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Processes of Identification in Families Enrolled in a Childhood Obesity Intervention: A Qualitative Study of Identities and Roles

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Abstract: Family involvement is important in interventions targeting childhood obesity. However, family-based interventions have limited impact. Being labeled obese or overweight and/or perceiving oneself as overweight is associated with weight gain over time. The links between weight perception, labelling, as well as individual and familial identities need to be studied more closely. This paper examines how dynamics of identity and identification within the family impact how the intervention is implemented into daily practices. The dataset consists of 15 semi-structured family interviews with a total of 15 children and 21 parents. The study showed an intense focus on the children's weight and weight loss. Identification as overweight or obese determined how the members of the enrolled families approached the intervention. Children and other family members who identified themselves as being overweight or obese took more responsibility for their own health behavior, but not necessarily in a positive manner. This often resulted in conflicts within the families. Healthcare professionals working with childhood obesity interventions need to consider how to deal with family identity dynamics to secure support as different identities within the family predicts whether the family members find the intervention relevant and whether the intervention was implemented positively into daily life.

Keywords: childhood obesity; identity; family; qualitative research

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1. Introduction

For several decades, there has been an increase in the prevalence of overweight and obese children and adolescents worldwide, leading to childhood overweight and obesity being one of the most serious public health challenges in the 21st century [1,2]. This development has also been seen in Denmark, where The Health Behavior in School-age Children (HBSC) study shows that every tenth 11-year-old child is overweight or obese [3].

Childhood overweight and obesity are reasons for concern, as it is estimated that about 70% of overweight and obese children remain overweight as adults [4]. Overweight and obesity may cause type 2 diabetes, asthma, hypertension, and reduced liver function already during childhood and adolescence. Besides physical consequences, childhood overweight and obesity may lead to psychosocial issues [3,5]. A systematic review by Rankin et al. [6] concludes that childhood overweight and obesity are associated with depression, anxiety, low self-esteem, lower scores on health-related quality of life (QoL), as well as emotional and behavioral disorders. These psychosocial problems may be influenced by obesity stigmatization, teasing, and bullying [6].

Studies have shown that, if children are to successfully achieve weight loss in both the short and long run, it is essential to involve the parents in childhood obesity interventions [7–10]. Children's eating behavior, food choices, and physical activity are predicted by parental support behavior [11,12]. However, recent reviews have concluded that family-based interventions only lead to small changes in children's weight [13–15]. Furthermore, studies

have shown that family involvement can be complex and result in inconsistent support and conflicts [16–20]. Knowledge about what influences parental support with overweight and obese children's physical activity, healthy eating, and, thereby, weight loss is limited [21].

Perception and identification of bodyweight are important in interventions aimed at overweight and obesity. In the childhood obesity and public health research, it is assumed that parents must perceive their children as overweight or obese and be concerned about the consequences of overweight and obesity for interventions to have any effect [22–24]. However, Andreassen et al. [25] found that parents of young obese children tried to protect the children from feeling stigmatized by hiding the fact that the children needed to lose weight. The focus of the parents on protecting the children changed as the children grew older. This entailed the parents involving the children more actively and encouraging them to take more responsibility [25].

Being labeled "too fat" by either family members or non-family members at the age of 10 is associated with obesity at the age of 19 [26]. Parent communication and behavior regarding children's overweight and obesity may influence the development of weight concern, body dissatisfaction, and attempts at weight-control among children [27–30]. Furthermore, a recent systematic review shows that individuals, including children, who perceive themselves as overweight are at risk of weight gain over time [31].

Studies have shown an association between parental identity and parental support regarding physical activity and healthy eating [21,32]. Lithopoulos [21] found that, among parents of an overweight or obese child, parents' affective attitude toward a behavior predicts their identity. Parental identity, in turn, predicts parents' self-regulation in supporting their child and self-regulation predicts parents' support with the child's healthy eating and physical activity behavior. Furthermore, parents who view themselves as healthy eaters or as physically active are motivated to support self-regulatory behaviors, which motivates parental support behavior [21]. Thus, social identity must be considered a crucial concept in a health-promoting context [33,34].

The links between weight perception, labelling, as well as individual and familial identities need to be studied more closely. To do so, it is important to understand what happens in the family during participation in a family-based intervention. Therefore, the objective of the present study was to investigate how a childhood obesity intervention affects the enrolled families' everyday life as well as study how the dynamics of identity and identification within the family impacts how the intervention is implemented and acted out in daily life. To do this, it is of great importance to study identity theories and incorporate them into our analytic strategy.

2. Theory, Methods, and Setting

2.1. Identity Theory

According to Jenkins [35], all human identities are social identities because interaction with other people is always a part of our own identification. Jenkins defines identity as: "our understanding of who we are and who other people are, and, reciprocally, other people's understanding of themselves and of others (which includes us)" [35] (p. 19). Haslam [36] argues that social identity is of great importance to one's health behavior, because the group of people we surround ourselves with affects our health behavior [36]. Groups are relational structures, which we are a part of, and which help define who we are. For this reason, social identities can be associated with both positive and negative health outcomes, depending on the way in which individuals understand and respond to the social structural conditions they are surrounded by [36].

Waterman defines identity as: "a clearly delineated self-definition comprised of the goals, values, and beliefs to which the person is unequivocally committed. These commitments evolve over time and are made because the chosen goals, values, and beliefs are judged worthy of giving a direction, purpose, and meaning to life" [37] (p. 331). In this way, Waterman focuses on how goals, values, and beliefs give direction, purpose, and meaning. This is another way of pointing out that constructions of meaning made based on a person's

self-understanding or identity are part of a perpetual process of making sense and ascribing meaning to the social environment, especially of trying to determine how to fit into that environment. Every meaning-making observation changes the background against which the next observation is made, causing what Waterman labels evolving commitments.

Charles Taylor links identity to knowledge and meaning. He states: "I can define my identity only against the background of things that matter" [38] (p. 40). This quote can be used to describe why some people are able to define their identity against the background of issues related to health and illness, and why some cannot relate to these issues at all. What matters to some does not matter to others, and what is deemed meaningful in some contexts is irrelevant in others. Taylor talks about these things that matter in the context of authenticity in contemporary cultures and societies, thus very much describing the interplay between the individual child or family and the social contexts in which they are trying to understand themselves and into which they are trying to fit. Taylor goes on to talk about what it takes for people to be able to define themselves and distinguish themselves from other people. It is not enough to simply be different from others. One needs to be different in areas that matter and make sense to other people. If health matters within a certain social context, then being different within that particular horizon of meaning will have significance, because it will be within the domains of recognizable self-definitions [38]. In relation to identity formation, the domains of recognizable and therefore possible self-definitions are important, as these limit the scope of acceptable and meaningful identities for both the individual person and the social context. In a classroom or at a school, these recognizable self-definitions will at all times determine which health-related issues are important enough to form the basis of self-definitions, and therefore also which issues are important enough to be different from others within. As such, horizons of significance are also directly connected to individual choice, in the sense that choices are, in reality, restricted to fit within the horizons. If self-choice is not really self-choice, then the choice to act positively on the basis of health knowledge and health information is not, in reality, an open choice either. In a health promotion context, where health choices and health behavior are of central concern, the connection between identity, choice, and behavior is essential when exploring the often-missing link between knowledge and action [38].

Taylor's concept of social imaginaries adds a relational aspect to the case of acquiring and acting on the basis of identity. It elaborates on the connections between expectations and common understandings of how we make choices and act in society and in relational contexts: " . . . the ways people imagine their social existence, how they fit together with others, how things go on between them and their fellows, the expectations that are normally met, and the deeper normative images that underlie these expectations" [39] (p. 23). This can be used to clarify how difficult it is to make changes in health behavior on an individual level as well as on a group or societal level. There will always be an element of having to fit into a certain group and an ensuing element of imagining how that group might interpret these changes. On the other hand, it is equally difficult to choose not to change if a certain change becomes the norm and thereby the expected behavior.

Combining these theoretical elements, we obtain a diverse, theoretically informed analytical strategy focusing on psychosocial aspects of identity in the context of intra-familial dynamics related to daily life with childhood overweight or obesity.

2.2. The Family-Based Childhood Obesity Intervention under Study

The intervention under study was family based and situated at a pediatric outpatient clinic in a rural municipality in Denmark. The intervention consisted of consultations with a health professional, where the children participated with either one or both parents. At the first consultation, the children's body measurements (e.g., height and weight) were taken; the families were informed about healthy lifestyle, including guidelines for physical activity and nutrition recommendations. At the subsequent consultations, the content depended on the needs of the family, but often consisted of follow-up body measurements as well as evaluation of adherence to the recommended guidelines. The consultations

took place every sixth week. The period of the intervention depended on the needs of the families; however, the families were usually enrolled for two years. The intervention was free of charge for the families.

2.3. Recruitment Process

Recruitment of study participants was carried out with assistance from one of the health professionals at the out-patient clinic. The health professional obtained consent from 29 families to pass on their contact information to the researchers. Of these 29 families, 15 were selected based on the inclusion and exclusion criteria.

The only inclusion criterion was that the age of the child was to be between 9 and 12 at the time of the interview. Hence, children older than 12 years would be excluded, as they would be categorized as teenagers and assumed to be more independent of their parents. Furthermore, typical conflicts between teenagers and parents could overshadow potential conflicts related to their enrollment in the family-based intervention [40]. Furthermore, as children's cognitive capacity, ability to reflect on interview questions, and participate in a family interview depends on age [40,41], children younger than 9 years were excluded in order to ensure that the children would be able to understand and answer the questions posed. Other exclusion criteria were families with complex issues at home, children living in a foster family, or families in which the parents did not speak Danish.

2.4. Family-Based Interviews

Fifteen semi-structured interviews were conducted to investigate how the childhood obesity intervention affected the enrolled families as well as to study the dynamics of identification and identity in the family and its importance to health behavior changes. Prior to the interviews, we had some initial reflections regarding whether the interviews should be family interviews or separate individual interviews with children and parents. Our concern about family interviews was that some experiences might be concealed due to the presence of other family members [40]. However, as the themes of the interviews could be particularly sensitive to the children and families, and because the children were only between the age of 9 and 12, we had some ethical considerations with separating the children from their parents. When pilot-testing the two interview formats, we established that the family interview created a safe environment, and we did not observe that either the children or the parents concealed important experiences or circumstances. In addition, the family interviews allowed us to gain insight into family interactions, dynamics, and communicative roles, which was considered beneficial [40,42,43]. Therefore, we decided that the interviews were to be family based. The interviews included two or three family members.

The semi-structured interview guide consisted of three main topics: (1) before first consultation, (2) consultations at the pediatric outpatient clinic, and (3) the families' everyday lives (family roles and support). To ensure the children's participation in the interviews, all questions were made child friendly and some of them were specifically designed for the children to answer.

2.5. Participants

The researchers contacted families that met the inclusion and exclusion criteria. The study population ended up including 15 families. A total of 36 persons participated, including 10 girls, 5 boy, 14 mothers, and 7 fathers. The children were on average 10 years old at the time of the interviews, and based on the families' own stories, they had on average participated in the intervention for one year and six months. The families are displayed in Table 1.

Table 1. Overview of the families.

Family	Child's Name	Sex	Age	Participant in Interview	Time in the Intervention
A	Trine	Female	9	Mother	4 months
B	Karoline	Female	10	Mother	1 year and 8 months
C	Johanne	Female	9	Mother	1 year and 2 months
D	Linus	Male	11	Father	4 years
E	Jane	Female	11	Mother and father	2 years
F	Freja	Female	9	Mother	11 months
G	Nanna	Female	9	Mother and father	1 year and 9 months
H	Louise	Female	10	Mother	2 years
I	Camilla	Female	9	Mother	1 year
J	Vigga	Female	9	Mother	3 months
K	Maria	Female	10	Mother and father	2 years
L	Martin	Male	12	Mother and father	2 years
M	Laurits	Male	11	Mother and father	1 year
N	Christoffer	Male	11	Mother	1 year and 6 months
O	Kalle	Male	10	Mother and father	6 months

After interviewing these 15 families, all three researchers agreed that the dataset had sufficient information power and therefore no more interviews were needed. This strong information power coupled with the theoretically explorative nature of our study mean that it was deemed suitable for analysis [44]. This is in line with methodological literature on the subject concluding that even small sample sizes can be highly informative and meaningful if the research adheres to expected standards of qualitative studies [45].

2.6. The Interviews

Thirteen of the interviews were conducted in the families' homes. This setting was chosen to create a comfortable situation for the families. Evidence suggests that it is often preferable to interview people in their own homes, as the setting affects the content of the interview [46]. In two of the families, this setting was not possible. Therefore, one interview took place at one of the parent's workplace and another took place at the child's school. These settings were chosen by the families themselves.

The interviews were carried out by one researcher and two assistants, who took turns being the main interviewer. The interviews lasted on average 65 min. All interviews were recorded and transcribed verbatim. In the transcriptions, the participants were anonymized using fictional names, while sensitive information was encoded so as to ensure anonymity. As the intervention took place with only two health professionals responsible, we anonymized both their names and professions to ensure full anonymization.

2.7. Analysis

The data were analyzed using Thematic-Network Analysis, which follows six steps [47]. The six steps are displayed in Figure 1. During the initial step, the transcriptions were encoded. We searched for responses and reactions concerning how the intervention impacted the families' everyday lives and self-understandings. During the second step, the relevant themes were identified and encoded as basic themes, with an added analytical focus based on the identity theories employed. During the third step, the thematic network was constructed for the themes to be grouped. This resulted in three themes: (1) Identification of overweight or obesity and weight loss as a success criterion, (2) The children's health behavior in relation to identity and self-perception, and (3) Existing roles, self-perceptions, and identities in the family, which all contributed to illuminating the overall objective of our study. Subsequently, an outline for presentation of the results was prepared, and the empirical evidence was investigated and interpreted further [47]. The thematic network can be found in File S1.

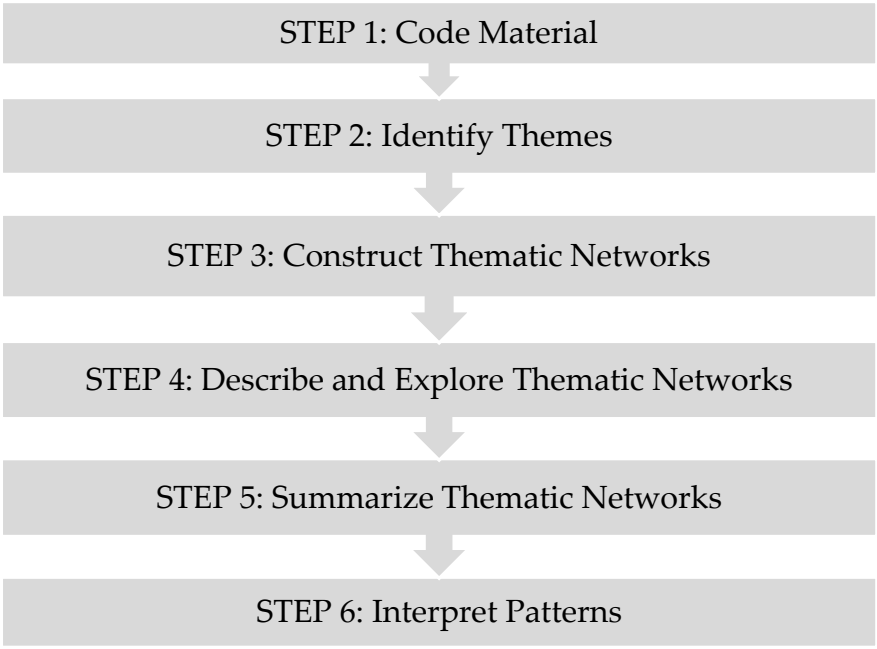

Figure 1. The six steps in the Thematic-Network Analysis.

2.8. Ethical Considerations

During the interviews, it was important that the families did not get the impression that the overweight or obesity as well as other general health issues were worse than they perceived them to be prior to the interviews. This meant that we did not directly articulate the overweight or obesity.

Before the interviews, all participants were informed about the purpose of the study. To ensure that the children understood the purpose of the study, it was explained in a child-friendly manner. Thereafter, written consent was obtained from all adult participants. Because the children were between the age of 9 and 12, written consent from the parents was considered sufficient. However, we considered it important to obtain verbal consent from the children.

The study was approved by the Danish Data Protection Agency (Rec. No.:2012-58-0004) and followed the codes of ethics found in the Helsinki II Declaration. According to Danish legislation, interview studies require no approval from an ethics committee.

3. Results

Below, the themes are presented without theoretical reflections and implications. This means, that as much as these themes are the results of a theoretically informed analytical process and therefore in no way can be considered un-theoretical, we have made a point of initially presenting them in as empirically grounded a way as possible. The findings will be discussed on a more theoretically abstract level in the ensuing discussion section.

All the families had basically positive attitudes about the intervention. Several of the parents mentioned that the health professional did a great job explaining to the children why they needed to make changes in their everyday lives. The health professional used visual communication to help the children understand the amount of sugar and fat in different foods and their harmful consequences for blood vessels, which was described by many as an eye-opener. The parents believed that the health professional had realistic expectations of the children and additionally said that they felt involved in the process and that they had received good advice.

3.1. Theme 1: Identification of Overweight or Obesity and Weight Loss as a Success Criterion

The interviews revealed that several of the parents directly identified their children as "overweight", "chubby", or as someone who weighed too much and needed to lose weight.

> "*It was because you were a little overweight, right. You had to try to lose some weight [. . .]*" (Trine's mother, Family A)

However, in some families, the parents were surprised by the way in which the health professional spoke about the overweight or obesity. The interviews revealed that the health professional directly identified the children as chubby or even fat.

> "*During the first consultation, the health professional sat down and said, "well Maria, you are too fat." That's where I thought, is that how you're supposed to say it?*" (Maria's mother, Family K)
>
> Mother: "*She [health professional] called you . . . "*
>
> Karoline: "*Fat*"
>
> Mother: "*Yes. Karoline was hurt by this. [. . .]*"
>
> Karoline: "*Yes*" (Family B)

Identifying the children as chubby or fat seems to impact parents and children differently. Where the parents found it as helpful because it meant that they did not have to do it, some children were hurt. In other words, the health professional's identification of children as chubby or fat directly impacted the children in a negative way emotionally.

The identification as overweight or obese and the general emphasis on weight loss played a significant role in the intervention. When the families described the consultations at the hospital, measurement of height and weight and the general development in weight since the previous consultation was very much in focus. Some families even described the consultations as a control visit.

> "*[. . .] but we have not had any concrete goals set out for us, besides maintaining the weight*" (Martin's mother, Family L)
>
> "*Well, we have gone there for control every sixth week*" (Louise's mother, Family H)

The focus on weight and weight loss was also reflected in some of the children's descriptions of their thoughts and feelings prior to the consultations.

> Interviewer: "*So when you are going to the hospital, what kind of feelings do you have?*"
>
> Nanna: "*I'm excited*"
>
> Interviewer: "*Why?*"
>
> Nanna: "*To see what the scale says*" (Family G)

Several children described this excitement regarding weight loss. It seemed like the weight became the sole indicator of whether the children had done well. This was further underlined by the recognition given by the health professional.

> "*But there is also another good thing. If you've lost weight, you'll get a present*" (Louise, Family H)
>
> Interviewer: "*What has been the best thing about visiting the health professional?*"
>
> Laurits: "*Achieving the things we have bet on, and getting stuff*"
>
> Interviewer: "*What could a bet be about?*"
>
> Laurits: "*A toy*"
>
> Mother: "*It's because, the health professional is like, if you have done what we agreed, then you'll get a present. She has a box, like a gift box, where you can pick a toy. You may only do so if you've lost weight*" (Family M)

"*Yes, we talk about that it's exciting to see what the scale says, because there's something about a present if you haven't gained weight*" (Camilla's mother, Family I)

The children received a present from the health professional when they had lost weight. This kind of recognition regarding weight loss underpins the notion that the children's body size is undesired and that they need to change to achieve success. The present and the associated recognition gave the children a feeling of having done well.

"*It's just nice, because it shows you that you have done well and deserve a present*" (Louise, Family H)

"*It's very nice, then I know I've done well [. . .]*" (Maria, Family K)

The interviews clearly revealed that the children's weight and change in weight were a symbol of success or failure in the intervention. The focus on the children's weight and weight loss at the consultations underlines the assumption that identification of overweight or obesity plays an essential role. This also highlights the fact that this intervention targets the overweight or obese child and not the family.

3.2. Theme 2: The Children's Health Behavior in Relation to Identifying with the Issue of Obesity and the Intervention

The study showed a difference in how much responsibility the children took regarding the recommended guidelines and, thus, in their own health behavior. In some families, the children tried to avoid the guidelines provided by the health professional whenever possible. Some parents and children expressed it like this:

"*It was probably a bit because we found out, that the candy bowl actually needed to be refilled quite often. And then we sort of figured that when we weren't looking, it might get a little crazy. So, you took advantage of the fact that we looked away.*" (Karoline's mother, Family B)

"*Sometimes I just take some candy myself.*" (Trine, Family A)

In those families, it was clear that the children followed their own desires, instead of the provided guidelines, when their parents were not there to control their health behavior. It seemed like the provided guidelines were only followed by the children when they were told to do so by their parents and not because they themselves identified a problem with the existing health behavior. In these families, the parents therefore had full responsibility for the changes. We found that several of these children did not identify themselves as overweight or obese in the interviews.

Other children were relating more to the problems identified in relation to their weight as well as their health behavior. When these children compared themselves to other children, it was clear that they perceived themselves as overweight or obese. Maria and Johanne said:

"*[. . .] because I have a cousin, who is very slim and can be a little bit mean [. . .]. She might not be able to behave like that, if I was together with my other cousin who maybe was a little overweight as well".* (Maria, Family K)

Johanne: "*[. . .] then he [big brother] actually thought that he had become a bit overweight*"

Mother: "*But he's not, I wouldn't say that*"

Johanne: "*He's much thinner than me*" (Family C)

There was a clear association between the children's awareness of their own weight status, the need for weight loss, and the amount of responsibility they took for their own health behavior. This meant that the children who identified themselves as overweight or obese and described a need for weight loss were also the ones who took more responsibility for the health behavior changes. Maria's parents, Camilla's mother, and Nanna's mother explained:

Father: "*But it should also be mentioned, that Maria does restrain herself too.*"

Mother: "*Yeah, she does. She's actually gotten quite good at it.*"

Father: "*Yeah, instead of just stuffing herself and things like that.*" (Family K)

"*Camilla, you're probably the one who has been the most committed, because the health professional showed you at one point, what just five cookies could do, right. So, when we have been home and wanted a cookie or something like that, then you would skip it. And we [the rest of the family] would feel guilty and stop after one cookie.*" (Camilla's mother, Family I)

"*[. . .] Nanna, she [. . .] has started saying "I can't eat that because I have to lose weight." So, she has by herself reached a point, where she knows what it means to for her.*" (Nanna's mother, Family G)

According to their parents, these children were aware of the guidelines and restrictions. Their awareness meant that the children themselves were at the forefront when it came to changing their health behavior. Several of the families mentioned that this awareness and action regarding their own health behavior was something that had developed over time, such as in Family K and G, where Maria has "gotten quite good at it" and Nanna has "started mentioning it" after having been enrolled in the intervention for some time. This indicates that the intervention influenced the children's perception of themselves as well as their health behavior.

3.3. Theme 3: Existing Roles, Self-Perceptions and Identities within the Families

Several families explained that the guidelines were adhered to by all family members and that the intervention was a joint family project. Some families reported the following:

"*We generally eat low-fat all of us, because no one has ever been hurt by that.*" (Karoline's mother, Family B)

"*Well, we've chosen to do this together. Because he [Linus] should not have to do this alone.*" (Linus' father, Family D)

However, throughout the interviews, it became evident that the intentions described by the families did not always apply in practice. In several families, different rules applied to fathers and siblings.

"*Now there are two kinds of milk in the house; whole milk for dad and big brother, and low-fat milk for us [Vigga and Mother].*" (Vigga's mother, Family J)

"*Dad and big sister get candy on Fridays*" (Karoline's mother, Family B)

"*It means that we can't get her [sister] to eat healthy at all. No, she's living her own life with that food. She doesn't eat vegetables nor wholegrain either, she doesn't like that*" (Mother, Family N)

There was a general tendency in the interviews for the families to explain siblings' lack of involvement and special rules with the argument that they were skinny. In some families, it was furthermore explained that it was considered fair that the siblings could live by different rules because of the weight difference.

"*Especially because the big brother basically can tolerate it, or he eats it, but Linus cannot, and he should not*" (Linus's father, Family D)

This illustrates that parents often identified the overweight or obese child and the siblings differently. The overweight or obese child would be identified as "chubby", while siblings would be identified as "skinny." This identification and perception affected the way the children were treated, and the consequences were that the overweight or obese children were the only ones who were expected to change health behavior to lose weight, while siblings could maintain their existing behavior. This shows that the families saw overweight and obesity, and thereby the overweight or obese child, as the identifiable center of the intervention, which affected the degree of sibling involvement.

The fathers' role in the intervention and in relation to the weight issue in general was also discussed in several interviews:

> Karoline: "*He [father] is just like . . . Hey can I taste? And then I just say like, if you want a piece of mine, then I want a piece of yours. It is just a tiny piece. It does not hurt.*"
>
> Interviewer: "*Are you then allowed to trade with him?*"
>
> Karoline: "*Well yes [. . .] then I'm just like, going through his candy and just pick one thing. I do that often*"
>
> Mother: "*Often?*"
>
> Karoline: "*No, not often. But I do it sometimes*" (Family B)

While not explicitly related to identity processes, this dialogue between Karoline and her mother is significant because the father occupies a role that does not entail joint responsibility for Karoline's adherence to the guidelines. There was a clear general tendency for the fathers to often find it difficult to set boundaries and thereby support the overweight or obese children regarding their health behavior. Some fathers (such as Karoline's) even counteracted the guidelines by tempting Karoline not to adhere, which encouraged some children to not follow the provided guidelines and restrictions.

The mothers often occupied a more central role in relation to the intervention. It was typically the mothers who went to the consultations with the children and who set boundaries in daily life. However, for some mothers, the desire for personal weight loss played a role as well.

> "*I'm paying attention as well, because I want to drop some kilos too*" (Vigga's mother, Family J)

Vigga's mother's desire to lose weight shows that she thought she weighed too much, which affected her participation and involvement in the intervention. In other families, the desire for weight loss was something that involved the whole family:

> "*Also because all four of us have challenges with the fact that we want to lose weight. Then you just realize you need to adapt*" (Freja's mother, Family F)

The family members' identification with their own bodyweight and their perception of themselves as someone who had weight challenges and therefore needed to lose weight influenced support regarding the intervention. The identification as overweight or obese seemed to be essential to how family members identified with the intervention and therefore ascribed meaning to the intervention. This influenced their focus on their health behavior.

As this identification as "skinny" or "chubby" appeared to influence both health behavior and involvement in the intervention, it meant that the family was divided into different groups based on their self-perceptions: those who followed the guidelines and tried to change health behavior and those who continued the old health behavior. Based on these findings, it appears that there was a connection between identity and the degree of support. The number of family members who identified themselves as needing to lose weight influenced how much support the overweight or obese child received:

> Mother: "*[. . .] that might be one of the things, that can motivate, that it is the whole family*"
>
> Martin: "*Yes, that is also one of my motivations, that at least my mom is with me on this*" (Family L)

4. Discussion

We found that, overall, the families had positive experiences of the intervention. The family's descriptions reflected an intense focus on the children's weight and weight loss, and we furthermore found that explicit recognition from the health professional was given as a reward for successful weight loss. The results showed that identification as overweight or obese determined how the children as well as their siblings and parents

approached the intervention. This meant that children who identified themselves as being overweight or obese were more aware of what weight loss meant to them and thus took more responsibility for their own health behavior. Thus, being identified as overweight or obese seems to have a somewhat positive effect on immediate and short-term health behavior change. The same pattern also applied to other family members for whom the identification as "skinny" or "chubby" played a significant role in their actions regarding health behavior. All of this means that attending the intervention often resulted in a division within the families. Fathers and siblings often did not identify with the intervention, the guidelines, and restrictions and therefore continued the old health behavior. On the other hand, mothers and the target children often identified strongly with the intervention and the general health information and therefore changed or at least made an effort to change their health behavior.

However, this identification also highlights the notion that the children had the "wrong" body size and needed to change it in order to fit in. This identification of not fitting in is very likely to increase the risk of weight stigma, and the identification as overweight or obese is therefore not a desired identity trait. Existing research has shown that children with overweight and obesity risk experiencing stigma from peers, teachers, parents, and family members [48–50]. As the information about overweight and health received in consultations seemed to affect identity, the settings of educative information and communication is important to consider when addressing weight and health management.

This balance between the negative and the seemingly positive aspects of identifying as overweight or obese needs to be studied more closely before any of the present findings can be used to inform guidelines or recommendations concerning how to approach children and their families living with overweight or obesity. It is therefore important to stress that we are not claiming that being labelled or identifying as overweight or obese is a good thing or that it should be an explicit part of any childhood obesity intervention. We are merely highlighting that identity and processes of identification seem to have the potential to add to our knowledge about children and families in the context of weight management interventions. The ensuing discussion needs to be read in light of this.

Looking at the existing literature, it becomes clear that our finding showing that several of the parents seeing their child as overweight or obese can be assumed to be a positive dynamic, if this identification is crucial to an intervention having a positive effect – resonates with other studies [22–24]. However, the intense focus on weight and identification of overweight or obesity, which largely characterized the intervention under study, may have the opposite effect on the children's weight and thus cause weight gain [26,51,52]. Given that the present study did not investigate the children's weight status and weight development, it is not possible to conclude any direct effects on weight. Still, the results showed that the fact that the children needed to lose weight was not hidden from them, which meant that they were actively involved in the intervention. This finding is in line with Andreassen et al. [25], which shows that parents involved the children more actively as they grew older. However, Andreassen et al. [25] stress that this gave rise to a stigmatization dilemma, meaning that parents found themselves jeopardizing either their children's physical health, as a consequence of not doing anything about the overweight or obesity, or their mental health, as a consequence of addressing the overweight or obesity in negative terms. Our study showed that some children were hurt by the identification. This is an important finding because overweight and obese children are already at increased risk of experiencing depression and low self-esteem due to obesity stigmatization, teasing, and bullying [6]. The results showed that several of the children saw their weight at the consultation as a measure of whether they had done well, which may be a source of weight concern, body dissatisfaction, and attempt at weight control due to others' (parents'/health professionals') perception of the child being overweight or obese [27–30,53,54].

The association found between children's own identification of overweight or obesity and the responsibility they took regarding their own health behavior to lose weight is in line with the findings of Haynes et al. [31], who reveal a strong cross-sectional association

between perceived overweight or obesity and intentions or attempts to lose weight. Thus, the children's social identity seems to be important to carrying out a successful intervention. However, the same review [31] also found strong evidence that perceived overweight or obesity is associated with future weight gain, suggesting that the immediate positive effects of perceived overweight or obesity have the opposite effect in a longer-term perspective. This strongly underlines the notion that the children's identification as overweight or obese is a negative dynamic in the long run.

Like other studies in this field [16–20], we found that involvement of the family in the intervention was complex and resulted in different degrees of support. When parental support behavior predicts children's eating behavior, food choices, and physical activity [11,12], it is difficult for children to navigate regarding health behavior, especially if the mother and the father display significantly different health behavior.

That identification as overweight or obese plays a crucial role for family members and their involvement, and the notion that this results in inconsistent support is backed up by other studies showing that it is especially challenging to adhere to new guidelines if not all family members need to lose weight [18–20]. In our study, there was a clear association between parents' identification as chubby or overweight and their self-regulation as well as parental support behavior. This finding is in contrast with the results of Lithopoulus [21], which show that identifying with a specific health behavior predicts parental support. Thus, it may be questioned whether having parents who self-identify as overweight or obese and support their children by trying to change health behavior and lose weight themselves might result in weight gain due to parents' perception of themselves as overweight or obese [31].

Regarding identity theory, our results have several potential implications for the use of existing theory as well as for the development of new theoretical constructs. The results clearly indicate that Jenkins' theoretical framework [35] is applicable to a childhood obesity intervention context, as interaction with other people greatly affected how the participants and especially the children identified themselves and thus their identity. Participating in the intervention involved a confrontation with health professionals' identification of the children, which underlined the perception that they were overweight or obese, thus affecting the children and their health behavior. It was clear that all family members self-identified by comparing themselves to others, and this identification meant that the family-based intervention was less family based, given that identification as "skinny" or "chubby" determined who needed to change health behavior. Social identity was thus crucial to family dynamics regarding health behavior. Because health behavior is affected by the social structures and groups we surround ourselves with [36], the different health behaviors occurring within the families (social group) due to the intervention must be considered confusing. If the health behavior becomes contradictory within this group, it must be difficult for the children to navigate their own health behavior.

Taylor's concepts of horizons of significance [38] and social imaginaries [39] are also applicable to the childhood overweight and obesity context. It is significant that children as well as their parents identify with the intervention and the overall overweight and obesity issue when things are seen as relatable, important, and authentic. This may seem like a rather basic finding, but when we add the consideration of whether this importance is based on positive or negative reasons, this may lead to a theoretical approach that allows us to discern between negative stigmatization or positive identification. This is also where the social imaginaries play a potential role by illuminating the potential for both individual and social action based on identity and identification. When the intervention is seen as a way to positively fit into social contexts that make sense and when it provides an image of a future state of health, we have a concept that enables the process of identity formation and general identification processes to be used to positively identify with elements of any intervention. This element of possible change can be even more focused on sustainable health behavior change by incorporating the focus on identity as an evolving self-definition comprising goals, values, and beliefs [37].

4.1. Strengths and Limitations

One of the significant strengths of our study is use of the family-based interview method [40]. This helped us gain insights into many aspects of the intervention and its effect on daily life. Furthermore, we experienced that all families expressed both positive and negative thoughts regarding the intervention, and sometimes even negotiated meaning during the interviews, which gave us valuable insights into intra-familial meaning-making dynamics.

Even though we witnessed both positive and negative reactions to intervention elements, one of the potential limitations of the study is the risk of selection bias, as the health professional from the intervention helped recruit the families, which might furthermore have affected the family's thoughts about the intervention. We did, however, focus explicitly on recruiting as diverse a group of participants as possible.

In the interviews, it differed whether one or both parents were present, and the mothers were more present than the fathers. This means, the insights we have gained are more characterized by the mother's perspective and to a lesser extent by the father's perspective. However, this underpins our finding that mothers are often more involved in the intervention than fathers are.

Another limitation of the study is the risk that the family members did not express all their thoughts due to each other's presence [40]. We were aware of this, and thus tried to manage this risk by posing questions to each family member, thereby encouraging them to be active in the interview.

All the interviews were conducted at a comfortable location chosen by the family. This resulted in a relaxed atmosphere, and our impression was that the families felt more at ease and confident about sharing their feelings about the intervention and their emotions in general, which resulted in long meaningful interviews.

A genuine dialogue between the family members materialized during all the interviews, which confirmed that the family-based interviews were a valuable method. Thus, the dialogue and dynamic were of great importance to gaining backstage insight into the families' lives [40].

4.2. Implications for Research and Practice

First and foremost, it is of great importance to study the balance between negative and positive effects of identifying as overweight or obese among children as well as among the rest of the family. Future studies must also investigate the association between identity-based dynamics in families enrolled in a childhood obesity intervention and actual effects on overweight or obesity.

Furthermore, provided that the children succeed in changing their behavior, it must be assumed that they will lose weight and thus be categorized as "normal" at some point. Therefore, research is needed on whether there is a shift in identity over time, in that regard investigating what consequences enrollment in the intervention has for identity and children's body image in the long run. A longitudinal study design in which the children and their families are followed over time would make it possible to address this issue.

The results of the present study illustrate that families often put the child at the center of changes, as it is the child who has been identified as overweight or obese and therefore must lose weight. As previous qualitative studies have found the same tendency [16,18–20], the results of our study give healthcare professionals the tools to consider how to deal with family identity dynamics in childhood obesity interventions. The present study illustrates that children and their family members have different identities, which affects whether they find the intervention relevant for themselves as a family and as individuals.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/obesities2040027/s1, File S1: Thematic Network.

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