613-827-0959
Any questions regarding rights as a human subject and participant in this study please contact the following:

Ethics and Compliance Officer
Office of Research Services
University of Ontario Institute of Technology
Oshawa, ON  L1H 7K4
905-721-8668 ext 3693
REB File #: 13-044

Agreement

Dear Researcher:
I have read the information in the consent document. I agree to participate in the study. I will ask any questions I have about the study, *Exploring the lived experience of Registered Dietitians counseling children living with obesity and their families*, conducted by Brittany Roberts, BA, MHSc Candidate, of University of Ontario Institute of Technology, at the time of the interview. My agreement indicates that I voluntarily agree to be in the study and have been told that I can change my mind and withdraw my consent to participate at any time. I am not giving up any of my legal rights by agreeing to participate in this study.

I prefer to participate in a telephone interview YES ___ NO _____

I prefer to participate through the email survey YES ____ NO ____

If yes, my email address is ________________________________

Audio-taping for telephone interview

By agreeing to participate in this study, I consent to being audio-taped, and my words and comments transcribed, without any identifying names and/or attributes, included in future publications by the researcher.

Member Check and Follow up for telephone interview

I consent to having the transcription of my interview sent to me in order to comment on anything inaccurate or add anything I wish to enlarge on. I also consent to having the researcher contact me via telephone or email one week after I receive the transcript to see if there is anything I wish to change or enlarge on prior to finalizing the transcription.
Preferred Telephone number(s)

Preferred Email Address

**Summary of Study**

By providing an email address or mailing address below, I consent to having the summary of the completed study sent to me. I wish to have this document sent to me via:

Email: ______________________________

Or

Mail: ______________________________

_____________________________________

_____________________________________

_____________________________________

_____________________________________

_____________________________________

_____________________________________

_____________________________________

_____________________________________

_____________________________________
Appendix E

Consent to Participate - Survey

Exploring Registered Dietitians’ lived experiences counseling children living with obesity and their families

PARTICIPANT PSEUDONYM: DATE:

Answering Introductory Questions:

You give your consent to answer introductory questions by doing so.

1. What year were you born?

2. What year did you graduate?

3. What school and program did you graduate from?

4. Where did you do your training/internship?

5. How long have you been practicing?

6. Years of practice counseling children (5-17 years of age) living with obesity?

7. What is the age range of the children living with obesity you have counseled?
   - What proportion of children under 10 are above the 97th percentile?
   - What proportion of children over 10 are above the 97th percentile?

8. Have you taken any continuing education or specific training in this area since you graduated in this area?
Survey Questions

You give your consent to answer survey questions by doing so.

1. How would you characterize/describe your RD practice? (How does counseling children living with obesity fit into the practice? Central? Marginal?)

2. Tell me about your experience working with children who are living with obesity and their family.

3. Is there a story/situation they really stands out for you?

4. How do you define obesity to a family member?

5. Tell me about the first time you counseled a child living with obesity and their family and how has your practice in this area remained the same or changed from that first time?

6. You do certain things to help children living with obesity and their families – what kind of things do you do?

7. What do you consider as being a successful intervention and how do you know when you have been successful – how do you measure success?

8. Are there any resource implications when counseling children living with obesity and their families?

9. How do you assess the family’s role/practices with their child related to obesity?

10. How do you motivate the family to eat better?

11. Does the family ever talk to you about issues that do not involve food?
   • What are some of these issues?
   • How do you deal with these issues?

12. How comfortable are you counseling on physical activity?
   • Are you aware of the physical education guidelines for children?
     o Do you make your clients aware of them?
     o Do you use them in your practice?
   • How do you motivate the family to become more active?

13. How prepared were you by your education to work with children living with obesity and their families?

14. With the numbers of children living with obesity on the rise, how should schools prepare RDs in educating them to deal with this population?
15. Sometimes own life experience comes into your own practice, is there anything in your life that comes into play? For example, your own experience with obesity/weight issues, do you have children and if so, do they struggle with weight issues, and/or is there anything that you have learned throughout your life that influences your practice when counselling children living with obesity and their families?

16. Is there anything else you would like to tell me about your experience of counseling children living with obesity and their families?
Appendix F

Interview Guide

PARTICIPANT PSEUDONYM:  

DATE:

Answering Introductory Questions:

Do you agree and give your consent to answer introductory questions?

What year were you born? __________ What year did you graduate? __________
What school and program did you graduate from? __________________________
Where did you do your training/internship?______________________________
How long have you been practicing?__________
Years of practice counseling children (5-17 years of age) living with obesity? ______
What is the age range of the children living with obesity you have counseled? ______
  - What proportion of children under 10 are above the 97th percentile? ________
  - What proportion of children over 10 are above the 97th percentile? __________

Have you taken any continuing education or specific training in this area since you
graduated in this area? ____________

Interview Questions

How would you characterize/describe your RD practice? (How does counseling children
living with obesity fit into the practice? Central? Marginal?)

_Umbrella Question:_ Tell me about your experience working with children who are
living with obesity and their family.

  o Is there a story/situation they really stands out for you?
How do you define obesity to a family member?
Tell me about the first time you counseled a child living with obesity and their family. How has your practice in this area remained the same or changed from that first time?

You do certain things to help children living with obesity and their families – what kind of things do you do?

What do you consider as being a successful intervention and how do you know when you have been successful – how do you measure success?

Are there any resource implications when counseling children living with obesity and their families?

How do you assess the family’s role/practices with their child related to obesity?

How do you motivate the family to eat better?

Does the family ever talk to you about issues that do not involve food?

- What are some of these issues?
- How do you deal with these issues?

How comfortable are you counseling on physical activity?

- Are you aware of the physical education guidelines for children?
  - Do you make your clients aware of them?
  - Do you use them in your practice?
- How do you motivate the family to become more active?

How prepared were you by your education to work with children living with obesity and their families?

With the numbers of children living with obesity on the rise, how should schools prepare RDs in educating them to deal with this population?

→ Sometimes own life experience comes into your own practice, is there anything in your life that comes into play?

- dietitian’s own experience with obesity
- history of weight issues?
- have children?
- do they have weight issues?
- anything learned throughout their life?

Is there anything else you would like to tell me about your experience of counseling children living with obesity and their families.
Appendix G

Timeline

October 2013
- REB Application

November 2013
- REB Approval

November/December 2013
- 1st round of recruitment
- 2 participants

December 2013
- REB Amendment

January 2014
- REB Amendment Approval

January – March 2014
- 2nd round of recruitment
- 6 participants

March/April 2014
- Data analysis
- 1st draft thesis
April/May 2014
  o Thesis edits with supervisor

May 2014
  o Thesis sent to committee

June 2014
  o Committee meeting
  o Final edits for thesis
  o Thesis sent to external examiner

August 2014
  o Thesis defense
Appendix H

Date: November 6th, 2013
To: Brittany Roberts (Graduate Student) and Gail Lindsay (Supervisor)
From: Bill Goodman, REB Chair
REB File #: 13-044
Project Title: Exploring Registered Dietitians’ experiences counseling children living with obesity and their families
DECISION: APPROVED
START DATE: November 6th, 2013 EXPIRY: November 6th, 2014

The University of Ontario, Institute of Technology Research Ethics Board (REB) has reviewed and approved the above research proposal. This application has been reviewed to ensure compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCP52) and the UOIT Research Ethics Policy and Procedures.

Please note that the (REB) requires that you adhere to the protocol as last reviewed and approved by the REB.

Always quote your REB file number on all future correspondence.

Please familiarize yourself with the following forms as they may become of use to you.

- Change Request Form: any changes or modifications (i.e. adding a Co-PI or a change in methodology) must be approved by the REB through the completion of a change request form before implemented.

- Adverse or unexpected Events Form: events must be reported to the REB within 72 hours after the event occurred with an indication of how those events affect (in the view of the Principal Investigator) the safety of the participants and the continuation of the protocol. (I.e. an-anticipated or un-mitigated physical, social or psychological harm to a participant).

- Research Project Completion Form: must be completed when the research study has completed.

- Renewal Request Form: any project that exceeds the original approval period must receive approval by the REB through the completion of a Renewal Request Form before the expiry date has passed.

All Forms can be found at http://research.uoit.ca/faculty/policies-procedures-forms.php

REB Chair
Dr. Bill Goodman, Faculty of Health Sciences
bill.goodman@uoit.ca

Ethics and Compliance Officer
compliance@uoit.ca

University of Ontario, Institute of Technology
2000 Simcoe Street North, Oshawa ON, L1H 7K4
PHONE: (905) 721-8688, ext. 5093

XXIII
Appendix I

Date: January 22nd, 2014

To: Brittany Roberts (Graduate Student) and Gail Lindsay (Supervisor)

From: Manon Lemonde, REB Vice-Chair

REB File #: 13-044

Project Title: Exploring Registered Dietitians’ experiences counseling children living with obesity and their families

DECISION: CHANGE REQUEST APPROVED

CURRENT EXPIRY: November 6th, 2014

The University of Ontario, Institute of Technology Research Ethics Board (REB) has reviewed and approved the above research proposal. This application has been reviewed to ensure compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and the UOIT Research Ethics Policy and Procedures.

Please note that the (REB) requires that you adhere to the protocol as last reviewed and approved by the REB.

Always quote your REB file number on all future correspondence.

Please familiarize yourself with the following forms as they may become of use to you.

- **Change Request Form:** any changes or modifications (i.e. adding a Co-PI or a change in methodology) must be approved by the REB through the completion of a change request form before implemented.

- **Adverse or unexpected Events Form:** events must be reported to the REB within 72 hours after the event occurred with an indication of how those events affect (in the view of the Principal Investigator) the safety of the participants and the continuation of the protocol. (i.e. un-anticipated or un-mitigated physical, social or psychological harm to a participant).

- **Research Project Completion Form:** must be completed when the research study has completed.

- **Renewal Request Form:** any project that exceeds the original approval period must receive approval by the REB through the completion of a Renewal Request Form before the expiry date has passed.

All Forms can be found at [http://research.uoit.ca/faculty/policies-procedures-forms.php](http://research.uoit.ca/faculty/policies-procedures-forms.php)

<table>
<thead>
<tr>
<th>REB Vice-Chair</th>
<th>Ethics and Compliance Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Manon Lemonde, Health Science</td>
<td><a href="mailto:compliance@uoit.ca">compliance@uoit.ca</a></td>
</tr>
<tr>
<td><a href="mailto:manon.lemonde@uoit.ca">manon.lemonde@uoit.ca</a></td>
<td></td>
</tr>
</tbody>
</table>

University of Ontario, Institute of Technology
200 Simcoe Street North, Oshawa ON, L1H 7K4
PHONE: (905) 721-3668, ext. 3693
### Appendix J

#### Demographics

<table>
<thead>
<tr>
<th>Name (Pseudonym)</th>
<th>Age</th>
<th>Year graduated</th>
<th>Years practicing</th>
<th>Years counseling children living with obesity</th>
<th>Age range of children living with obesity counseled</th>
<th>Proportion of children under 10 above 97th percentile</th>
<th>Proportion of children over 10 above 97th percentile</th>
<th>Continuing education</th>
<th>Childhood Obesity: Central or Marginal in Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alice</td>
<td>42</td>
<td>1998</td>
<td>15</td>
<td>2-3</td>
<td>4-18</td>
<td>10%</td>
<td>20%</td>
<td>Yes</td>
<td>Central</td>
</tr>
<tr>
<td>Ann</td>
<td>28</td>
<td>2009</td>
<td>4</td>
<td>-----</td>
<td>5-12</td>
<td>-----</td>
<td>-----</td>
<td>No</td>
<td>Marginal</td>
</tr>
<tr>
<td>Danielle</td>
<td>50</td>
<td>1988</td>
<td>26</td>
<td>16</td>
<td>2-18</td>
<td>40%</td>
<td>80%</td>
<td>Yes</td>
<td>Central</td>
</tr>
<tr>
<td>Emily</td>
<td>35</td>
<td>2005</td>
<td>8.5</td>
<td>5</td>
<td>1-18</td>
<td>BMI&gt;99% or BMI&gt;95%+comorbidity</td>
<td>BMI&gt;99% or BMI&gt;95%+comorbidity</td>
<td>Yes</td>
<td>Central</td>
</tr>
<tr>
<td>Grace</td>
<td>46</td>
<td>1994</td>
<td>&gt;20</td>
<td>&gt;20</td>
<td>-----</td>
<td>40%</td>
<td>60%</td>
<td>Yes</td>
<td>Marginal</td>
</tr>
<tr>
<td>Leah</td>
<td>42</td>
<td>1996</td>
<td>15</td>
<td>5</td>
<td>4-17</td>
<td>90%</td>
<td>80%</td>
<td>No</td>
<td>Central</td>
</tr>
<tr>
<td>Lucy</td>
<td>26</td>
<td>2012</td>
<td>2+</td>
<td>2</td>
<td>4-18</td>
<td>10-20%</td>
<td>30-40%</td>
<td>No</td>
<td>Marginal (used to be central)</td>
</tr>
<tr>
<td>Mallory</td>
<td>40</td>
<td>2002</td>
<td>11</td>
<td>11</td>
<td>4-18</td>
<td>30%</td>
<td>30%</td>
<td>Yes</td>
<td>Marginal</td>
</tr>
</tbody>
</table>