Doctoral Thesis

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A Qualitative Exploration of Stigma Experienced by Individuals Living With Higher Weight

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Ethics	5933	9086	15019
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Abstract

This thesis is comprised of four chapters including a systematic literature review, empirical research paper, a critical appraisal and an ethics application section. The systematic literature review synthesises the available qualitative literature exploring the experiences of weight stigma for pregnant people living with obesity. Nine papers were included in the review which were analysed using a thematic synthesis approach. The empirical paper offers an exploration of stigma from the perspective of caregivers of young people living with higher weight. The methodology used involved caregivers participating in a semi-structured interview to discuss their experiences of stigma and the subsequent impacts. Additionally, caregivers were invited to participate in a Photovoice task whereby they were asked to capture what weight stigma means to them and how it makes them feel, visually. The interview data was then analysed using Interpretative Phenomenological Analysis. The critical appraisal includes a summary of the findings from the systematic literature review and the empirical paper followed by a discussion of the considerations, challenges and reflections associated with this research. The fourth section includes the ethics application process of the empirical paper and supporting documents.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at the Division of Health Research at Lancaster University from December 2023 to March 2025. The work presented here is the author's own, except where due reference is made. The work has not been submitted for the award of a higher degree elsewhere.

Name: Jess Doyle

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Chapter One: Literature Review

The Experiences of Stigma for Pregnant People Living with Obesity: A Thematic Synthesis

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Prepared for: British Journal of Health Psychology: Please see appendix 1-A for Author Guidelines.

Abstract

Purpose: Weight stigma can negatively impact health and wellbeing of people living with obesity. However, limited research has explored how this manifests during pregnancy. This review synthesised qualitative literature to explore how weight stigma is experienced by pregnant individuals living with obesity and its consequences.

Methods: An electronic search was performed in PsycInfo, Academic Search Ultimate, CINAHL and MEDLINE. Thematic synthesis was employed to identify themes from nine papers.

Results: Three themes and four subthemes were developed: (1) dehumanising and intrusive treatment (1.1), focus on weight (1.2), high-risk status (2), deprived of good care (2.1), lack of specialised care (2.2), disempowerment and (3) tainted pregnancy experience.

Conclusions: Medicalisation of obesity and pregnancy can harm the pregnancy experience. Recommendations include improving communication, ensuring person-centred care and addressing systemic biases. The intersectionality of stigma for PPLwO should be explored further.

Keywords: *pregnancy, stigma, obesity, overweight, thematic synthesis, experience*

Introduction

Societal messages portray obesity as stemming solely from poor diet and inactivity (Chaput et al., 2014), yet research recognises obesity results from complex biopsychosocial factors (British Psychological Society [BPS], 2019). Guidelines recommend holistic assessment and tailored interventions (National Institute for Health and Care Excellence [NICE; NG246], 2025), reflecting Foresight Report findings that over 100 factors influence weight (Government Office for Science, 2007). Despite this, individual blame persists and drives weight stigma towards people living with obesity (PLwO).[1]

Weight stigma may be driven by beliefs that PLwO are lazy or unmotivated to improve their health leading to discriminatory behaviours (Puhl & Heuer, 2010). Experiences of stigma might include verbal abuse and discrimination, feeling watched and ignored, and having limited access to suitable seating and facilities (Lewis et al., 2011). Linking obesity to controllable causes is associated with greater bias (DeJong, 1993). As awareness of obesity grows in the public health domains, it is not surprising that rates of stigma have increased (Brown et al., 2022).

Interestingly, women living with obesity are more likely to experience stigma than their male counterparts (Sattler et al., 2018). This could reflect increased stigma internalisation in women (Himmelstein et al., 2017), potentially impacted by the value ascribed to thinness for women in Western societies (Buote et al., 2011).

One in four individuals were classified as living with obesity, at the time of their first pregnancy appointment, in the United Kingdom (UK) (Royal College of Midwives, 2023). Obesity in pregnancy is linked to risks like preeclampsia, gestational diabetes and foetus risks of stillbirth and congenital anomalies (Leddy et al., 2008), prompting guidelines for increased

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[1] Living with obesity will be used herein as this is most synonymous term to the research discussed within this review.

monitoring for pregnant people living with obesity (PPLwO) (Maxwell et al., 2019). Yet this risk-focussed approach is often distressing (Incollingo Rodrigues et al., 2020) and may promote maternal blame extending to the unborn child (Parker, 2014; Lee et al., 2022).

Given the medicalisation of obesity and pregnancy, research has largely focused on the experience of stigma for PPLwO in healthcare. For example, Mulherin et al. (2013) suggested PPLwO were more likely to report negative experiences of care and providers perceived them less favourably. However, given that this research was conducted in Australia, this may be less relevant culturally for places where both pregnancy and obesity are not as medicalised and/or stigmatised.

The research exploring the impact of stigma towards PPLwO is limited. However, Rodriguez et al. (2019) found that irrespective of weight status prior to pregnancy, experience of weight stigma was associated with more mental health difficulties which can lead to poorer health behaviours and higher weight retention. Stigma can even predict poor health outcomes more strongly than BMI (Pearl et al., 2017; Tomiyama et al., 2018), and is associated with anxiety, bulimia, depression, low self-esteem, substance use, and eating disturbances (Papadopoulos & Brennan, 2015; Wu & Berry, 2017). Despite the use of different measures of stigma, these findings were consistent across both reviews and provide clear evidence for the role of stigma and increased distress. However, these findings were based on primarily cross-sectional and correlational designs, thus, limiting causal conclusions.

Therefore, it can be feasible to suggest that PPLwO are at higher risk for stigma and the associated negative consequences, given pregnancy is a time associated with a higher likelihood of weight gain, body image dissatisfaction and mental health vulnerabilities (Jones et al., 2014; Howard et al., 2014; Silveira et al., 2015), thus can exacerbate pre-existing vulnerabilities associated with LwO (Tomiyama et al., 2018; Pearl et al., 2017).

Although some reviews exist exploring stigma across the pregnancy journey and in healthcare/maternity settings (Hill & Rodriguez, 2020; Ryan et al., 2023; Cunningham et al., 2025). None focus specifically on the lived experiences of PPLwO that consider all settings beyond healthcare alone. After all, stigma is not limited to healthcare and has the potential to negatively impact individual health and wellbeing, despite the source. Therefore, this review aims to synthesise current qualitative literature to answer the following research questions:

- How do PPLwO experience stigma?
- What are the consequences of experiencing stigma?

A qualitative approach was chosen to capture the complexity of lived experiences and perspectives. Understanding these experiences can help inform supportive services and reduce stigma to improve outcomes for PPLwO (Wu & Berry, 2017).

Materials and Methods

The review protocol was registered on Prospero on 7th February 2024 (ID: CRD42024484114). The synthesis was guided by the ENTREQ checklist (Tong et al., 2012) and PRISMA guidelines (Page et al., 2021).

2.1 Search Strategy

Guidance was sought from university information management specialists in the development of this search strategy. The search terms were refined using a combination of MeSH terms and free text-terms to ensure a highly sensitive search strategy. The research question was separated into four key concepts (obesity, stigma, pregnancy, and qualitative) which informed the search string presented in Appendix 1-B. Electronic searches were conducted in PsycInfo, Academic Search Ultimate, CINAHL and MEDLINE to ensure comprehensive coverage which derived from a range of multidisciplinary databases. Hand searches of the reference lists of the included studies were also conducted.

2.2 Eligibility Criteria

Inclusion and exclusion criteria are outlined below and listed in Table 1. Studies that focussed on exploring people's experiences of stigma, who were living with obesity, during pregnancy were eligible for inclusion. Studies were included if stigma was addressed as part of the research question, but also if stigma was presented in at least one significant named theme or sub-theme and had at least two supporting quotes within the results section. The studies included involved participants providing a current first-person account of their experiences of pregnancy or a retrospective account after birth. Studies were excluded when data from third parties or other parts of the pregnancy journey, were analysed together as a primary aim of the research. Additionally, studies were excluded if they were not presented in English and if they were published before 2010 as this year marked the introduction of maternal obesity guidelines (NICE, 2010).

[Insert Table 1]

2.3 Study Selection

A filter was used upon retrieval of the relevant papers to ensure papers published prior to 2010 were excluded before screening. The search strategy resulted in a total of 2456 papers from all four databases being retrieved and imported into Endnote. The search was completed initially on 31st December 2023 and was re-run on 17th May 2024 to include any newly released papers from January to April 2024, however no papers were identified for full-text screening in the re-run. Duplicates were identified and removed. The remaining 1374 studies were screened by firstly reading the title and abstract; those that were considered for full-text screening were moved to a separate group in Endnote. This was completed by just one reviewer (JD). After initial screening, 75 articles were eligible for full-text screening and were imported into Rayyan. Full-text screening was required if a) the article seemed to meet inclusion criteria (to check that this was the case) or b) inclusion/exclusion criteria could not be determined based on the title and abstract alone, thus needed to be read fully to determine whether the article was eligible for inclusion. Additionally, a second reviewer (LS) screened 10% of the full-text papers to ensure a form interrater reliability (Nevis et al., 2015).

There was one disagreement during this process and both reviewers collaboratively decided to reject the article, thus a third reviewer was not needed to reach a consensus. Once all eligible studies were identified, reference lists were hand-searched, however, no papers were identified for full-text screening. If key inclusion information was missing or unclear (such as the weight status of participants), the article was rejected from the analysis. Nine empirical papers were accepted for analysis (see Figure 1 for PRISMA flowchart).

[Insert Figure 1]

2.4 Characteristics of Included Studies

Seven of the nine studies recruited participants through healthcare settings with two studies recruiting participants online, (Lingetun et al., 2017; Dejoy et al., 2016). Of the two who recruited participants online, Dejoy et al. (2016) sought to explore experiences of the maternity care system in the United States of America (USA) whereas Lingetun et al. (2017) analysed private blogs in Sweden to understand participants' experiences of pregnancy, generally. The other settings ranged from high-risk obstetric clinics in Canada (Nagpal et al., 2021), antenatal services in England (Heslehurst et al., 2015) and Denmark (Lindhart et al., 2013), maternity services in Australia, England and United States of America (USA) (Mills et al., 2013; Furber & McGowen, 2011; Hurst et al., 2021) and diabetic antenatal clinics in England (Jarvie, 2017).

Sample sizes ranged from nine participants to 30, with a total of 159 participants included across all papers. Given that most of the research was conducted within healthcare settings, most articles defined obesity as a Body Mass Index (BMI) of 30 or more (Heslehurst et al., 2015; Dejoy et al., 2016; Jarvie, 2017; Lindhart et al., 2013; Mills et al., 2013). Two articles referred to those with a BMI of 35 or greater (Nagpal et al., 2021; Furber & McGowen, 2011), and one was defined using a BMI of 40 or greater (Hurst et al., 2021). Lingetun et al. (2017) was the only paper to include self-report as a means of defining their participants as living with obesity or overweight. Table 2 summarised the study characteristics.

[Insert Table 2]

2.5 Data Extraction

Data extraction was performed by JD using a data extraction form in Microsoft Word. The following data were extracted: citation, aim relevant to the review, location, sample characteristics, method, analysis, results, and quality appraisal score.

Given that the research question focussed specifically on the experience of stigma and only two articles focused on this as a primary aim, data extraction involved the extraction of all information within the relevant themes/subthemes relating to stigma. This included direct quotations and the author's interpretations of the data. Credibility was ensured through inclusion criteria specifying there were at least two direct quotes to support the themes (Hannes et al., 2011). Furthermore, if there was data relevant to stigma in other themes, which did not warrant the full theme being analysed, this was extracted providing there was a direct quote to support the findings. Similarly, in papers where there was a quote that was not in line with the specified time points related to the pregnancy journey, but had a full theme relating to the primary aim of the review, the quote would not be omitted, when extracted for the analysis. For example, quotes that were disregarded included singular quotes discussing stigma during breastfeeding (Lindhart et al., 2013), preconception counselling (DeJoy, 2016), and after birth (Furber & McGowen 2011).

2.6 Quality Appraisal

Eligible studies were assessed for quality using the Critical Appraisal Skills Programme (CASP) tool by JD. The CASP tool consists of 10 questions used to evaluate the methodological rigour of each study. The CASP is deemed appropriate for a variety of health-related qualitative studies and is endorsed by the Cochrane Qualitative and Implementation Methods Group (Noyes et al., 2018). The author used the CASP to generate an overall score to each criterion as advised by Boeije et al. (2011) (0 = criterion not met; 1 = criterion partially met; 2 = criterion totally met).

Quality appraisal was performed by the first reviewer (JD) and where this was unclear, JD discussed it with the second reviewer (LS), in supervision. The second reviewer (LS) appraised one paper independently and discussed this with the first reviewer to ensure consistency in their approach. There were no disagreements within this process that were not resolved through discussion, therefore a third reviewer was not required.

Given it is not recommended to use scores to arbitrarily exclude papers (Noyes et al., 2018), scores were included in Table 2 to allow readers to draw their own conclusions within the interpretation of results (Lachal et al., 2017). The quality appraisal scores ranged from 15-20 and so appeared to be of a high standard within the interpretations. Six out of nine papers were unable to adequately consider the relationship between researcher and participants, which accounts for most of the methodological limitations observed.

2.7 Data Synthesis

A qualitative thematic synthesis approach was employed (Thomas & Harden, 2008). This method is beneficial as it integrates findings from multiple qualitative studies, whilst ensuring that the original study findings are preserved. Additionally, this type of synthesis is useful for thin data, i.e. data that may be considered limited in depth, given the paucity of research exploring stigma in this client group as a primary aim (Flemming et al., 2019).

In line with the approach, primary qualitative data and author interpretations were extracted from the studies and imported into NVivo 20 software for analysis. Line-by-line coding of the included data was transformed into free codes which remained close to the data. These free codes were then organised/grouped into clusters of related concepts and/or categories using the drag and drop functions within NVivo. Similar clusters were grouped into descriptive themes which were iteratively refined and changed. After the generation of the descriptive themes, they were analysed in light of the review question to generate new interpretations. The analysis was completed by one independent reviewer (JD), who consulted second reviewer (LS) through each step of the analysis. See Appendix 1-C for a theme development example.

2.8 Reflexivity

Given that reflexivity is a significant part of qualitative research, it is important to address the authors' professional and personal stance which may impact the findings (Williams & Morrow, 2009). The main author's experiences (JD) stem from a clinical psychology background, obesity stigma and pregnancy are new topic areas that she has engaged in academically. Additionally, JD is a white, cisgender female of child-bearing age who has not experienced obesity or pregnancy. Furthermore, JD would consider herself a feminist which may impact the interpretation of the results.

The second reviewer (LS), has a broader knowledge of obesity and has worked academically within this area for many years. The third reviewer (RN) has a background in environmental and behavioural determinants of health and well-being. Between the review team, there was a diverse range of experiences and perspectives that were drawn upon collaboratively, to ensure within the analytic process interpretations were compared and discussed. The lead author (JD) utilised a reflexive journal discussed any potential biases in interpretations with the review team (Thomas & Harden, 2008).

Results

From the analysis, three primary themes and four subthemes were generated from the data. These included (1) dehumanising and intrusive treatment, (1.1) focus on weight, (1.2) high-risk status, (2) deprived of good care, (2.1) lack of specialised care, (2.2) disempowerment, (3) tainted pregnancy experience. The first theme encompasses individual stigmatising interactions, the second extends to systemic stigmatisation and the third represents the overarching consequences of such experiences.

PPLwO often experienced their weight as overshadowing their interactions with healthcare professionals (HCPs), due to their obesity status equating to a “high-risk” clinical label. The interaction of both these subthemes contribute to dehumanising and intrusive treatment. This classification contributes to both interpersonal stigma (e.g. judgements and assumptions) and structural stigma, such as increased surveillance, reduced autonomy, and lack of personalised care. These experiences led to negative psychological impacts through unmet expectations of affirming care, which led to a lack of trust in HCPs and reduced help-seeking. The mechanisms proposed which may underpin the findings include risk-averse practice, moral messaging of obesity in pregnancy, and embodied shame. This conceptual framework is illustrated in Figure 2.

[Insert Figure 2]

3.1 Dehumanising and Intrusive Treatment

Across the studies, dehumanising and intrusive treatment consisted of two subthemes including a focus on weight and "high-risk" status. A focus on weight left participants feeling judged and dehumanised in their interactions with others. High-risk in the maternity context referred to a risk of pregnancy complications leading to increased surveillance, which felt intrusive and unjustified to many.

3.1.1 Focus on Weight

With one exception (Jarvie, 2017), all studies suggested that participants were hyperaware of their weight and did not appreciate it being highlighted within antenatal appointments: "I know my weight is too high, I'm not here to see you about my weight" (Heslehurst et al., 2015, p.18). Despite whether participants connected with the weight description, all studies conveyed data to suggest that the person's weight was the primary focus throughout their pregnancy journey. This acknowledgment left participants feeling as though they were not seen as a person but rather a "number on the scale" as illustrated by Dejoy et al. (2016, p.219) and echoed across papers (Furber & McGowen, 2011; Lingetun et al., 2017; Mills et al., 2013; Nagpal et al., 2021):

“Alison likened this to being put in a ‘bucket’, ‘you’re overweight “beepbom” you’re in this bucket. It’s sort of like they have a bucket for different people and you don’t feel like you’re in a bucket you just feel like you’re a person’.” (Mills et al., 2013, p.316).

This quote suggests how individuals were stereotyped according to their weight and other parts of their identity were disregarded leaving participants feeling disheartened, devastated, upset and “slammed against the wall” (Lindhart et al., 2013, p.1103). Assumptions were often made during interactions with HCPs, loved ones, and even members of the public speculating about the babies’ size: “So, my weight was part of the picture. It was the first thing that people saw and first thing people commented on, and half of the time it was the only thing people commented on.” (Hurst et al., 2021, p.7). Lingetun et al. (2017, p.68) stated “comments about their pregnant body and questions about the size of the baby or if they were expecting twins was common”. This implies how PPLwO were treated as publicly accountable for their size due to it being a time of heightened responsibility for a new life, which can contribute to feeling blamed and shamed.

Communication of weight-status and its associated risks varied across studies. Whilst most people experienced direct and relentless communication about their weight from HCPs, few acknowledged a perceived discomfort around discussing weight and desired more directness and advice: “As one woman explained, these conversations can go ‘either way, it’s either avoidance ... or quite attentive, it’s one or the other, there’s no sort of middle ground’ (Anita).” (Mills et al., 2013, p.314).

These findings imply how obesity extended beyond a health concern to a broader process of depersonalisation and objectification which disregards individual identity. Most participants experienced an over attentiveness to their weight whilst few identified an avoidance to addressing it, inferring an all-or-nothing approach. Despite the contradictions in what participants desired, it can be suggested that a more balanced and sensitive way of communication was sought after.

3.1.2 High-risk Status

Acknowledgement of the person's weight was often met with an immediate classification of the individual's pregnancy being defined as a high-risk, putting themselves and their unborn baby at risk of harm. There was evidence of more testing and surveillance in PPlwO in four papers (DeJoy et al., 2016, Jarvie, 2017; Lindhart et al., 2013; Lingetun et al., 2017). These included testing for diabetes, preeclampsia, and non-stress tests. Furthermore, there were extra check-ups, and weigh-ins "beyond what they felt a thinner woman would receive" (DeJoy et al., 2016, p.220). Participants had to show HCPs their dietary records (Jarvie, 2017) and one participant described requiring her husband's signature to prove she was not lying (DeJoy et al., 2016). These actions situated the pregnancy experience within social structures of power and control whereby PPLwO felt they were being treated punitively to comply with HCPs. Some participants felt that excessive testing was inappropriate, unnecessary and not driven by evidence: "There was no sign of gestational diabetes in the 3-hour fasting test. But she decided to go ahead and indicate that I was a gestational diabetic (DeJoy et al., 2016, p.220)

Furthermore, there was evidence of conflation of risks experienced by participants about their pregnancies (Nagpal et al., 2021; Lingetun et al., 2017; Lindhart et al., 2013; Jarvie, 2017; DeJoy et al., 2016; Mills et al., 2013; Heslehurst et al., 2015). These conflated risks of complications included not being able to deliver the baby vaginally, developing gestational diabetes, having an "obese child that's gonna' have diabetes" (Jarvie, 2017, p.83), not being able to breastfeed, not going into labour independently, and having a large baby. Indeed, many of these predictions lacked supportive evidence such as passing the tests, having no history of complications, and having smaller than-expected babies post-birth inferring that care may have been driven by implicit biases as opposed to medical evidence. This was also highlighted systemically as Therese attributed her referral to specialist care to "it's just the criteria that they have down there." (Mills et al., 2013, p.316). This quote illustrates how stigma may be embedded within maternity healthcare structures which may be shaped by intentions to reduce risk, yet inadvertently perpetuate systemic inequalities for PPLwO.

Moreover, participants experienced this as "scare tactics" (Hurst et al., 2021, p.7) across five studies which led to fear and frustration in participants and their families (Nagpal et al., 2021; Hurst et al., 2021; Jarvie, 2017; DeJoy, 2016; Mills et al., 2013). Below are two quotes illustrating the impact of scare tactics:

"I spent so much time being scared of things that didn't come true. And I think it's just important for [providers] to realize that a risk factor is a risk factor but that isn't worth scaring every plus-sized woman that comes into their office." (Dejoy et al., 2016, p.221).

"I think they believe using words like that will shock you into thinking, 'Oh, I need to lose weight,' and that's not what happens." (Nagpal et al., 2020, p.116).

When balancing such risks, three studies (Mills et al., 2013; Lindhart et al., Furber & McGowen, 2011) noted participants reported feeling that their babies' wellbeing was prioritised, which further added to their dehumanising treatment: "I didn't realise how little they do to help you for the sake of the baby, it's like there's the baby, then there's you…but it's like the baby comes first and you are like an oven. (Participant L)" (Furber & McGowen, 2011, p.441).

These findings suggest that risk communication was often entangled with moral judgement, institutional risk management imperatives and implicit bias, rather than personalised, evidence-based care. The increased surveillance and disproportionate risk messaging appear more rooted in assumptions about PPLwO who are constructed as risky and morally accountable for both their health and their babies'.

3.2. Deprived of Good Care

The second theme describes how participants experienced an absence of tailored and responsive care through endorsing a one-size-fits-all approach which led to a perceived loss of control within their care. Both subthemes represent structural manifestations of stigma, where the lack of specialised care directly contributed to participants' disempowerment and experiences of embodied shame.

3.2.1 Lack of Specialised Care

The subtheme refers to the use of standardised equipment and procedures for PPLwO despite the need for more specialised care. For example, six papers suggested how expectant mothers were warned about difficulty seeing/hearing their baby during scanning due to their weight (Furber & McGowen, 2011; Lingetun et al., 2017; Lindhart et al., 2013; Hurst et al., Mills et al., 2013; Jarvie, 2017). This meant that some participants experienced pain and humiliation; this was attributed to the participant's weight, reinforcing that their body was problematic, rather than the equipment not being inclusive:

"I was there flat on my back and the ultrasound scanner had pushed and crushed my body from the outside and the inside to get a view of the baby but had to give up. She finally said that it was my fault she could not get a good view as I was too fat." (Lindhart et al., 2013, p.1103).

Furthermore, other equipment flaws recognised across the studies included ill-fitting blood pressure cuffs, gowns, underwear, and clothing in addition to the paper on the examination table being too small and difficulties in placing the epidural, during labour.

Another way in which participants experienced stigma was through the communication of generic advice which was not tailored to the individual's needs. Despite the previous theme highlighting how most interactions with HCPs tended to focus on the participant's weight, there appeared to be a lack of helpful support to address weight management through pregnancy.

Studies highlighted that lack of tailored advice included not trying to support the cause of obesity; "People assume that you should be losing weight, but they don't ever try to find the cause behind the weight or why you're this way in the first place." (Nagpal et al., 2021, p.116) and deliberately withholding key information due to the belief that participants do not value their health: "If there is bias that because 'you're overweight you don't take care of your health so we aren't going to give you all the information is kind of the feeling you sometimes get.'" (Hurst et al., 2021, p.8). These quotes illustrate how implicit beliefs about obesity being a choice and how PPLwO are unmotivated to improve their health may impact their ability to seek appropriate support.

One participant proposed that this lack of specialised information is not only apparent in healthcare but also in general self-help resources (Dejoy et al.'s (2016, p.220):

"There's not a lot of information out there for those of us for how our bodies are changing…I've had a baby bump since I was 8 years old! So, the way they explain how our bodies change doesn't affect us. We have questions that we don't know who to ask."

Additionally, there was also evidence of inconsistent information being discussed with participants regarding weight gain during pregnancy. Given the lack of and/or inconsistent advice, a couple of studies suggested that participants had used the internet to supplement the advice given by their team (Hurst et al., 2021; Dejoy et al., 2016).

These findings highlight how maternity care is often designed around a normative body ideal, leading to PPLwO to feel physically excluded and personal blamed rather than recognising system failures, reinforcing embodied shame. Moreover, the absence of tailored advice reflect deeper structural biases suggesting that PPLwO are perceived as unworthy of support or incapable of behaviour change. This may leave PPLwO feeling unsupported and misunderstood with reduced opportunities to receive person-centred care.

3.2.2 Disempowerment

The sub-theme referred to participants feeling disempowered due to their care appearing to be dictated by HCPs rather than collaborating with PPLwO. Across all studies, there were reports of negative interactions with HCPs driven by power imbalances, implicit biases and risk-averse practices.

Many participants suggested they felt lectured and stereotyped due to their weight status, and the quote below likened her treatment to that of a bully:

"There was a nurse . . . who said before I stepped on the scale, "I hope you don't break it."…It reminded me of schoolyard bullies who would say [stuff] like, "Hope you don't break the see-saw.""(DeJoy et al., 2016, p.221).

Participants reported they were not informed or involved in many of the decisions related to their care. This included being referred to specialist services or to an anaesthetist regarding a caesarean, being measured, being labelled as diabetic despite passing the test, being denied a water-birth, and being given an electric bed for labour. Participants communicated that this lack of involvement in key decision points in their pregnancy led to feelings of embarrassment and a sense of powerlessness. For example, "The GP weighed me and measured my BMI without even speaking to me about it. Then I am referred to a special practice for fat pregnant women without my consent" (Lindhart et al., 2013, p.1104).

Participants voiced feeling coerced or forced into decisions they did not want. These included feeling pressured into further testing and discouraged from birthing preferences. For instance, Hurst et al. (2021, p.8) reported “One woman who felt pressured into further testing was told by her provider “… we are trying to avoid having a stillborn baby here…””. This quote highlights how the health of the baby was prioritised and this was verbalised to provoke guilt and shame, reinforcing PPLwO being seen as immoral. There was a recognition that these decisions may have been informed by guidelines, however, there was an acknowledgment that guidelines did not allow for consideration of the individuality of one’s care.

This subtheme illustrates how participants experienced a loss of control over their pregnancy care which left them feeling silenced and disempowered. Decisions were made for them, not with them, reinforcing a power imbalance that undermined autonomy and trust. This care appeared driven by risk avoidance and a rigidity to system guidelines.

3.3 Tainted Pregnancy Experience

The last theme describes how the weight status of the participants negatively impacted their pregnancy journey leading to unmet expectations, tainting their pregnancy experience and increasing reluctance to engage with HCPs.

Participants identified a range of difficult feelings evoked through experiences of stigma. The most common feelings described by participants included feeling upset, worthless, anxious, angry, uncomfortable, dismissed, guilty, humiliated, angry, ashamed, blamed, and feeling ‘othered’. Participants suggested these feelings initiated responses such as reduced help-seeking, compensatory behaviours to control weight, withdrawal, worrying, and rebelling against medical advice. The following quote illustrates how hypervigilant a participant became due to worrying about not meeting HCPs’ expectations:

"I'm very careful to wear my lightest clothes. I take off my shoes, even if they're the thinnest flip-flops. I even think about how much gel I put in my hair because I'm so afraid of the problem of gaining too much weight." (DeJoy et al., 2016, p.221).

Furthermore, having to do a glucose tolerance test was so distressing that a participant knew of others who had made themselves sick to avoid doing it, illustrating the perceptions that view medical tests as avenues to encourage blame:

"I have spoken to three people now who've had to have it [GTT] because of their BMI and they actually went to the toilet and made themselves sick. It's another way of almost defrauding the system so you don't have to go through with it." (Jarvie, 2017, p.82).

Despite a lot of participants voicing excitement for their pregnancy, it appeared that their excitement was quickly overshadowed by weight stigma. A quote illustrated by Lindhart et al. (2013, p.1103) reported "I was so excited, after years of struggling to become pregnant, I finally met my midwife. After approximately 10 minutes into the conversation, she suddenly said. 'Don't expect to be able to breastfeed when your BMI is so high'." Additionally, another participant in Lindhart et al. (2013, p.1104) reported:

"I did not know what to expect being first time pregnant. I had an expectation of what we were going to talk about. It was most concentrated about my weight and how much I was allowed to gain during pregnancy. My partner did not feel we got an answer to our questions and we decided to pay for a consultation at a private midwifery practice afterwards."

Additionally, four studies (Mills et al., 2013; Lingetun et al., 2017; Furber & McGowen, 2011; Jarvie 2017) noted that participants' experiences of their pregnancy bump may be different from others. There were expectations that their bump may reduce weight stigma inferring how:

"The women discussed how pregnant they looked and longed for their stomach to grow even more. As the stomach changed shape during the pregnancy, the women felt relieved and satisfied with their body. They were disappointed when they still looked obese and described that they were looking forward to having a pregnant stomach, as that would affect how others viewed them.” (Lingetun et al., 2017, p.68).

Differences in bump experiences made women more self-conscious of their weight as they perceived their bump to not be as prominent:

“They’re all going to have big bellies, but it’s the skinny thighs and the skinny bum. I’d love to go and that’s why I bought the swimming costume but I don’t know if I can do it (Participant N, 32 weeks pregnant).” (Furber & McGowen, 2011, pp. 439-440).

This theme shows how weight stigma can overshadow the entire pregnancy experience, replacing excitement with shame, anxiety, and self-surveillance, thus, reshaping the entire meaning and memory of pregnancy. Participants’ emotional and behavioural responses reflect the internalisation of a healthcare system that treated their bodies as problematic which led to a loss of expected positive pregnancy experiences.

Discussion

This review provides the first thematic synthesis exploring stigma for PPLwO, which was not limited to healthcare settings. The findings add to the wealth of evidence suggesting how stigma can manifest for PLwO and the negative consequences of this (Puhl & Heuer, 2010; Lewis et al., 2011; Papadopoulos & Brennan, 2015; Puhl & Suh, 2015; Wu & Berry, 2017). The review adds to the evidence base focusing on the pregnancy context. It can be argued that stigma is amplified through medicalisation of pregnancy and obesity, in addition to the intersection of multiple identities such as gender, parental status, and weight; situating experiences within broader structures of power and control.

While stigma was often enacted interpersonally, these experiences can be understood within the structural context of medicalised maternity care. Nearly all the studies included situated pregnancy within biomedical frameworks which led to increased surveillance, risk categorisation and a loss of autonomy (Ryan et al., 2023; Yuill et al., 2020). Therefore, research suggests that medicalisation constructs pregnant individuals as risky and needing control and treatment (Healy et al., 2016; Johanson et al., 2002), and often at the expense of the individual's needs, due to feeling as though their baby was prioritised (Snowden et al., 2011). Therefore, when PPLwO presented in healthcare settings, their obesity may have symbolised a higher risk and thus encouraged increased monitoring as advised in medical guidelines (Royal College of Obstetricians and Gynaecologists, 2018). However, for PPLwO, these interventions are experienced as disproportionate to the level of risk presented and they often perceived that expression of risks are conflated (Houghton et al., 2008; Chowdhry, 2019). Similarly, HCPs may act pre-emptively to reduce perceived risks (Healy et al., 2016), which could lead to an increase of 'unwanted' medical interventions (Cole et al., 2019), leaving PPLwO feeling powerless and controlled. This over-monitoring and risk-averse practice may have reflected structural stigma whereby institutional processes embedded bias into routine practice (Link & Phelan, 2001; Hatzenbuehler & Link, 2014).

Structural stigma may be enacted through policies placing PPLwO automatically on high-risk pathways and having limited access to appropriately adapted resources and equipment (e.g. ultrasound scanners and blood pressure cuffs) (Tran et al., 2024). For example, there is no evidence-based guidance on weight gain in pregnancy in the United Kingdom for PPLwO (Linton et al., 2020) and practice guidelines can be deemed ambiguous (Goddard et al., 2023). This could explain why advice from HCPs often appeared inconsistent and generic (e.g. eat less, move more; Merrill & Grassley, 2008). Moreover, barriers to tailored communication may include a lack of specialist education regarding obesity aetiology (Whitaker et al., 2016), which could maintain weight biases held by HCPs (Remmert et al., 2019), and a lack of confidence and training regarding weight-based communication and obstetric risks for maternity staff (Robins et al., 2025). These barriers may explain why participants experienced an all-or-nothing approach to weight-based communication.

These practices may also be compounded by attribution theory (Weiner, 1985) whereby obesity is framed as a moral failing and PPLwO are deemed to be in control of their weight thus, diminishing empathy and endorsing moralised care (Phelan et al., 2015), particularly when the risks are extended to their baby. Therefore, these experiences, may reinforce embodied shame as maternity services appear not to be designed for the bodies of PPLwO and provoke feelings of exclusion and feeling personally blamed.

Pregnancy was frequently described as a time of increased moral responsibility and participants expressed sadness that their excitement was overshadowed by stigmatising care. Therefore, the consequences of treatment in the first two themes led to an overarching tainted pregnancy experience. This encompassed unmet expectations, such as the idea that having a 'bump' would deter weight stigma (Padmanabhan et al., 2015) and that their journey would be a time for excitement and celebration. Unfortunately, many participants experienced "mother-blame" and a deprivation of "that same excitement, support that anyone else would" experience (Bombak et al., 2016, p.100). Participants seemed proud of their pregnant status and saw their bump as an escape from their overweight identity, reflecting the depth of internalised stigma. Weight-bias internalisation (WBI) refers to the belief in social stereotypes relating to obesity and negative self-evaluations due to one's weight (Durso & Latner, 2008, which can present as barrier to health (Pearl & Puhl, 2018) and gestational weight management (Nagpal et al., 2022.) Therefore, positive experiences felt important during this time, to buffer against WBI, which can have further implications for the wellbeing of both mother and baby.

This review reinforces the detrimental psychological impact of weight stigma towards PPlwO. Negative experiences with HCPs may contribute to psychological distress in addition to reduced help-seeking (Hill & Incollingo Rodriguez, 2020). Research cites the predictive nature of weight stigma upon postnatal depression symptoms and weight retention postpartum (Incollingo Rodriguez et al., 2019). Biopsychosocial models have conceptualised how weight stigma during pregnancy can result in stress, mental health difficulties and unhealthy coping strategies, which can influence health outcomes through pregnancy complications (DeJoy & Bittner, 2015) and lead to a downstream childhood obesity risk (Incollingo Rodriguez & Nagpal, 2021). Therefore, services should consider the impact on both parent and child as a driver to reduce stigma and support individuals who may have been impacted by stigma.

These findings align with intersectionality theory (Crenshaw, 1989), which helps explain why stigma is intensified when multiple identities interact with systems of power. For example, being female, being pregnant and living with obesity. Obesity can lead to assumptions of ill health and poor lifestyle choices (Ryan et al., 2023; Goldberg, 2014; Tomiyama et al., 2018). When parents are labelled as living with obesity they are then also considered as ‘inept’, ‘neglectful,’ and ‘uncaring’ towards their child (Kalinowski et al., 2012), thus the added responsibility for foetal health, may contribute to PPLwO being treated as publically accountable for their health. Lastly, given pregnancy is often associated with a female identity, the medicalisation of pregnancy can be argued to be rooted in a patriarchal model where women’s bodies are medically constructed as inferior due to their reproductive capabilities (Prosen & Krajnc, 2019). Similarly, gender and ethnicity can influence weight stigma consequences, as women are argued to suffer disproportionately from weight bias, than men; this can be further exacerbated for certain ethnic groups (Fikkan & Rothblum, 2012). Therefore, these intersections require further exploration, particularly for those of different cultures and ethnicities to explore different attitudes towards obesity in pregnancy.

4.1 Clinical Implications

Given the dehumanising experience PPLwO communicated across studies reviewed, this highlights the importance of developing communication strategies to address an individual’s weight in a sensitive yet informative manner, given that many PPlwO seek to understand their risks (Charnley et al., 2024). Christensen et al. (2019) highlight some recommendations such as gaining consent to communicate respect when discussing an individual’s weight. Furthermore, they also suggest motivational interviewing (MI) as a useful model for training staff in (Miller et al., 2012). The use of MI in obstetrics focusses on using more open questions to explore a patient’s weight and has been found to improve competency and professionalism in staff (Lindhart et al., 2014; Lindhart et al., 2015), resulting in better patient outcomes. Additionally, Nagpal et al. (2019) recommend the development of practical tools such as conversation guides to further support staff with communication (Heslehurst et al., 2015). Moreover, HCPs should seek to reduce scaremongering through the objective and clear communication of risks so that individuals feel respected and understood (Christenson et al., 2019). Most importantly, the review highlighted the importance of positive interactions with HCPs, thus interactions should involve positive reinforcement, encouragement, respect and empathy to increase hope and self-esteem across the pregnancy journey (Keedle et al., 2022). Clinical psychologists may be best placed in health services to train staff and support their use of communication strategies. Therefore, services could embed training for midwives incorporating weight communication strategies and weight management guidance for this population within induction processes. The GLOWING study has trialled a one-day intervention incorporating these strategies and found a high level of acceptability and feasibility when delivered in maternity services; showing promise for all HCPs to be trained (Heslehurst et al., 2024). Therefore, further research should seek to evaluate such interventions further, examining outcomes for HCPs and also PPLwO.

To ensure PPLwO do not feel excluded within their care, services should ensure a weight-inclusive environment through accessibility to appropriate equipment for larger-size bodies such as chairs and scanning equipment (Talumaa et al., 2022; NICE, 2025), and resources tailored to individual need (Vasilevski et al., 2025). This may include developing tailored educational resources specifically for PPLwO regarding weight gain in pregnancy, expected body changes and ensuring all standardised materials reflect a range of body sizes and lived experiences. Collaboration can be encouraged through active listening and shared decision-making whereby PPLwO and HCPs can consider the options together, allocating appropriate time to do so (Hawke et al., 2024). A scoping review identified that access to written shared information as well as continuity of care are important enablers of shared decision-making (Hawke et al., 2024). Therefore, services could ensure written collaborative plans are captured in patient notes and that these are monitored and evaluated and that processes prioritise a continuity of care throughout service procedures.

Many stigmatising experiences can be driven by implicit biases of HCPs (Remmert et al., 2019; Phelan et al., 2015) who may believe the individual is at fault for their weight status, thus are perceived more negatively (DeJong, 1993). Therefore, it is important to address these biases to ensure PPlwO are not treated negatively. Mechanisms to address implicit weight bias may include further education regarding the aetiology of obesity and the impact of stigma for PPlwO; this may enable HCPs to holistically assess and understand an individual's journey with their weight, rather than making assumptions and offering simplistic advice based on their own biases (Roberts et al., 2023). Furthermore, Phelan et al. (2015) propose that increased opportunities for positive contact with PlwO could reduce bias through challenging stereotypes; however, this may not be feasible within healthcare. Therefore, reflective practice could be a valuable avenue to explore and share positive experiences with PPlwO in addition to encouraging more learning, introspection and self-awareness in maternity settings (Helyer, 2015). Reflective practice is recommended to reduce and manage stigma in similar settings, therefore may provide a foundation for further investigation (The Royal College of Obstetricians and Gynaecologists, 2023). Maternity services could embed a regular reflective practice for staff to attend to monitor the impact of their biases.

4.2 Future Research

Despite the inclusion criteria purposively not limiting the research to just healthcare settings, the majority of the research identified was conducted in healthcare settings. Further research should explore stigma experiences more generally; this may involve qualitatively investigating stigma across different sources and settings which are prominent in the obesity literature, for example, close relationships and/or work settings (Puhl et al., 2008). Similarly, given that several of the papers did not include consistent reporting of ethnicities/cultures, further research should explore experiences of stigma in different cultures and contexts. For example, it may be beneficial to explore these concepts in non-westernised countries where obesity and/or pregnancy are not as medicalised and/or stigmatised. For example, larger bodies within places such as Puerto Rico and Tanzania are traditionally valued; thus there may be differences in experiences, however, they are also said to be adopting more westernised attitudes (Brewis et al., 2011). Similarly, more research investigating the intersection of stigmatised identities should be considered, to understand the interacting layers contributing to weight stigma. For example, comparing the experiences of stigma during pregnancy for PPLwO compared to pregnant people with “normal-weight”, to ascertain the influence of weight versus pregnancy healthcare for all individuals.

High-quality research investigating the effectiveness of interventions targeting weight stigma in healthcare is limited, this could reflect the lack of interest in the area, potentially due to the acceptance of weight stigma in society (Westbury et al., 2023). Furthermore, Brown and Flint (2013) also speculate that systemic stigma may also act as a barrier to accessing funding to implement and evaluate such interventions. Therefore, further research should be conducted to understand which interventions provide the most effective outcomes for reducing weight bias and stigma in healthcare settings.

4.3 Strengths and Limitations

This review included data of a high quality which was observed through CASP scores of 15 and above. Furthermore, the quality of the data was also accounted for within the inclusion and exclusion criteria which highlighted a minimum of two supportive quotes for each named theme, which can enhance the credibility of the results.

However, despite these strengths, the limitations include the lack of generalisability of the findings to wider populations. Despite the aims of the review which were to explore stigma for PPlwO generally, the majority of the research identified, was conducted within healthcare settings, limiting their applicability. All of the research cited was conducted in Westernised countries and many of the studies did not address ethnicity within their demographic data. Therefore, cultural differences and experiences may not be captured in the findings of this review and should be interpreted with caution.

4.4 Conclusion

Overall, this review synthesised PPlwO's experiences of stigma from nine published qualitative research studies. Although the review attempted to explore stigma generally, eight of the nine published studies discussed stigma in the context of healthcare. These outcomes reinforced the harmful nature of stigma experienced by PPlwO, and highlighted how the medicalisation of obesity and pregnancy can contribute to dehumanising and disempowering experiences within healthcare. Therefore, findings emphasise the importance of sensitive communication, person-centred care and systemic stigma reduction strategies within healthcare to support this population. The review identified the complex intersectionality of stigmatised features for PPLwO and should be explored further.

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Tables and Figures

Table 1

Inclusion and Exclusion Criteria for Systematic Literature Review

Inclusion Criteria	Exclusion criteria
• Papers that employed a qualitative methodology or if mixed methods were used, the qualitative data was collected and analysed separately • Papers whereby stigma was addressed as a research aim or was addressed in the results in at least one named significant theme or sub-theme, with at least two supporting quotes • Papers whereby the target sample: - Is/was living with obesity, during pregnancy (defined by either BMI classification for "overweight" (25-29.9) and "obese" (30+) or self-report of being a larger size or qualitative equivalent) - Provides a first-person account of their experience of stigma throughout the pregnancy journey overall (defined as from the first trimester up until childbirth)	• Adolescents and children will not be included (<18 years of age) • Studies not published in English • Studies published prior to January 2010 • Case studies/ grey literature/ theses • Any studies whereby they explore the perspectives from third parties only or analyse the data with participants who do not meet the inclusion criteria (e.g. with people who are considered within "normal" BMIs) • Any studies which combine and analyse data from other aspects of the pregnancy journey as the primary aim, such as pre-pregnancy e.g. fertility and post pregnancy e.g. motherhood. • Any studies which focus on childbirth only

Table 2

Study Characteristics Table

Authors and year	Aim relevant to the review	Country	Sampling/setting	Sample characteristics	Data Collection Method	Analysis	Relevant themes/ sub-themes extracted	Quality Appraisal Score
Nagpal, T. S., da Silva, D. F., Liu, R. H., Myre, M., Gaudet, L., Cook, J., & Adamo, K. B. (2021).	To describe the experiences of weight stigma in prenatal clinical settings among high-risk pregnant women living with obesity	Canada	Purposive sampling: High-risk obstetric clinics in Kingston	*N* = 9 pregnant women with obesity (BMI ≥35kg/m2) who were receiving specialised care in their third trimester Ethnicity, *n* = 8 (White), *n* = 1 (Asian) Mean age = 31	One-to-one semi-structured telephone interviews	Inductive content analysis	Three themes: ‘Poor communication’, ‘Generalisations of all women with obesity’ and ‘Associating all health conditions with weight’	16
Heslehurst, N., Russell, S., Brandon,	To explore obese pregnant	UK	Purposive sampling:	*N* = 15 Pregnant women living	One-to-one low-structured	Thematic analysis	One theme: ‘Women’s	18

H., Johnston, C., Summerbell, C., & Rankin, J. (2015).	women's experiences to better understand factors which need to be considered when developing services that women will find acceptable and utilise.		Antenatal dietetic service in the North East of England	with obesity (defined as a pre-booking BMI≥30kg/m^2) who were referred to an antenatal dietetic service in the Northeast of England, UK Ethnicity: White (*N* = 15)	depth-interviews were carried out in a location of the participant's choice e.g. Children's centres, own homes, maternity units etc.		experience of negativity'	
DeJoy, S. B., Bittner, K., & Mandel, D. (2016).	To explore the experiences of women with obesity in the maternity care system in the United States	USA	Purposive sampling: Online communities for plus size pregnant women in the USA	*N* = 16 Women who defined themselves as "plus size" and also self-reported a BMI≥30kg/m^2 who were currently pregnant or	One-to-one semi-structured telephone interviews	Inductive analytical process	Two themes: 'Depersonalized care' and 'Setting the tone' Data regarding preconception counselling was omitted in 'Depersonalized care' theme	20

				recently postpartum Mean age: 31.1 Race/ethnicity: White (n = 12), Latina (n = 2), African American (n = 1), Asian (n = 1)				
Furber, C. M., & McGowan, L. (2011).	To explore the experiences related to obesity in women with a body mass index (BMI)>35 kg/m2 during the childbearing process	UK	Purposive sampling: Participants were approached during gestational diabetes screening around 28 weeks of gestation in one maternity service in north of England	N = 19 Women with a BMI $\geq$35kg/m^2 were interviewed in their 3rd trimester and 3-9 weeks after birth Age range: 20 – 44	One-to-one semi-structured interviews at the study site	Framework analysis	Two subthemes: ‘The humiliation of being pregnant when obese’ (the last quote was omitted as it was about after birth) and ‘the medicalisation of obesity when pregnant’	17

				White British (*n* = 18), Asian (*n* = 1)				
Hurst, D. J., Schmuhl, N. B., Voils, C. I., & Antony, K. M. (2021).	To better understand the bias and stigma that women with BMIs ≥40 kg/m 2 experience while receiving prenatal care	USA	Purposive sampling: Participants were contacted through reviewing medical records of those with a pre-pregnancy BMI of 40 or above and had delivered in the last three years from a prenatal service in the Midwest of the United States.	*N* = 30 Women with BMIs ≥40 kg/m^2 who received prenatal care at a university-affiliated teaching hospital in the Midwest region of the United States. Mean age = 34.97 Not Hispanic: (*n* = 29), Hispanic *(n* = 1)	One-to-one telephone semi-structured interviews	Thematic content analysis	Four sub-themes: ‘Weight affects care’, ‘Missing the picture’, ‘Prior experiences and fear’ and ‘Just say it’	19

Jarvie, R. (2017).	To explore the lived experiences of women with co-existing maternal obesity (BMI ≥ 30) and Gestational Diabetes Mellitus (GDM)	UK	Purposive sampling: Participants who were pregnant and had co-existing maternal obesity and GDM recruited from diabetic antenatal clinics at two NHS hospital trusts in the South West of England	*N* = 27 Women with co-existing BMI ≥ 30 and GDM. Participants were predominantly of low socio-economic status (SES). Age range- 19-43	Qualitative sociological design was utilised. Data were collected using a series of sequential in-depth narrative interviews during pregnancy and post-birth and fieldnotes.	Cross sectional thematic analysis of the data set was undertaken, alongside the construction/analysis of in-depth biographical longitudinal case profiles of individual participants	One theme: ‘Stigma’	16
Lingetun, L., Fungbrant, M., Claesson, I.-M., & Baggens, C. (2017).	To describe what pregnant women who present themselves as overweight or obese write about their	Sweden	Purposive sampling: Used the data of those who had self-identified as overweight/obese and discussed their pregnancy in private blogs	*N* = 13 blogs Written by different people who identify as overweight/ obese. Age range- 21- 40	Data was extracted from various blogs and analysed separately.	Thematic analysis	One theme: ‘Perspectives on the pregnant body’	15

	pregnancy in their blog.							
Mills, A., Schmied, V. A., & Dahlen, H. G. (2013).	To examine the experience of women with a pre-pregnant BMI $\geq$ 30 kg/m2, in their encounters with healthcare professionals during pregnancy	Australia	Purposive sampling: Participants were approached if they were in their third trimester or had recently given birth and had a BMI of 30 or greater at their first appointment in teo maternity units in Sydney, Australia	*N* = 14 Women with a body mass index greater than 30 kg/m^2 Age range- 25 – 42	Face-to-face semi-structured interviews in a variety of locations such as private room in the hospital, post-natal ward and participants' home	Thematic Analysis	Three themes: 'Get alongside us' and 'Wanting the same treatment as everybody else' and 'Being overweight and pregnant'	17
Lindhardt, C. L., Rubak, S., Mogensen, O., Lamont, R. F., & Joergensen, J. S. (2013).	To examine the experience of women with a pre-pregnant BMI > 30 kg/m2, in their encounters	Denmark	Purposive sampling: Random selection by birthday/weekday and recruited to special midwife-led antenatal clinics for people	*N* = 16 Women in their second trimester of pregnancy with a pre-pregnant BMI > 30kg/m^2	Face-to-face semi-structured interviews in the participant's homes	Phenomenological approach	Two themes: 'Accusatorial response' (quote from 16b was omitted due to it being regarding breastfeeding) and ' A lack of advice and	17

	with healthcare professionals during pregnancy	with a pre-pregnancy BMI of >30kg/m^2	Ethnicity and ages not reported		helpful information’

Figure 1

PRISMA Flow Diagram

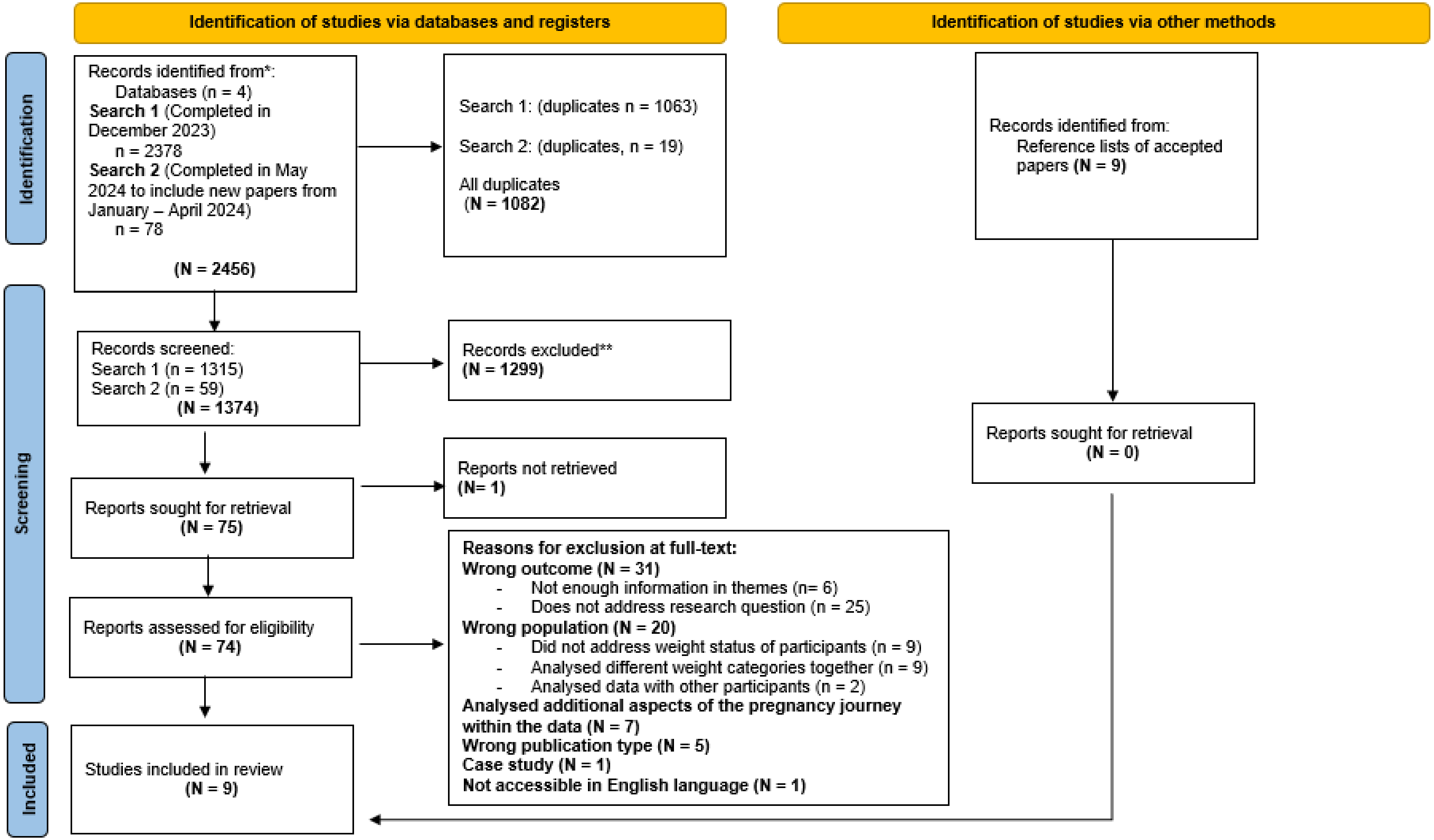
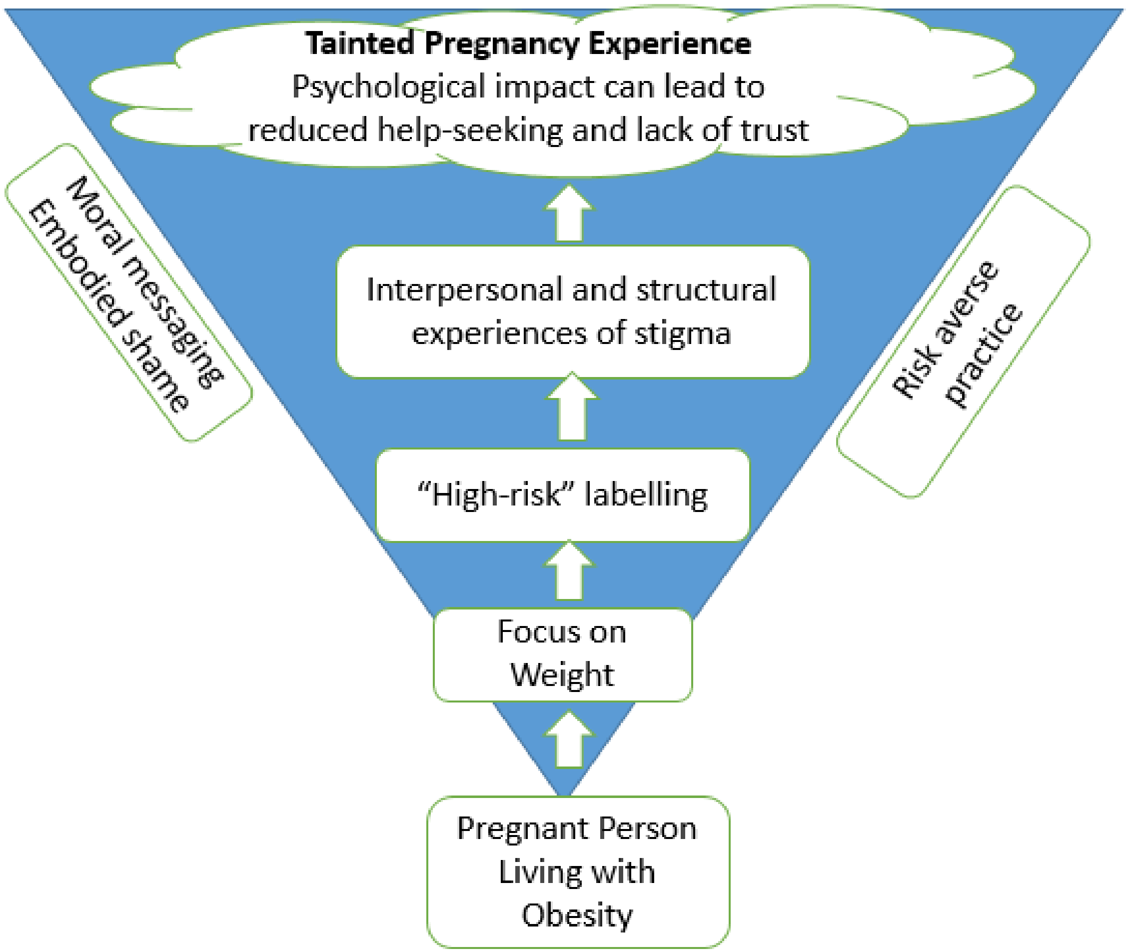


Figure 2

Conceptual Thematic Map



Appendices

Appendix 1-A: Author Guidelines of Chosen Journal for Submission: British Journal of Health Psychology

BJHP AUTHOR GUIDELINES

Sections

1. Submission
2. Aims and Scope
3. Manuscript Categories and Requirements
4. Preparing the Submission
5. Editorial Policies and Ethical Considerations

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

New submissions should be made via the Research Exchange submission portal. Should your manuscript proceed to the revision stage, you will be directed to make your revisions via the same submission portal. You may check the status of your submission at anytime by logging on to submission.wiley.com and clicking the “My Submissions” button. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com.

All papers published in the British Journal of Health Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

Data protection:

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at https://authorservices.wiley.com/statements/data-protection-policy.html.

Preprint policy:

This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

The British Journal of Health Psychology publishes original research on all aspects of psychology related to health, health-related behaviour and illness across the lifespan, including:

- experimental and clinical research on psychological factors aetiology;
- experiential and lived experience of health and illness;
- psychological and behavioural management of acute and chronic illness;
- health-related behaviour change and maintenance;
- psychological factors in screening and medical procedures;
- positive psychological approaches to health and illness;
- psychosocial factors in health-related behaviours;
- influence of emotion on health and health-related behaviours;
- psychosocial processes relevant to disease outcomes;
- psychological interventions in health and disease;
- psychological aspects of prevention and public health.

Papers must make a clear potential contribution to health psychology theory, knowledge and/or practice and employ rigorous research design and methodology.

We do not publish studies where the main focus is on mental health or psychopathology. In addition, we typically do not publish cross-sectional studies or those using only student populations unless there is a strong rationale for doing so.

Papers describing intervention development (without also presenting an analysis of the outcomes of the intervention) will usually only be considered if they make a contribution to health psychology theory, knowledge and/or practice beyond the specific intervention context.

The journal encourages submissions of papers reporting experimental, theoretical and applied studies using quantitative, qualitative and mixed-methods approaches. Research carried out at the individual, group and community levels is welcome. It also welcomes systematic reviews and meta-analyses. Submissions concerning clinical applications of Health Psychology principles and interventions with relevance for Health Psychology outcomes and populations are particularly encouraged.

3. MANUSCRIPT CATEGORIES

The types of paper invited are:

- papers reporting original empirical investigations, using quantitative, qualitative or mixed methods;
- theoretical papers which report analyses of theories in health psychology;
- review papers, which should provide systematic overviews, evaluations and interpretations of research in a given field of health psychology (narrative reviews will only be considered for editorials or important theoretical discourses);
- methodological papers dealing with methodological issues of particular relevance to health psychology;
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Authors who are interested in submitting papers that do not fit into these categories are advised to contact the editors who would be very happy to discuss the potential submission.

Papers describing single study quantitative research (including reviews with quantitative analyses) should be no more than 5000 words (excluding the abstract, reference list, tables and figures). For papers describing 2 or more quantitative studies, the word limit is 6000 words (excluding the abstract, reference list, tables and figures). Papers describing qualitative or mixed methods research (including reviews with qualitative analyses) should be no more than 6000 words (including quotes, whether in the text or in tables, but excluding the abstract, tables, figures and references).

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

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Parts of the Manuscript

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- A short running title of less than 40 characters;
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- Abstract;
- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

Author Contributions

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Abstract

For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions. As the abstract is often the most widely visible part of your paper, it is important that it conveys succinctly all the most important features of your study. You can save words by writing short, direct sentences. Helpful hints about writing the conclusions to abstracts can be found here.

Keywords

Please provide appropriate keywords.

Acknowledgements

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Statement of Contribution

All authors are required to provide a clear summary of 'what is already known on this subject?' and 'what does this study add?'. Authors should identify existing research knowledge relating to the specific research question and give a summary of the new knowledge added by your study. Under each of these headings, please provide 2-3 (maximum) clear outcome statements (not process statements of what the paper does); the statements for 'what does this study add?' should be presented as bullet points of no more than 100 characters each.

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As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.

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- References;
- Tables (each table complete with title and footnotes);
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Appendix 1-B: Search Strings Used for Each Database

Database	Search string
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	OR discriminat* OR bully* OR bullied OR teasing OR tease* OR perception OR attitud*) AND (DE "QUALITATIVE research" OR DE "CONVERSATION analysis" OR DE "FOCUS groups" OR DE "META-synthesis" OR DE "PARTICIPANT observation" OR DE "PHENOMENOGRAPHY" OR DE "QUALITATIVE research in education" OR DE "INTERVIEWING" OR DE "INTERVIEWING -- Technique" OR DE "COGNITIVE interviewing" OR DE "FORENSIC Assessment Interview Technique" OR DE "POLICE questioning -- Technique" OR DE "THEMATIC analysis" OR DE "NARRATIVE inquiry (Research method)" OR DE "GROUNDED theory" OR DE "FOCUS groups" OR DE "ACTION research" OR DE "ACTION research in nursing" OR DE "DIARY studies" OR DE "ETHNOGRAPHIC analysis" OR DE "EXPERIENCE" OR DE "VIEWS" OR DE "MIXED methods research") OR TI (qualitative* or interview* OR "focus group" OR narrative* OR phenomenolog* OR “grounded theory” OR “action research” OR ethnograph* OR "mixed methods" OR experien* OR view* OR perspective* OR account*) OR AB (qualitative* or interview* OR "focus group" OR narrative* OR phenomenolog* OR “grounded theory” OR “action research” OR ethnograph* OR "mixed methods" OR experien* OR view* OR perspective* OR account*)
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	OR DE "Focus Group Interview" OR DE "Intake Interview" OR DE "Interview Schedules" OR DE "Job Applicant Interviews" OR DE "Psychodiagnostic Interview" OR DE "Semi-Structured Interview" OR DE "Focus Group" OR DE "Focus Group Interview" OR DE "Journal Writing" OR DE "Grounded Theory" OR DE "Observation Methods" OR DE "Direct Observation" OR DE "Participant Observation" OR DE "Experiences (Events)" OR DE "Adversity" OR DE "Anniversary Events" OR DE "Combat Experience" OR DE "Crises" OR DE "Disasters" OR DE "Early Experience" OR DE "First Experiences" OR DE "Holidays" OR DE "Life Experiences" OR DE "Life Review" OR DE "Trauma" OR DE "Traumatic Experiences" OR DE "Vicarious Experiences" OR DE "Mixed Methods Research" OR DE "Interpretative Phenomenological Analysis" OR DE "Thematic Analysis" OR DE "Narrative Analysis" OR DE "Narratives") OR TI (qualitative* or interview* OR "focus group" OR narrative* OR phenomenolog* OR “grounded theory” OR “action research” OR ethnograph* OR "mixed methods" OR experien* OR view* OR perspective* OR account*) OR AB (qualitative* or interview* OR "focus group" OR narrative* OR phenomenolog* OR “grounded theory” OR “action research” OR ethnograph* OR "mixed methods" OR experien* OR view* OR perspective* OR account*)
CINAHL	(MH "Obesity+") OR (MH "Obesity, Maternal") OR (MH "Obesity, Morbid") OR TI (obes* OR overweight or “high body mass index” or “high bmi” or fat or weight or adipos* OR bariatric OR ((weight OR BMI OR size) N3 (gain OR increase OR high OR excess OR heavy OR change)) OR heavy OR AB (obes* OR overweight or “high body mass index” or “high bmi” or fat or weight or adipos* OR bariatric OR ((weight OR BMI OR size) N3 (gain OR increase OR high OR excess OR heavy OR change))) AND (MH "Pregnancy+") OR (MH "Attitude to Pregnancy") OR (MH "Pregnancy Outcomes") OR (MH "Pregnancy, High Risk") OR (MH "Pregnancy in Diabetes") OR (MH "Obesity, Maternal") OR (MH "Gestational Weight Gain") OR (MH "Pregnancy Complications, Psychiatric") OR (MH "Perinatal Nursing") OR (MH "Perinatal Care") OR (MH "Prenatal Care") OR (MH "Maternal-Child Health") OR (MH "Maternal Health Services") OR TI (pregnan* OR matern* OR expectant OR gestation* OR prenatal OR perinatal OR antenatal OR antepartum) OR AB (pregnan* OR matern* OR expectant OR gestation* OR prenatal OR perinatal OR antenatal OR antepartum) AND (MH "Stigma") OR (MH "Weight Bias") OR (MH "Prejudice") OR (MH "Discrimination") OR (MH "Attitude to Obesity") OR (MH "Attitude to Pregnancy") OR (MH "Social Attitudes") OR OR TI (Stigma* OR discriminat* OR bully* OR bullied OR teasing OR tease* OR perception OR attitud*) OR AB (Stigma* OR discriminat* OR bully* OR bullied OR teasing OR tease* OR perception OR attitud*) AND ((MH "Qualitative Studies+") OR (MH "Focus Groups") OR (MH "Narratives+") OR (MH "Clinical Exemplars") OR (MH "Open-Ended Questionnaires") OR (MH "Descriptive Research") OR (MH "Interviews+") OR (MH "Observational Methods+") OR (MH "Videorecording") OR (MH "Vignettes") OR (MH "Projective Techniques+") OR (MH "Multimethod Studies")) OR TI (qualitative* or interview* OR "focus group" OR

	narrative* OR phenomenolog* OR “grounded theory” OR “action research” OR ethnograph* OR "mixed methods" OR experien* OR view* OR perspective* OR account*) OR AB (qualitative* or interview* OR "focus group" OR narrative* OR phenomenolog* OR “grounded theory” OR “action research” OR ethnograph* OR "mixed methods" OR experien* OR view* OR perspective* OR account*)
MEDLINE	((MH "Obesity+") OR (MH "Obesity, Maternal") OR (MH "Obesity, Morbid")) OR TI (obes* OR overweight or “high body mass index” or “high bmi” or fat or weight or adipos* OR bariatric OR ((weight OR BMI OR size) N3 (gain OR increase OR high OR excess OR heavy OR change)) OR heavy) OR AB (obes* OR overweight or “high body mass index” or “high bmi” or fat or weight or adipos* OR bariatric OR ((weight OR BMI OR size) N3 (gain OR increase OR high OR excess OR heavy OR change)) OR heavy) AND ((MH "Pregnancy+") OR (MH "Gestational Weight Gain") OR (MH "Pregnancy Outcome") OR (MH "Pregnancy, High-Risk") OR (MH "Obesity, Maternal") OR (MH "Pregnancy in Diabetics") OR (MH "Maternal Health") OR (MH "Maternal Health Services") OR (MH "Maternal-Child Health Services") OR (MH "Neonatal Nursing") OR (MH "Prenatal Care")) OR TI (pregnan* OR matern* OR expectant OR gestation* OR prenatal OR perinatal OR antenatal OR antepartum) OR AB (pregnan* OR matern* OR expectant OR gestation* OR prenatal OR perinatal OR antenatal OR antepartum) AND ((MH "Social Stigma") OR (MH "Weight Prejudice") OR (MH "Social Discrimination")) OR TI (Stigma* OR discriminat* OR bully* OR bullied OR teasing OR tease* OR perception OR attitud*) OR AB (Stigma* OR discriminat* OR bully* OR bullied OR teasing OR tease* OR perception OR attitud*) AND ((MH "Qualitative Research+") OR (MH "Interviews as Topic") OR (MH "Interview, Psychological") OR (MH "Focus Groups") OR (MH "Nursing Methodology Research") OR (MH "Anecdotes as Topic") OR (MH "Narration+") OR (MH "Personal Narratives as Topic") OR (MH "Diaries as Topic") OR (MH "Video Recording+") OR (MH "Videotape Recording")) OR TI (qualitative* or interview* OR "focus group" OR narrative* OR phenomenolog* OR “grounded theory” OR “action research” OR ethnograph* OR "mixed methods" OR experien* OR view* OR perspective* OR account*) OR AB (qualitative* or interview* OR "focus group" OR narrative* OR phenomenolog* OR “grounded theory” OR “action research” OR ethnograph* OR "mixed methods" OR experien* OR view* OR perspective* OR account*)

Appendix 1-C: Example of Stages of Analysis and Supporting Quotes for Theme "Deprived of Good Care"

Transcript Quotes	**Stage one-** **Initial codes**	**Stage two-** **Descriptive themes**	**Stage three-** **Analytical subtheme**	**Stage four-** **Analytical theme**
"I was there flat on my back and the ultrasound scanner had pushed and crushed my body from the outside and the inside to get a view of the baby but had to give up. She finally said that it was my fault she could not get a good view as I was too fat." (Lingetun et al., 2017)	Difficulties scanning causing pain Feeling blamed	Inadequate equipment	Lack of individualised care	Deprived of good care
"I mean it did upset me when they were like, 'Oh yeah it's because you're overweight' and 'You're rather larger' and we actually can't see properly because you are obese'" (Jarvie, 2016)	Equipment too small but blamed on weight			
"Women noted that some offices did not have large-size blood pressure cuffs, in other cases, the paper on examination tables was not wide enough, gowns were too small and left them	Lack of accessibility to larger equipment			

feeling exposed, and waiting room furniture was perceived as too dainty" (Dejoy et al., 2016)				
"The delivery beds and leg stirrups too narrow" (Lindhart et al., 2013)	Equipment too small			
"She was not informed beforehand that it might be difficult to scan an obese individual" (Lindhart et al., 2013)	Lack of information provided	Lack of helpful support		
"If there is bias that because 'you're overweight you don't take care of your health so we aren't going to give you all the information is kind of the feeling you sometimes get.'" (Hurst et al., 2021)	Withholding information			
"On the contrary, another woman said it was stigmatising to assume she wanted a dietary intervention for weight management." (Nagpal et al., 2021)	Inappropriate dietary counselling			

“Some women felt they received mixed messages or contradictory advice. In an ironic twist, at least three women were told they were not putting on enough weight during their pregnancy (Mills et al., 2013).	Inconsistent information received			
“Women reported using the internet more often for weight-related pregnancy advice than for general pregnancy advice.” (Hurst et al., 2021)	Internet use to supplement advice			
“Karen described how she had been asking her GP for a dietetic referral for a number of years but had been refused and told to just ‘go on a diet’. Karen felt that her request for support had been dismissed by her GP , yet whenever she had health problems these were blamed on her weight” (Heslehurst et al., 2015)	Withholding support Diagnostic overshadowing of difficulties			
“A couple of participants reported that they felt coerced into giving birth via caesarean: “I was not preeclamptic; I wasn’t diabetic; I wasn’t having any additional problems; I had no	Coercion into c-section	Power of healthcare professionals	Disempowerment	

complications. I was just fat while pregnant and therefore needed a c-section." " (DeJoy et al., 2016)				
"One woman who felt pressured into further testing was told by her provider "… we are trying to avoid having a stillborn baby here …" " (Hurst et al., 2021)	Pressured into testing			
"One woman who felt pressured into further testing was told by her provider "… we are trying to avoid having a stillborn baby here …" " (Hurst et al., 2021)	Pressured via scaremongering			
"There was a nurse . . . who said before I stepped on the scale, "I hope you don't break it." . . . It reminded me of schoolyard bullies who would say [stuff] like, "Hope you don't break the see-saw." "(DeJoy et al., 2016)	HCPs as a source of bullying	Attitudes towards patient		
	Lectured			

"They're always on you about it , telling me you cant do this, you cant gain that, stop gaining weight- they just keep going" (Nagpal et al., 2021) *"I had one doctor who came to see me in the hospital… I was eating a small snack-size bag of cookies, and he walked in and just totally scoffed at me that I was eating cookies"* (Dejoy et al., 2016)	Judgement of eating behaviours			
"The GP weighed me and measured my BMI without even speaking to me about it. Then I am referred to a special practice for fat pregnant women without my consent" (Lingetun et al., 2017)	Lack of collaboration	Decision-making		
"I then got a letter to see the anaesthetist which [midwife] never mentioned. I just got a letter through the post saying you have an	Lack of communication			

appointment with the anaesthetist" (Furber & McGowen, 2011) "A couple of participants who wanted midwifery care were transferred to obstetric care, even with no medical complications" (Dejoy et al., 2016) "Their comments, however, reflected concerns about how reliance on guidelines for such decisions led to a loss of individuality and lack of capacity by professionals to assess health concerns or risks on an individual basis" (Mills et al., 2013)	Preferences not considered Blindly following guidelines Loss of individuality			

Chapter Two: Empirical Paper

A Qualitative Exploration of Stigma for Young People Living with Higher Weight: A Caregiver's Perspective

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Abstract

Objectives: Young people living with higher weight and their caregivers often experience weight stigma, negatively impacting health and wellbeing. Caregivers offer valuable perspectives on the stigma experienced and its consequences.

Design: A qualitative approach was employed using semi-structured interviews and an optional Photovoice task, where participants visually represented their experiences.

Methods: Seven participants were recruited via convenience sampling and completed both data collection methods. Photovoice images were embedded into transcripts and the narratives were analysed using Interpretative Phenomenological Analysis.

Results: Three themes and five subthemes were developed: (1) resigning to weight stigma, (1.1) expecting stigma, (1.2) protecting from stigma, (1.3) weight as the “problem”, (2) condoning stigma, (3) loss, (3.1) loss of connection, (3.2) tainted childhood. These findings were conceptualised as a journey and suggest that caregiver strategies to protect against stigma may unintentionally reinforce its effects.

Conclusions: Interventions should offer psychological support to both young people and their caregivers, promote sensitive communication about weight and advocate systemic stigma reduction.

Keywords: *obesity, overweight, stigma, caregivers, children, qualitative*

Introduction

Over a quarter of young people (YP) (aged 2-15) are living with obesity and overweight within the United Kingdom (UK), placing them at risk for physical and mental health challenges (NHS Digital, 2024; Cawley, 2011). However, many population-based studies linking obesity to poor health overlook psychosocial mediators such as stigma, which can have greater impact on wellbeing than weight itself (Hunger & Major, 2015; Sutin et al., 2015). This paper uses the term "living with higher weight" (LwHW) [1] to classify YP of a larger body size from herein.

Despite many interacting factors contributing to higher weight (HW) (British Psychological Society, 2019), it is often framed as a personal failure, reinforced by simplistic advice to "eat less and move more" (Ryan et al., 2023), legitimising stigma and discrimination (Puhl & Heuer, 2010).

Attribution Theory (Weiner et al., 1988) suggests that stigma arises from beliefs about personal control over weight (DeJong, 1980), particularly in individualistic cultures (Crandall et al., 2001). These findings tend to reflect the common narratives which are endorsed by society as individual level solutions for weight management are promoted, failing to address the complex web of societal and environmental factors (Government Office for Science, 2007).

Unfortunately, young people living with higher weight (YPLwHW) are particularly vulnerable to bullying and teasing (Puhl & Lessard, 2020), with a meta-analysis finding significant associations across multiple studies comprising of over 100,000 participants across the world (Van Geel et al., 2014). YPLwHW experience stigma from their friends (Himmelstein & Puhl, 2019), family (Eisenberg et al., 2020), teachers (Nutter et al., 2019)

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[1] This is due to neutral terms being preferred when discussing YP (Brown & Flint, 2021), which was echoed for the participants in this study.

and HCPs (Roberts et al., 2021). Stigma can manifest as exclusion, verbal abuse, and cyberbullying (Puhl et al., 2011; Sergentanis et al., 2021). Indirect stigma also affects YPLwHW, as teachers may underestimate their abilities (Peterson et al., 2012), and parents may express bias or reduce financial support (Lydecker et al., 2018; Crandall, 1995).

Rather than promoting weight loss, stigma often leads to disordered eating and avoidance of activity due to the emotional toll of these experiences (Haqq et al., 2021; Puhl & Suh, 2015). Stigma experiences are deemed to be more frequent and impactful during childhood (Puhl et al., 2021) and can contribute to poor mental health (Warnick et al., 2022), health-related quality-of-life (Guardabassi et al., 2018) and social exclusion (Ramos et al., 2018). The NHS Long Term Plan (NHS England, 2019) recognises the need for enhanced holistic support for this growing population, given stigma could be considered a significant maintainer often ignored in weight management interventions.

‘Courtesy stigma’ can be experienced by an individual who has a close association with another of a stigmatised identity (Birenbaum, 1992; Goffman, 2009). This, in addition to being deemed as responsible for YP’s weight (Lee et al., 2022), could render caregivers more vulnerable to experiencing stigma, also. Caregivers are often blamed for the YP’s HW which can cause further discrimination and judgement regarding being “incompetent” and “neglectful” (Hamlington et al., 2015; Kleinendorst et al., 2017). Consequently, parents can also experience isolation and fear regarding their YP’s health due to these assumptions (Kleinendorst et al., 2017; Zenlea et al., 2017). Internalisation of stigma can contribute to poor mental health of the caregiver and can encourage negativity towards the YP, which can lead to avoidance of health-promoting practices (Gorlick et al., 2021). However, research in this area is limited and requires further exploration.

Given that National Institute of Clinical Excellence (NICE) guidance (2025) suggests a family-based approach to weight management is crucial, the views of caregivers can offer valuable insights beyond that of the YP alone. Caregivers can provide their perspectives and experiences of direct and indirect forms of stigma that YP might not have comprehended or been shielded from (Sjunnestrand et al., 2024). Furthermore, caregivers are central in supporting YP's wellbeing and are particularly influential towards their health-promoting behaviours (Savage et al., 2007).

Most of the literature regarding weight stigma is largely focussed on adults and when explored within YPLwHW this tends to derive from research in educational settings (Haqq et al., 2021). Although weight stigma might be discussed as a finding when exploring lived experience of HW in YP (Newson et al., 2024), research often does not investigate stigma as a primary research aim for YP and their caregivers. There have been few studies which have examined caregiver experiences of weight stigma; however, these reflect the perspectives of mothers (Gorlick et al., 2015; Jackson et al., 2007), caregivers of YP with Bardet-Biedl syndrome, (Hamlington et al., 2015), and parents/adolescents who are classified as "severely obese" (Roberts et al., 2021). Furthermore, they have relied solely on an interview format, which may limit the depth of understanding due to the potential production of rehearsed narratives (Mooney & Bhui, 2023) and the sensitive nature of the topic, potentially limiting disclosure (Eli et al., 2022).

This study sought to explore qualitatively, the perspectives of caregivers of YPLwHW and explore their experiences of weight stigma and the associated consequences and implications for them and the YP they support(ed). In addition, this study will build upon previous findings, utilising a Photovoice methodology seeking to elicit more in-depth and personal data from the caregivers of YPLwHW.

Findings will contribute to the provision of recommendations that could help develop meaningful support for YPLwHW and their families. Findings will be useful for clinical psychologists working within weight management and/or YP mental health contexts, to enhance psychological support.

Methods and Materials

2.1 Ethical Procedures

This study gained ethical approval by Lancaster University Faculty of Health and Medicine Research Ethics Committee (FHM-2024-3742-SA-1). Full documentation is provided in chapter four.

2.2 Design

A qualitative approach was employed due to the nature of the research question requiring an in-depth exploration of experiences and perspectives. Given the sensitivity of the topic, which can evoke shame (Lee et al., 2022), it was important to ensure a safe environment to facilitate discussion and collaborative data collection. Therefore, the approach utilised Photovoice methodology to support semi-structured interviews (Wang & Burris, 1997).

Photovoice is a visual participatory research methodology which encourages participants to visually document, reflect upon and communicate issues of meaning and concern (Wang & Burris, 1997). Photovoice can enable people who have often been marginalised, opportunities to be heard (Sutton-Brown, 2014). Ultimately, Photovoice can empower participants to take more control in research, through generating images that are meaningful to them and facilitate deeper understandings through strengthening psychological safety in their expression (Mooney & Bhui, 2023).Given the embodied and emotionally charged nature of stigma, traditional verbal interviews may limit access to the fullness of lived experience, which may not be easy to communicate verbally, given the multifaceted nature of phenomenological inquiry (Boden & Eatough, 2014).

One-to-one semi-structured interviews were deemed the most appropriate to support the elicitation of open-ended data to capture thoughts, feelings and beliefs whilst also enabling flexibility to delve deeper into personal meaning-making and potential sensitive issues for the participant (DeJonckheere & Vaughn, 2019).

2.3 Participants

Participants were purposively recruited if they had been or were currently caregivers of YP who were living with/ lived with HW between the ages 5-16. Caregivers might be deemed more responsible for their YP's weight during these ages, so were considered for inclusion in this research (Gorlick et al., 2021). Being a "caregiver" was defined as taking a significant role in supporting the YP's care and consideration of HW relied on caregiver self-report. Seven participants were considered eligible for inclusion (see Table 1 for full criteria). Participants were aged 38-61. Six participants identified as female, and one identified as male. Table 2 details the participant demographics and the gender and weight status of the YP discussed.[2]

[Insert Table 1]

[Insert Table 2]

2.4 Recruitment

Three methods were used to recruit caregivers which included approaching relevant weight management organisations, approaching schools and utilising convenience sampling.

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[2] Other details have been withheld to protect anonymity

The researcher contacted relevant individuals/organisations and asked them to share their research advertisement. A £10 incentive was offered to reimburse caregivers for their time. All the participants included came from the third, convenience sampling method with the other intended recruitment methods encountering a low response rate.

2.5 Materials

All the materials used for this study were developed with the guidance and feedback from of two experts-by-experience (EbEs) who were consulted in the development stages. The interview schedule was developed based on the aims of this study and in line with research of similar studies (Gorlick et al., 2021).

2.6 Procedure

Potential participants were encouraged to email the researcher to express an interest, and the researcher would contact them to determine their eligibility. Eligible participants were sent an electronic copy of the participant information sheet and consent form and asked to return them via email.

Participants were offered the opportunity to discuss any questions or concerns with the researcher prior to taking part. Additionally, participants were invited to take part in the photo-elicitation task, although this was not mandatory. They were informed that they could opt-out and participate solely in the interview aspect of the study. Photovoice instructions were provided and asked participants to take two photographs in their own time illustrating:

1. What weight stigma means to you
2. How weight stigma makes you feel [3]

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[3] Initially, the second image prompt was for participants to represent “the impact of weight stigma” however, this was changed after the first participant’s interview, due to this prompt not eliciting any additional data that differed from the interview.

There were no specific requirements in how participants were to take the photographs except clear instructions not to take photographs of other people. Participants were invited to send these to the researcher via email and instructions on how to encrypt images were also provided. Once consent was gained for the interview and the photo-elicitation task, the researcher arranged an interview using Microsoft teams.

2.7 Data Collection

Recorded online interviews were conducted from April 2024 to October 2024. Participants sent their images before the interview, to allow time for the researcher to bracket their preconceptions. In the interview, data collection included discussion of demographic information and setting the scene, followed by a discussion of the participants' images in line with the SHOWed technique (Wang, 1999), as they were shared on the screen. Participants were then interviewed about their experiences of stigma and the impact of those experiences. All participants included images to discuss in the interview, however, most participants used images which they had retrieved from online sources, therefore many of these cannot be included due to copyright legislation (see critical appraisal). Participants used their images in a variety of ways such as using them to represent a specific experience and to illustrate metaphors surrounding stigma experience. Appendix 2-B shows two photographs which were not included in the publication.

2.8 Data Analysis

The narratives of the interviews were analysed using an Interpretative Phenomenological Analysis (IPA) framework due to its focus on individual lived experience and value in examining topics which are complex, ambiguous and emotionally laden, such as stigma (Smith & Osborn, 2015). IPA is rooted in phenomenology, which seeks to produce an account of lived experience in its own terms, hermeneutics, which recognises the researcher's role in sense-making and idiography, which values the unique features of an individual's experience (Smith & Osborn, 2015). IPA was congruent with Photovoice's hermeneutic and phenomenological roots, whilst providing a means to express individual experience (Brunsden & Goatcher, 2007; Pietkiewicz & Smith, 2014). For example, IPA's focus on double hermeneutics meant that participants were given space to construct their experience visually, and then interpreted those representations during the interviews, allowing for deeper insight into their meaning-making. Due to the limited timeframe and scope of the study, analysis took a phenomenological approach to Photovoice whereby the images were not analysed as data per se, but served as data antecedents, in which the accompanying narrative was analysed (Latz & Mulvihill, 2017).

Data was viewed through a 'critical realist' ontological lens whereby an external reality was deemed to exist independent of a person's awareness and knowledge. A relativist epistemological position was adopted meaning that the nature of existence was varied and idiographic, thus context enabled the development of knowledge (Grace & Priest, 2015). Therefore, the researcher approached the analysis with the view that stigma exists (i.e. the external reality) but this experience differs amongst participants. For example, from a relativist position, the researcher was able to negotiate some tensions within the data; some participants discussed seeking to protect their children from stigma whilst also expressing frustration with their child's weight. Rather than resolving this contradiction, this was interpreted within the complex interaction of social norms, guilt and responsibility which influenced the theme development.

The analysis consisted of the following seven steps outlined in an iterative and fluid process as outlined by Smith et al. (2021). These included immersing oneself with the data, making exploratory notes across descriptive, conceptual, linguistic and interpretative domains and constructing experiential statements (see Appendix 2-C for coding example). Using the experiential statements, connections were searched for and organised into clusters to develop the initial themes. Each transcript generated Personal Experiential Themes (PETs) and subthemes and were collated for each participant (Appendix 2-D). These PETs were used to generate overall Group Experiential Themes (GETs) to explore patterns and points of convergence and divergence amongst the data. The most salient themes were generated in line with the research question and were critically discussed throughout analysis with the second researcher.

2.9 Validity and Reflexivity

Validity was demonstrated through the consideration of Yardley's (2017) four benchmarks of high-quality qualitative research. The researcher ensured that a reflective journal was maintained throughout the research process to acknowledge any potential biases. Photovoice images were embedded within the transcript to ensure the participants' role as experiential experts were not compromised (Papaloukas et al., 2017). To improve trustworthiness of findings, the analysis was supported by the research supervisor who read through two transcripts and interpretations were critically discussed. Further reflections of quality of the findings are discussed in chapter three.

3. Results

Three core themes and five sub-themes were developed: (1) resigning to weight stigma, (2) condoning stigma and (3) loss. These themes, presented in Table 3, are conceptualised as a journey, beginning with preparing to face stigma, followed by influencing factors, and ending with its consequences. This journey is further explored in the discussion. Pseudonyms were used to protect participant's confidentiality.

[Insert Table 3]

3.1 Resigning to Weight Stigma

All participants believed stigma was inevitable and, rather than challenge it, developed coping strategies. They anticipated stigma, tried to protect against it and often accepted the belief that HW was a problem requiring fixing.

3.1.1 Expecting Stigma

Four participants (Tabby, Sarah, Alan, Gillian) linked stigma to idealised, unrealistic media portrayals. Tabby reflected this in her visual data referencing celebrities in bikinis to illustrate the “filtered” media and society’s value of thinness. Sarah similarly noted: “That’s how they end up being bullied because they’re overweight and they’re different from other children”. Sarah’s comment may illustrate how stigma has become so normalised that the responsibility for bullying is implicitly placed on the YP’s body deviating from the “norm”.

Amy described her nephew James’ resilience stemming from prolonged exposure to stigma: “Maybe that’s because he’s dealt with it most of his life... he’s not that sad about it, which again is is sad in another sense because that has become the norm for him”. James’ desensitisation was an outlier; many caregivers observed negative effects on their YP, despite stigma’s frequency.

There appeared to be a significant cognitive load associated with anticipation, as YP were described as “self- conscious”, “quite cagey”, “aware” and “hyper-vigilant” of their differences in weight. Caregivers mirrored this awareness, which resulted in anxiety, guilt, frustration, sadness and hopelessness. They interpreted subtle behaviours, “a couple of looks” (Naomi), or people “nudging each other while he was eating this ginormous ice cream” (Amy), as judgemental. Often, they projected thoughts onto others: “People will be looking at you as if to say, you know, it’s... don't you think you should lose some weight and and put your kid on a diet as well" (Tina). Tina's quote may illustrate how her own experiences of LwHW may have amplified her vigilance and internalisation of societal surveillance. However, Gillian acknowledged her tendency to assume judgement despite any evidence: "So you kind of assume that people are judging you and maybe you know, maybe they're not actually". Therefore, portraying that anticipation may be just as harmful as experiencing stigma.

Furthermore, expecting stigma contributed to participants' sense of hopelessness towards a resolution. Many expressed uncertainties about how stigma could be resolved and there were beliefs regarding permanence of weight stigma for an individual, despite weight loss attempts: "Even though he could be like dead ripped, and they'd still make jokes about being overweight. Cos' that's what they do." (Tina)

Tabby illustrated her lived experience of weight stigma by combining two photographs of her at different weights (Figure 1). She discussed how she had received stigma at both weights: "I think if you're skinny or big… you get stigma… there's no in between." She also discussed this experience in relation to caring for differently sized YP, one who was deemed "too slim" and one who she was feeding too much. Therefore, her lived experience influenced how she expected stigma on both ends of the weight continuum and conveys a perceived lose-lose situation whereby stigma is always expected.

[Insert Figure 1]

3.1.2 Protecting from Stigma

Throughout the interviews, there was a clear role of the caregiver being the YP's protector and a sense of duty linked to this. Participants discussed how part of their identity was to advocate for their YP. Tabby shared she "had to have the loudest voice in the room" and Naomi stated: "as a mum, I couldn't not say nothing about that". All participants shared frustration and sadness towards the unfair treatment of their YP causing them to enable a protective mode as illustrated by Amy, “I would feel myself getting annoyed…I’ve even said to people you know, stop looking at him” suggesting a sensitivity to and readiness to protect from potential stigma. This also extended to siblings, with Tabby recounting her son hitting a bully to defend his brother: “My other son wasn't violent, but he turned to that stick up for his brother. So, it caused a lot of stress on the family as well” (Tabby).

However, protection often manifested as avoidance, of discussing weight and stigma directly. YP were deemed to be “massively overly sensitive” (Gillian) to any perceived criticism, putting up a “brick wall” (Tina) in response to dietary advice and many YP were secretive around food, suggesting an inability to tolerate weight-based discussions.

Examples of avoidance included caregivers seeking advice from the doctor rather than speaking to the YP, prohibiting the YP from weighing themselves (or look at the numbers if they were weighed), concealing letters about their weight and blaming themselves for wanting the family to eat healthier at home. Furthermore, language was often softened or vague. Sarah referred to her son’s HW as “bum and tum and always had boobies” and Alan highlighted the temporary nature of his son’s weight stating, “obviously he is a child… he tends to fill out and grow”. This suggested a reluctance to discuss the YP’s weight status explicitly, treating it as a taboo subject which was deemed by Naomi as “incredibly, incredibly hard to address”. Similarly, Tina reported: “How do you say to your kid, right, you're going to Slimming World? It's it's like that's another…They’re very ashamed of it.” The term ‘fat’ appeared to be the worst insult that a YP could receive by many participants as Naomi described “I know it’s not a swear word but it may as well be”.

Conversations about weight stigma between caregiver and the YP were rare. Caregivers often speculated about their YP’s internal world without direct discussion. Examples included

Sarah discussing how her son did not tell her he was being bullied and Alan using his lived experience to understand his son's insecurities when pulling at his tight clothing: "I've done it myself in the past, so I understand what he's doing. I I can't say I've explained to him or asked him what he's doing". This conveys a hesitancy to address stigma and its consequences, as caregivers may want to protect their YP from potential upset, thus shield them through avoidance of conversation which may draw attention to their weight, inadvertently reinforcing silence.

Lastly, caregivers also encouraged avoidance of potential stigmatising environments/activities. Examples included: moving school, swapping to homeschooling, taking the YP home for lunch, supporting YP to eat not in public, and encouraging the sibling to accompany the YP to protect them. It seemed that weight was constantly considered, but remained largely unspoken.

3.1.3 Weight as the "Problem"

Caregivers often internalised stigma, seeing HW as a problem to fix. Several shared some potential limiting beliefs about their YP's capabilities, citing reduced fitness. Two YP were described as only able to play a goal position in football: "because of his weight, he realised he wouldn't be able to run as quick as the other kids" (Sarah). This reflects how internalised stigma can reduce self-esteem and aspirations; reinforcing social exclusion through restricted participation

All but one participant, discussed at length ways in which they had desperately tried to support their YP to lose weight. This need to problem-solve helped participants focus on something which they could control as illustrated by Gillian's photograph in figure 2 and quote:

"It's kind of your fault. It's this way in the first place, so I kind of remember. You know, kind of desperately trying to…make healthier food or... just desperately grabbing at anything I could to try and to try and kind of sort the situation out."

This desperation reflects panic and urgency to change, driven by internalised shame and the belief that HW is a personal failure.

[Insert Figure 2]

Sarah, in contrast, admitted using food to communicate love and comfort, until he "sorted himself out" and lost weight in his teens. Sarah retrospectively felt guilt and shame about her feeding practices, likening herself to a killer and taking all the responsibility for her son's weight stating, "I weren't loving him, I was killing him"; again, reflecting deeply rooted assumptions that HW is the product of individual lifestyle, in which parents are complicit and/or responsible.

Some participants attempted to seek support for their YP's weight but felt that it was inadequate and dismissive. For example, Tabby reported she "got thrown some diet sheet and dietician forms" from Child and Adolescent Mental Health Services (CAMHS) and that HCPs told her stepson, Charlie, "to stop lying, because he was hiding food", reflecting the moral judgements associated with HW. Naomi and Gillian described schools failing to follow up after notifying them of weight concerns and other issues were prioritised due to HW being in the "too hard to fix box" (Naomi). Naomi illustrated this with an image labelled education" to represent what weight stigma meant to her, signifying the harm of systemic inaction. Similarly, Gillian stated: "Just kind of got this letter home going. Oh, by the way, your child's overweight and kind of that was that there wasn't any follow-up. There wasn't any support". Institutional silence and avoidance may reflect the lack of prioritisation to weight-related matters, reinforcing it as an individual problem rather than a shared responsibility. Conversely, Tina appreciated that a doctor did not address her son’s weight, feeling it would have added to his shame.

There were hints of YP being held responsible for their stigma, and weight loss was framed as a solution by caregivers, but potentially perceived as a punishment by YP: “A repercussion of that of me saying you know what James we really need to start trying a little bit harder again… James didn't want to spend as much time with me” (Amy).

Alan, however, questioned this logic: stating that losing weight “would only be conforming to the way everybody wants you be anyway”, reinforcing how the YP’s happiness should remain central in this decision. These contrasting perspectives illustrate the complex tensions caregivers face when navigating weight stigma, oscillating between internalising dominant narratives of blame and resisting them to protect the YP’s autonomy.

This theme reflects a deeply rooted sense of inevitability whereby resignation allowed participants to develop coping strategies to mitigate feelings of hopelessness. This meant that caregivers and YP often anticipated judgement and internalised the notion that HW was problematic and within their control. Efforts to protect inadvertently reinforced stigma and normalised shame.

3.2. Condoning Weight Stigma

This theme captures how experiences of weight stigma varied depending on the source, delivery, intent and whether the perpetrator understands the full picture. Figure 3 illustrates this mechanism.

[Insert Figure 3]

Across the interview data, there were mixed responses regarding how stigma was experienced from family members and friends. Six participants expressed neutrality or normalisation, particularly within families: “That'll be the first thing his brother will do was call him fat.” (Naomi) and “You know as siblings do…They will find your weakest points and they will go at it. Won't they? sibling rivalry” (Amy).

However, Sarah described her mother’s suggestion that her son takes “an anti-eating pill” as “awful” because “he was only so young”. Therefore, Sarah felt that stigma felt more harmful when coming from adults due to the view that they should have a better moral compass, this was reiterated for Amy and Tabby.

Indeed, three participants (Tina, Gillian, Sarah) expressed how stigma from friends was less condonable for them, although their YP appeared to tolerate this: “She just tends to comment on his weight quite a bit... But he kind of laughs... He's very fond of her…. I was like… Not happy with that” (Gillian). This may convey the YP’s expectations of enduring this treatment in social relationships, prioritising connection over personal comfort.

Alan shared a photograph (Figure 4) to illustrate how workplace culture normalises weight stigma as “banter”. He believed that within male-dominated work cultures there is an expectation to have a “thick skin”, thus, stigma is socially condoned through cultural norms such as humour. Alan also reported exposure to this environment may have influenced his son’s coping: “He does tend to try and like, be like an adult and be a bit more grown up”, suggesting how Alan’s son may internalise these norms, whereby discrimination is accepted.

[Insert Figure 4]

Most of the YP had experienced adverse childhood experiences (ACEs), mental health and neurodiversity which partly explained their HW. Therefore, many caregivers expressed frustration and experienced stigma as more cruel when others failed to consider their story, instead labelling them as “greedy”, “lazy”, and “feral”. For example, Naomi shared how her son was being punished at school due to teachers assuming “he's just refusing to take his coat off” but failing to recognise his sensory needs and desires to hide his body to protect himself from stigma. This illustrates how stereotyping can lead to misinterpretation and unjust punishment, reinforcing the pathologisation of protective behaviours. Caregivers were often blamed too and were assumed to be incompetent, uneducated, and unboundaried as evidenced by Tina’s dad commenting “you're making a rod for your own back”, reinforcing the belief that HW is associated with moral failure and parental inadequacy. Caregivers highlighted their actions behind the scenes and often felt their efforts were not acknowledged.

The perceived intent behind comments shaped how stigma was received. Stigma was better tolerated when framed as a concern from family who had the YP’s “best interest”. In contrast, well-intentioned actions from professionals were often interpreted as intrusive and offensive. Examples include schools over monitoring the YP’s packed lunch and eating behaviours, offering the caregiver a cookery class and GPs excessively weighing the YP when the primary issue was not weight-related. Additionally, positively framed comments from strangers also had the potential to be experienced as demeaning such as: “isn’t he a great little eater” (Amy) and “isn’t he a big lad” (Alan). This indicated closeness of the relationship could impact the acceptability of stigma for participants.

Overall this theme builds on from the initial theme and focusses on influential factors in stigma experience and acceptability. Stigma was more tolerated when coming from close others, especially when seen as well-intentioned. Humour and "banter" were used to soften harmful comments, often to preserve relationships. However, when stigma came from professionals or ignored individual needs, it was met with strong resistance.

3.3 Loss

The overarching theme of loss represents the emotional, relational and developmental consequences of weight stigma. Alan illustrated this using an image of darkness which represented the bleak consequences of stigma experiences. Albeit he changed his representation from “darkness” to “dark”, potentially highlighting some hope that it is not a permanent state.

3.3.1 Loss of Connection

This subtheme represents the disconnection in the relationships of the participant and the YP who they support. Firstly, the participants noted that they lack trust in certain people and organisations due to their experiences and/or their anticipation of experiences. Alan described “being on the back foot with other parents” and Tabby shared “I don't have much faith in professionals in that department, unfortunately”. This lack of trust impacted how open participants were as Tina illustrated through an image of an individual holding up a sad face mask. This represented how she and her son, tend to hide their true feelings, impacting their ability to be genuine and honest with others: “We put a face on and we're like, oh, yeah... But deep down, we're not, we’re very very sad.”

Similarly, there was evidence of YP hiding or withdrawing from their caregivers through “putting up a wall” (Tina), keeping “his cards close to his chest” (Alan), walking “a little bit on egg shells” (Gillian), and not being “one for talking and opening up about his feelings” (Sarah). This commonality may have sought to protect the YP from showing vulnerabilities but seemed to be a barrier towards having transparent discussions about their wellbeing, therefore, disconnecting YP from their caregivers.

Conversely, two caregivers reported how their experiences of stigma had “brought them closer” to the YP as the parent acted as a “safe net” (Tina). However, despite this, Tabby shared that her relationship with her birth-son was more impacted due to her focussing her time on Charlie: “We drifted apart, and I feel like crying. That pushed us apart. Really. My son felt like I was putting un-biological children first”. These contrasting experiences highlight how weight stigma can reshape family dynamics through deepening emotional bonds which may create perceived inequity within blended family structures.

Due to the YP’s physical withdrawal, this would exacerbate their emotional disconnection and reinforce their loneliness. Examples included: eating in the toilets, stopping hobbies, not attending social events, not wanting to go on school trips and having never “formed any real friendships”, and having “struggled to be part of the community”. Ultimately, participants felt as though their YP’s withdrawal was causing them to miss out on opportunities to develop friendships and networks, providing a sense of belonging. This invoked a lot of strong feelings as participants watched their YP feel “insecure”, have “low self-esteem” and be increasingly “self-loathing”. Tina reported that her son’s mental health meant that he was “wanting to kill himself”. Whilst avoidance behaviours served to protect, they paradoxically reinforced social disconnection and escalated psychological harm.

3.3.2 A Tainted Childhood

This subtheme represents the juxtaposition of both childhood, which is assumed to be a stage of freedom, creativity and self-exploration, and the “darkness” which is associated with weight stigma. Sarah’s image of a park symbolised this contradiction: “It's a park is supposed to be a happy place... And he used to fear that he'd have this type of, you know, stigma”. Places associated with childhood such as playgrounds, were described negatively across the data as “cruel”, “vicious”, and “nasty”.

Stigma from both peers and adults was seen as especially harmful during childhood, particularly as it appeared to impede a child's innocence, thus was deemed to be more immoral: "kids are very, very cruel anyway….the more that they see that the person was upset…the more that they'd carry on." (Tina). Amy also stated, "They're adult enough to know…it's really rude and disrespectful" to share judgemental comments around children. These quotes demonstrate a deep sense of injustice related to the treatment of YPLwHW, and the failure of adults to shield YP may be seen as a betrayal of their developmental needs.

Systemic stigma emerged in clothing access whereby most participants (except Naomi) described clothing as a mechanism for indirect stigma. Gillian described their yearly experience of clothes shopping was something which she dreaded and was "traumatic" for her son which she illustrated with a photograph of a tape measure in Figure 5.

[Insert Figure 5]

"It just kind of symbolised that upset for him I think… would make me feel bad then as well, because…as a parent… think it's your fault"

Not only did clothing highlight children's differences from peers but larger clothing was often more expensive and restricted the YP's freedom to express themselves: "It just didn't look like a child's outfit because it wasn't, and he couldn't choose all this bright stuff or choose all the stuff that his friends was wearing because he couldn't fit into it" (Amy).

Similarly, Naomi reported that her son was often encouraged to cook unhealthy snacks in school, which led to more restriction at home: "That frustrates me a little bit 'cause I think if he was eating healthier in the week, we'd be able to go out and have a family meal and enjoy a bit more". Therefore, Naomi's account reflects how systemic failures to support YPLwHW and their families, can distort the everyday experiences that should define a carefree childhood, reinforcing a childhood which is overshadowed by control and restriction.

Caregivers often had to balance managing weight with supporting developmentally appropriate needs, such as the “need to be children” (Alan) and needs to foster independence (Gill). For example, Alan was disturbed when his eight year old son asked to go to the gym: *“*You wouldn't just… at eight years old… asking to go to a gym and asking to train”. This underscores how stigma can accelerate the loss of childhood as YP become concerned with issues typically associated with adulthood such as body image and health.

Stigma also restricted participation in fun or social activities like swimming, trampolining, school trips, funfairs, waterparks and zip lining. These were typically activities which would highlight their weight or feel exposing in some way: “He wouldn't do trampolining in school because obviously as he bent down, there'd be a big dip and all his mates would be laughing at him.” (Tina)

This theme concludes the stigma journey, emphasising its enduring consequences. This theme reflects the emotional impact of stigma, including loss of trust in professionals, disconnection between caregivers and YP, and a disrupted sense of childhood. Stigma led to avoidance, social withdrawal, and reduced participation in typical youth activities, shaping their self-worth.

Discussion

This study aimed to explore how caregivers make sense of their experiences of weight stigma and the consequences of such, in relation to their YPLwHW. Using a qualitative design grounded in IPA and Photovoice methodology, the research sought to understand the emotional, relational and contextual dimensions of these experiences. The combination of these methods generated rich, layered data that highlighted the personal and societal complexities of stigma. The findings make an original contribution by centring caregiver voices who are often underrepresented, highlighting how stigma operates subtly as much as through overt discrimination, and through the exploration of the often overlooked, relational impact of stigma within families. These findings extend existing literature by illustrating how caregivers' attempts to protect YP from harm may unintentionally reinforce stigma, silence open discussion and compound emotional strain.

[Insert Figure 6]

Figure 6 visually represents the cyclical and cumulative journey of stigma as experienced by caregivers and their YP. Firstly, stigma was expected when one's body shape deviated from the 'norm', which led to caregivers enacting protective behaviours that often unintentionally reinforced stigma. Such protective mechanisms suggested an internalisation of dominant narratives that HW was problematic, shameful and required fixing (theme one; Haqq et al., 2021; Goffman, 2009). Over time, tolerance and normalisation of stigma (theme two) resulted in emotional and relational consequences, captured in theme three. Albeit, tolerance was influenced by many factors such as closeness of relationship (Puhl & LAtner, 2007), how the stigma was delivered (Lewis et al., 2011) and whether assumptions were made without understanding the journey and associated challenges. The cycle continued as experiences of loss reinforced expectations of future stigma. The map highlights how these themes are interconnected in a dynamic, cyclical process. The conceptual map aligns most closely with Link and Phelan's (2001) process model of stigma, illustrating how weight stigma is not a singular event but a self-reinforcing cycle shaped by labelling, stereotyping, and power. It also reflects Goffman's (2009) idea whereby YP are reduced to a "spoiled identity" leading to strategies of concealment and management.

Participants described a resignation to weight stigma, which was expected and normalised within their everyday lives. This is consistent with the high prevalence rates of stigma experiences for YPLwHW (Haqq et al., 2021). Findings highlighted how caregivers appeared to anticipate or be hypervigilant to perceived threats of stigma. Social identity threat describes the psychological state that occurs when individuals experience, suspect or anticipate devaluation of their identity due to their weight (Hunger et al., 2015; Lewis et al., 2011). Hence, it suggests that physiological stress is induced in the same way for anticipation of stigma, as it is for the direct experience of stigma, thus can be just as harmful to one's health (Tomiyama et al., 2018). This stress response can contribute to maladaptive coping strategies being employed such as disordered eating behaviours and avoidance of healthcare (Wetzel & Himmelstein 2023). Thus, it can have many negative consequences for the wellbeing of participants and their YP, through the perpetuation of HW and reduced opportunities for support. Furthermore, these coping strategies are strongest in individuals with higher weight-based internalisation (WBI) (Wetzel & Himmelstein, 2023), indicating those who self-stigmatise are at further risk. Moreover, this evidence highlights the need for perceived safe environments whereby YPLwHW and their caregivers do not fear stigmatisation, given that the anticipation of stigma can initiate the stress-response in the same way as experiencing stigma itself.

Caregivers appeared to internalise stigma as they viewed their YP's weight as a problem which needed to be fixed, although this was not addressed directly and was often expressed through supporting weight management behaviours. Due to this, participants appeared to avoid weight-talk and did not discuss the impact of stigma with their YP, which could encourage YPLwHW to feel that their weight is something to be ashamed of (Gillison et al., 2023). Experiencing shame is linked to WBI, which can exacerbate the impact of stigma upon psychological wellbeing (Sikorski et al., 2014; Pearl & Puhl, 2016).

However, this finding contrasts previous evidence which suggests that the higher the parents' WBI, the greater the frequency of weight-based conversations initiated with their YP (Pudney et al., 2019). Despite perceptions that weight-talk can harm YP's body image and wellbeing, Gillison et al. (2016) suggest that weight-talk can be helpful and supportive, when delivered in a non-critical way. One might suggest that avoidance might be attributed to the sensitive nature of weight and many caregivers feeling unable to approach it safely and sensitively (Sjunnestrand et al., 2024). This finding has similarly been reported in research of HCPs who feel ill-equipped to manage these situations (Turner et al., 2016), thus might lead to missed opportunities to support weight management, as found with a couple of participants. Therefore, navigating weight-talk requires a well-balanced response which is not critical nor avoided.

The findings highlighted the negative psychosocial consequences associated with stigma, for caregivers and YPLwHW. Loss of connection was apparent amongst caregivers as they felt unable to trust other parents and organisations, which could potentially hinder help-seeking behaviours (Gorlick et al., 2021), contribute to self-blame for their YP's weight (Roberts et al., 2021) and model to YP that others cannot be trusted. Additionally, loss of connection for YP was represented by a reluctance to share their distress with their caregivers, in addition to withdrawing from social activities with others (Ramos et al., 2018; Strauss & Pollack, 2003). Social exclusion can contribute to higher risks of depression, poor self-esteem, impaired school performance, and suicidality in YP who have experienced weight stigma (Haqq et al., 2021; Sutin et al., 2018).

A novel finding identified within this study, was how loss was also interpreted from a developmental lens. Firstly, participants acknowledged how stigma can interfere with YP's freedom to explore, interactions with others, and independence which are important to facilitate cognitive and social development (Piaget, 1976). Additionally, participants acknowledged the perceived restriction many YP experienced in comparison to their peers. This restriction appeared to reinforce YPLwHW's differences from their peers, at a significant time when conformity supports social identity development (Lalli, 2020).

Reflexivity

The authors' positionality of being an outsider in the context of this research phenomenon may have supported further meaning-making within the data. For instance, within supervision, I discussed how I was not able to elicit as many direct individual experiences of stigma and many of the interviews discussed at length, their attempts to support their YP's weight management. This facilitated reflection on how stigma may have felt very difficult for participants to articulate and how it may have felt easier to focus on what they could control, potentially seeking to reduce perceived blame. This outsider insight allowed me to acknowledge the potential taboo nature of discussing this topic which left elements unspoken; this was weaved into the themes.

Clinical Implications

Firstly, this paper has identified the need for psychological support for YPLwHW and their families, to help manage the impact of stigma on wellbeing. Services and Clinical Psychologists (CPs) providing support to YPLwHW, should consider a holistic, person-centred assessment and appropriate therapeutic intervention, if required, to ensure a minimal impact on mental wellbeing. Interventions to support YPLwHW should consider including tools to support self-acceptance, self-esteem, and practical coping skills to manage stigma effects in an attempt to overcome avoidant strategies (Newson et al., 2024). Indeed, compassion-focussed therapy lends itself to addressing shame, and has been shown to increase self-compassion, reduce self-criticism and improve depression in adults LwHW (Carter et al., 2023). However, the literature is limited when exploring its efficaciousness in

YPLwHW. Given that WBI can be identified as a mediator between stigma and wellbeing, some promising results have been reported in psychological interventions to address WBI for YPlwHW, albeit have found mixed results about their efficacy compared to control conditions (D'Adamo et al., 2024).

The findings from this paper highlight how some protective mechanisms which are employed by caregivers, such as encouraging an avoidance of weight-talk may contribute to YP's WBI (Baber et al., 2023). Caregivers are potentially well suited to challenge some of these stigmatising narratives, given they are influential in fostering YP attitudes about weight (Arroyo & Segrin, 2013). Therefore, given caregivers and HCPs express discomfort in addressing weight (Turner et al., 2016; Sjunnestrand et al., 2024), further training and education could be provided by CPs to support professionals working with YPLwHW and their families, to initiate weight-based conversations in a supportive and sensitive manner. This may include education of positive communication strategies such as asking for consent and using neutral weight-based language (Auckburally et al., 2021) or training in motivational interviewing (MI). MI shows promising results given that 81% of studies investigating MI in paediatric weight management found statistically significant results in its favour (Lutaud et al., 2023). Although the research is limited regarding specific interventions, a tool for parents to support communication was deemed helpful, acceptable and relevant in supporting these conversations (Baber et al., 2023). Furthermore, Braddock et al. (2023) recommends screening all YPLwHW for weight stigma experiences to adhere to trauma-informed care principles (Williams et al., 2022). Indeed, screening everyone would support open discussions regarding stigma so services can anticipate and support any psychological support needs.

Lastly, the most effective and ethical approaches to addressing stigma is to target the attitudes and behaviours of the individuals and institutions that do the stigmatising

(Tomiyama et al., 2018; Pearl, 2018). NICE Guidance (2025) recommends engagement with more systemic efforts to advocate for better treatment and care for those LwHW. CPs could support stigma reduction strategies more systemically through supporting reflective practices, seeking to challenge assumptions related to individuals, providing training highlighting the determinants of weight and supporting empathy-evoking interventions for clinicians (Talumaa et al., 2022).

Future Research

These findings are interpreted in line with the weight-based social identity threat model (Hunger et al., 2015), however, this model has not been explored within caregiver populations. Therefore, further research could explore whether the weight-based social identity threat model is applicable to caregivers through identity threat by association.

Given the potential requirement for therapeutic support for YPLwHW, further research should endeavour to identify the most robust therapeutic framework for YPlwHW to support WBI and associated difficulties. Additionally, there is minimal research on interventions to support caregivers as most of the research considers caregivers as an agent of change as opposed to an active participant in need of support themselves. Therefore, more research should investigate what specific support caregivers would require. Given that caregivers often feel isolated and unsupported (Kleinendorst et al., 2017), support groups may be a promising intervention for caregivers to share experiences and engage in peer support, thus requires further investigation.

Lastly, given the participants in this study were all White British, from the North of England and the majority were female, further research could explore the perspectives of more diverse groups of caregivers.

Strengths and Limitations

This study provides an insight into understanding caregiver experiences of stigma in relation to their YPlwHW. The use of a novel Photovoice methodology to elicit participant experiences and views was a strength of the study as it provided an alternative means of data collection, helping to elicit a meaningful narrative of the participant that they were in control of. However, the small sample size and demographics of the participants means that the findings from this study are not generalisable nor are they representative of more diverse population groups. Further consideration is discussed in the critical appraisal.

Conclusions

This research utilised a novel approach to explore the perspectives of caregivers in relation to their experiences of weight stigma in relation to their YPLwHW. The findings highlight the normalisation of weight stigma and the development of protective coping strategies that caregivers and YP have employed. Although implemented with good intent, it was postulated that some of the strategies could reinforce stigma and have negative consequences concerning loss. These findings highlighted the need for support in initiating weight-based conversations in addition to stigma prevention and support interventions.

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Tables and Figures

Table 1

Inclusion and Exclusion Criteria for Study Participation

Inclusion criteria	**Exclusion criteria**
Participants who: • Are aged 18 or over • Identify as a primary caregiver of a young person who lives with/lived with HW between ages 5-16 • Has experienced stigma in relation to their YP's weight	Participants who: • Do not speak English • Do not live in the United Kingdom • Are currently under psychological home treatment services and present in acute psychological distress

Table 2

Demographic Information of Participants and the Young Person They Support(ed)

Participant	Naomi	Tina	Gillian	Sarah	Alan	Amy	Tabby
Relationship to YP	Mum	Mum	Mum	Mum	Dad	Auntie	Former step-mother
Gender	Female	Female	Female	Female	Male	Female	Female
Deprivation score [1]	7	1	5	10	7	1	7
Ethnicity	White British	White British	White British	White British	White British	White British	White British
Education	Degree	College	College	College	College	Degree equivalent	College
Employment	Full-time employed	Unemployed	Full-time employed	Unemployed	Self-employed	Full-time employed	Full-time employed
Weight status (BMI or self-report)	BMI- 28.8 (Overweight)	Self-described as “morbidly obese”	Self-described as average	BMI- 23.8 (Healthy)	BMI – 29.7 (Overweight)	BMI – 21 (Healthy) Self-described as “lean and muscular”	BMI – 23 (Healthy) Self-described as “average/curvy”

---

[1] **(Decile 10 = Least deprived, Decile 1 = Most deprived) as per https://alasdairrae.github.io/postcodez/**

Young Person Information							
Gender	Male	Male	Male	Male	Male	Male	Male
Weight status	BMI- 37.3 (Obese) Reported as “overweight”	Reported YP would refer to self as “obese”	Reported as “overweight” but preferred term “larger”	Reported as “overweight”	Estimated BMI- 23.8 (Overweight)	Estimated BMI- 37.5 (Obese) Reported as “Clinically overweight”	Reported that YP would have been described as “obese” but reported she prefers term “overweight”

Table 3

Summary of Themes and Subthemes

Themes	Subthemes
Theme 1: Resigning to weight stigma	1.1 Expecting stigma
	1.2 Weight as the “problem”
	1.3 Protecting from stigma
Theme 2: Condoning Stigma	
Theme 3: Loss	3.1 Loss of connection
	3.2 A tainted childhood

Figure 1

What Weight Stigma Means to You - Tabby

Note: This photo has been edited to preserve the participants' identity

Figure 2

How Weight Stigma Makes You Feel - Gillian

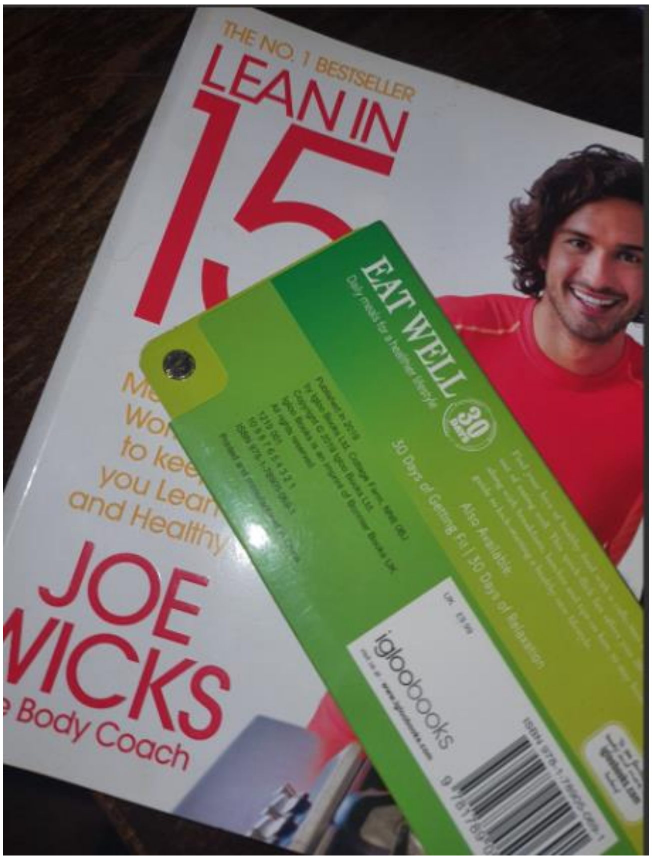


Figure 3

A Conceptual Map to Illustrate Theme 'Condoning Stigma'

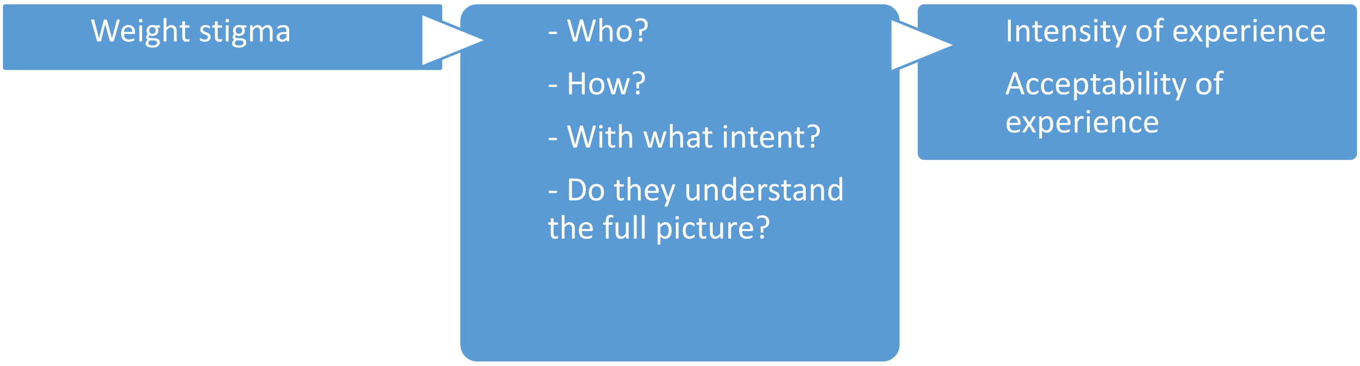


Figure 4

What Weight Stigma Means to You - Alan

Figure 5

What Weight Stigma Means to You - Gillian

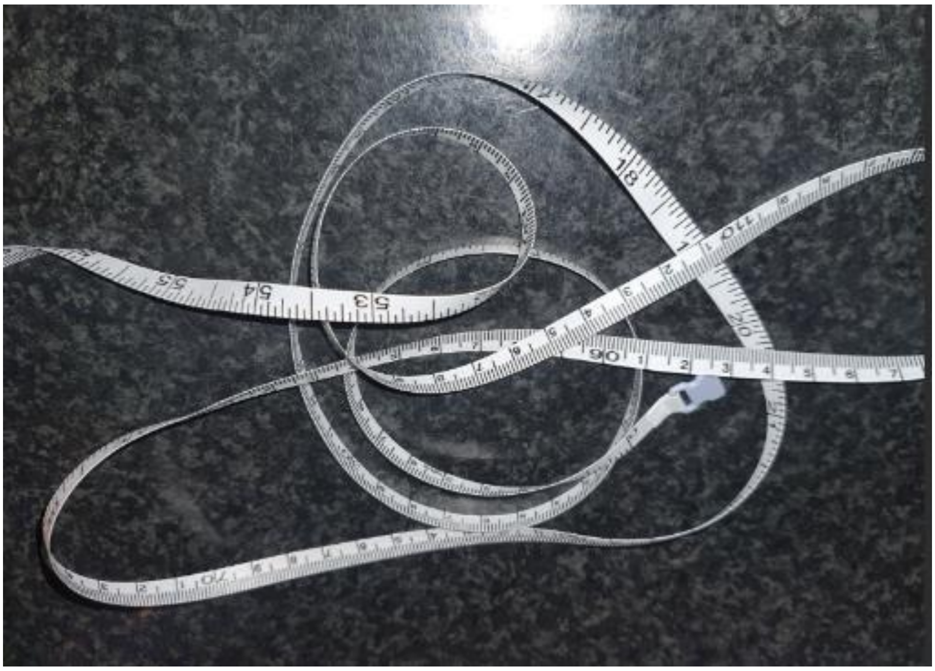
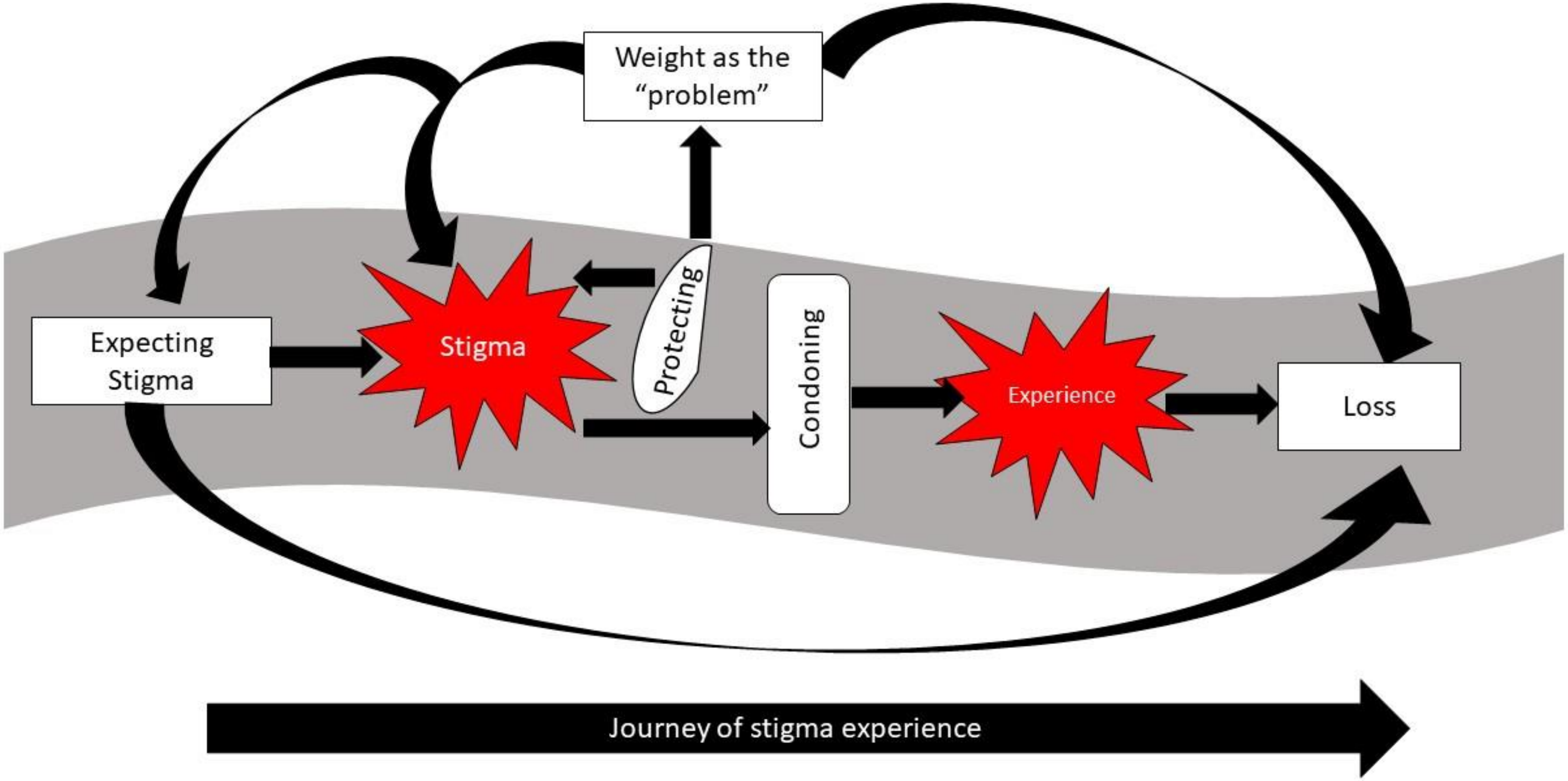


Figure 6

Conceptual Map of Themes to Represent the Journey of Stigma Experience



Appendices

Appendix 2-A: Author Guidelines of Chosen Journal for Submission: British Journal of Health Psychology

BJHP AUTHOR GUIDELINES

Sections

1. Submission
2. Aims and Scope
3. Manuscript Categories and Requirements
4. Preparing the Submission
5. Editorial Policies and Ethical Considerations

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

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This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

The British Journal of Health Psychology publishes original research on all aspects of psychology related to health, health-related behaviour and illness across the lifespan, including:

- experimental and clinical research on psychological factors aetiology;
- experiential and lived experience of health and illness;
- psychological and behavioural management of acute and chronic illness;
- health-related behaviour change and maintenance;
- psychological factors in screening and medical procedures;
- positive psychological approaches to health and illness;
- psychosocial factors in health-related behaviours;
- influence of emotion on health and health-related behaviours;
- psychosocial processes relevant to disease outcomes;
- psychological interventions in health and disease;
- psychological aspects of prevention and public health.

Papers must make a clear potential contribution to health psychology theory, knowledge and/or practice and employ rigorous research design and methodology.

We do not publish studies where the main focus is on mental health or psychopathology. In addition, we typically do not publish cross-sectional studies or those using only student populations unless there is a strong rationale for doing so.

Papers describing intervention development (without also presenting an analysis of the outcomes of the intervention) will usually only be considered if they make a contribution to health psychology theory, knowledge and/or practice beyond the specific intervention context.

The journal encourages submissions of papers reporting experimental, theoretical and applied studies using quantitative, qualitative and mixed-methods approaches. Research carried out at the individual, group and community levels is welcome. It also welcomes systematic reviews and meta-analyses. Submissions concerning clinical applications of Health Psychology principles and interventions with relevance for Health Psychology outcomes and populations are particularly encouraged.

3. MANUSCRIPT CATEGORIES

The types of paper invited are:

- papers reporting original empirical investigations, using quantitative, qualitative or mixed methods;
- theoretical papers which report analyses of theories in health psychology;
- review papers, which should provide systematic overviews, evaluations and interpretations of research in a given field of health psychology (narrative reviews will only be considered for editorials or important theoretical discourses);
- methodological papers dealing with methodological issues of particular relevance to health psychology;
- we particularly welcome papers reporting effectiveness (for example, Randomised Controlled Trials) and process evaluations of interventions in clinical and non-clinical populations.

Authors who are interested in submitting papers that do not fit into these categories are advised to contact the editors who would be very happy to discuss the potential submission.

Papers describing single study quantitative research (including reviews with quantitative analyses) should be no more than 5000 words (excluding the abstract, reference list, tables and figures). For papers describing 2 or more quantitative studies, the word limit is 6000 words (excluding the abstract, reference list, tables and figures). Papers describing qualitative or mixed methods research (including reviews with qualitative analyses) should be no more than 6000 words (including quotes, whether in the text or in tables, but excluding the abstract, tables, figures and references).

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

Please refer to the separate guidelines for Registered Reports.

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Recognizing the importance of research transparency and data sharing to cumulative research, British Journal of Health Psychology encourages the following Open Research practices.

Sharing of data, materials, research instruments and their accessibility. British Journal of Health Psychology encourages authors to share the data, materials, research instruments, and other artifacts supporting the results in their study by archiving them in an appropriate public repository. Qualifying public, open-access repositories are committed to preserving data, materials, and/or registered analysis plans and keeping them publicly accessible via the web into perpetuity. Examples include the Open Science Framework (OSF) and the various Dataverse networks. Hundreds of other qualifying data/materials repositories are listed at the Registry of Research Data Repositories (http://www.re3data.org). Personal websites and most departmental websites do not qualify as repositories.

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- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (if you do submit separate files, we encourage you to also include your figures within the main document to make it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
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Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion.

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The manuscript should be submitted in separate files: title page; statement of contribution; main text file; figures/tables; supporting information.

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- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
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For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our Author Services site.

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For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions. As the abstract is often the most widely visible part of your paper, it is important that it conveys succinctly all the most important features of your study. You can save words by writing short, direct sentences. Helpful hints about writing the conclusions to abstracts can be found here.

Keywords

Please provide appropriate keywords.

Acknowledgements

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

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All authors are required to provide a clear summary of ‘what is already known on this subject?’ and ‘what does this study add?’. Authors should identify existing research knowledge relating to the specific research question and give a summary of the new knowledge added by your study. Under each of these headings, please provide 2-3 (maximum) clear outcome statements (not process statements of what the paper does); the statements for 'what does this study add?' should be presented as bullet points of no more than 100 characters each.

Main Text File

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

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Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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- research with student populations is appropriately justified
- the word count is within the stated limit for the Journal (i.e. 5000 words, or 6,000 words for qualitative papers)

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Appendix 2-B: Other Photographs Elicited by Participants as part of Photovoice Methodology

Amy- What weight stigma means to me

Amy- How weight stigma makes you feel

Appendix 2-C: Example of Coding for Tina

Experiential statements	TRANSCRIBED TEXT	Exploratory notes
	Researcher: 0:19 OK, so so I've got your photo up here. So the first one is obviously what weight stigma means to you? So would you mind just talking to me a bit about why you've chose the the photo that you've taken?	
Shared experience of frequently being targeted as a person who has excess weight	Tina: 0:35 I picked that one basically because when you're overweight, a lot of people do judge it. They point at you and they're like and they rip the shit out of you basically and like.	Speaking from personal experience Judgement from others instantly Judge IT- overweight separate to person? Point at you - singled out? Rip the shit out of you - powerful language

'So much' grief that you become desensitised	There's just so much you get a lot of grief.	So much, it loses its power? "a lot of grief" - lecturing?
Being pointed out due to perceived abnormality, Withdrawal from physical education due to stigma	It's like, see, Samuel. like he'd go to do PE, but then people would be like, oh, look at him. Look at him. And then he he got, he withdrew. He didn't want to do PE then.	Samuel singled out in PE - laughing stock? Novelty of seeing a larger person? Withdrawal as a consequence of stigma
	Researcher: 1:08	
	So it's a sense of like being pointed at and singled out.	
	Tina: 1:12	
	Yeah, yeah. You're singled out very much.	Reinforcement of "very much" 'You are' - speaking from experience, shared expectations as a larger person?
	Researcher: 1:16	

Expectations/rules of being a larger person = excluded Expectation of being bullied as the norm for a larger person	And in the photo, what? What do you think is kind of what? What are you seeing what's happening? Tina: 1:25 Basically they're they're just bullying them. Researcher: 1:30 And how how does that relate I suppose to yours and Samuel's experience? Tina: 1:37 Well say he he just got even his even his mate was used to skit at him. Everyone just skitted at him, everyone	Just bullying them - expected?

Close friends participating in mocking	just pulled him down all the time and so much so knocked his confidence so badly.	Even his mate- close friends participating in mocking- socially acceptable in male friendships? Everyone just pulled him down - stigma as purposeful and intentional
Stigma as excessive, purposeful and everyone is involved.	And it's it's just not nice, jess really not. [shakes head]	So much/all the time/so badly - intensifiers- communicating it as excessive
Disapproval of stigma	Researcher: 1:55	Disapproval from caregiver - 'not nice'- simplistic view - associated with children?
	And why? Why do you think? I suppose, thinking about your photo, why do you think that this problem exists around weight stigma?	
	Tina: 2:06	
Generalising stigma as the fault of everyone and driven by nastiness and lack of understanding	People don't understand it.	Lack of understanding = stigma
	People are just nasty. [laughs]	Nastiness as internal to the person Laughs- way of coping? Dismissing experiences

Appendix 2-D: Personal Experiential Themes for Each Participant

Participant	Themes	Sub themes
Tina	1. Hopeless resignation to a higher power	1a. Cruelty
		1b. Stigma as all-encompassing
		1c. Inevitability
	2. Protection from stigma	2a. Parent as protector
		2b. Putting on a mask
Sarah	1. Blame	1a. Lack of discipline
		1b. Mum as the spoiler
		1c. Regret
	2. Protection	2a. Protection of self
		2b. Parental protection
Gillian	1. All-or-nothing approach	1a. Avoid
		1b. Hyperawareness
	2. Stuck	2a. Responsibility
		2b. Shame
	3. Isolation	

Alan	1. The inconvenient/unspoken truth	1a. Shared experience 1b. Preference for problem-solving 1c. Normalisation of stigma
	2. Tough love	
	3. Uncovering hidden meanings	
Amy	1. Judgement of what is visible	
	2. Experiencing stigma is the ‘norm’	
	3. Adults as responsible	
Tabby	1. Comparing	1a. Comparing to ideals 1b. Comparing to family
	2. Judgement based on assumptions	2a. Judging eating behaviours 2b. Isolation
	3. Hopelessness	3a. Stigma will always exist 3b. Stuck

Naomi	1. Constant awareness of weight	1a. Cognitive load 1b. Doing and fixing 1c. Weight as unspoken
	2. Systemic discrimination	2a. Blanket approach to treatment 2b. Lack of support

Chapter Three: Critical Appraisal

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The critical appraisal reflects on findings from the systematic literature review (SLR) and the empirical paper (EP). It outlines key strengths and challenges of the EP's research process and offers personal reflections on recruitment, data collection, ethical considerations and the quality of the data. Additionally, clinical implications, future research and personal reflections of my engagement with the topic will also be discussed.

Research Findings

Firstly, the SLR used a thematic synthesis (Thomas & Harden, 2008) to identify themes associated with the experiences of weight stigma for pregnant people living with obesity (PPlwO)[1], deriving from qualitative studies. Three main themes and four subthemes were developed: (1) dehumanising and intrusive treatment, (1.1) focus on weight, (1.2) high-risk status, (2) deprived of good care, (2.1) lack of specialised care (2.2) disempowerment and (3) tainted pregnancy experience. Clinical implications included the need for sensitive communication strategies and addressing systemic discrimination within healthcare.

The EP explored stigma experienced by young people living with higher weight (YPLwHW[2]) and their caregivers, using semi-structured interviews and visual data via Photovoice (Wang & Burris, 1997). Data were analysed using Interpretative Phenomenological Analysis (IPA; Smith et al., 2021; Keating, 2021). Three themes and five sub-themes were developed from the data: (1) resigning to weight stigma (1.1) expecting stigma, (1.2) weight as the "problem" (1.3) protecting from stigma, (2) condoning stigma, (3) loss, (3.1) loss of connection, (3.2) tainted childhood. Clinical implications included

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[1] It is acknowledged that there is a difference in how weight is addressed for each of the populations, PPlwO is used due to its congruence with the terms used in the literature and 'obesity' will be used in a medical context

[2] YPLwHW is used as it reflected the preferences of the participants in the EP

increasing confidence to initiate weight-related discussions and developing support for YPLwHW and their caregivers.

Firstly, both papers identified beliefs that higher weight (HW) was a problem which needed to be fixed, rather than a difference to be accepted. Within the SLR, ‘obesity’ was seen as problematic due to its association with “high-risk” pregnancy, implying increased risk of diabetes, pre-eclampsia, and birth complications. Whilst guidelines recommend additional monitoring and testing due to these risks (Royal College of Obstetricians and Gynaecologists [RCOG]; 2018), PPLwO often perceived interventions as disproportionate and perceive that expression of risk is often conflated (Houghton et al., 2008; Chowdhry, 2018). Similarly, caregivers of YPLwHW seemed resigned to the idea that their young person (YP) should lose weight to reduce stigma, leading to efforts to support weight loss. However, these protective strategies may have reinforced the idea that individuals are solely responsible (Black et al., 2014). This resignation may reflect the perceived inevitability of stigma (Puhl et al., 2008), creating hopelessness about resolution. These shared experiences may stem from negative stereotypes associate HW with poor health or moral failure (Puhl & Heuer, 2010). Therefore, the inclusion of both populations strengthen the conclusions made as both are held morally responsible and share the emotional labour involved in protecting others from harm.

In contrast, the papers differed in how weight was addressed. For PPLwO, weight often dominated healthcare interactions, closely tied to perceptions of risk to the individual and their foetus. Whereas, in the EP, caregivers often avoided weight-talk, perceiving it as too taboo/sensitive or potentially upsetting the YP (Sjunnestrand et al., 2024). Similarly, caregivers also reported that healthcare and school professionals avoided the topic, missing opportunities for support. These differences may stem from the SLR’s medical focus, where participants were recruited based on BMI of 30, a common threshold for specialist support (RCOG, 2018). In contrast, the EP relied on self-report and did not involve a medical context.

Consequently, weight may have been more visible and risk-linked in healthcare, explaining its explicit mention. Including both groups complicates conclusions due to differing power dynamics and responses to weight-based conversations across family and medical systems.

Participants

Strengths

There is limited research exploring weight stigma experiences in non-clinical populations of YPLwHW. Research tends to derive from medical, educational and/or research settings (Roberts et al., 2021; Haqq et al., 2021; Gorlick et al., 2021). Therefore, although not anticipated, recruitment stemming from convenience sampling meant that findings represented caregivers whose young person's HW was not necessarily being supported clinically. This provided novel insights whereby the YP's HW was not a particularly defining feature within their life, as they were not accessing specialist weight management support.

Interviewing caregivers regarding their experiences, in addition to their observations of their YP, enabled the elicitation of more nuanced and abstract interpretations, such as systemic discrimination, which the YP may not have been aware of. The sample shared lived experience of being a caregiver for YPLwHW but also differed in educational and socio-economic backgrounds, which could support a variety of perspectives being analysed.

Challenges

Despite some of the strengths, there were challenges during recruitment which could have led to some limitations in the sample. Initially, the advertisement asked "does your child live with obesity?" however, upon reflection and discussion with stakeholders within the recruitment process, this type of passive recruitment would require identification with an obesity label (Lee et al., 1997). Additionally, caregivers may lack awareness of their YP's

HW identity if they are also living with HW and/or may express denial of their YP's HW status (Gerards et al., 2012), which could have posed a barrier to expressing interest.

Furthermore, the term 'obesity' can be stigmatising itself, therefore, it was determined to use the term 'excess weight'[3] which can be deemed more neutral (Puhl, 2020). Consequently, the advertisement was reframed so potential participants did not have to relate to the concept of childhood obesity/overweight and were asked "have you experienced stigma due to your child's weight?" This was to target those who did not perceive their child as living with HW and/or experienced stigma as unwarranted.

During the development of the project, I anticipated that there may be some challenges discussing stigma in the interview, which was accounted for through the consideration of Photovoice to build rapport. However, given the high prevalence of YPLwHW (NHS Digital, 2022), I did not anticipate how reluctant and hesitant some organisations and individuals would be to share the advertisement, particularly schools. This surprised me as schools are involved in the National Child Measurement Programme (Office for Health Improvement & Disparities, 2024) to monitor and inform caregivers of their YP's HW status. This highlighted how taboo it can appear to encourage discussion of weight and stigma and how sensitivity is key in addressing this. Therefore, after acknowledging these difficulties, I made an amendment to my ethics to offer a financial reimbursement. This was to acknowledge the sensitivity of the topic and reimburse caregivers for their time, given some financial barriers to engaging caregivers in research (Pescud et al., 2014).

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[3] My choice of weight-related terms evolved throughout the research process and I decided to write up using the term HW as I felt like it reflected diversity as opposed to being linked with medical problems

Data Collection

Throughout data collection I experienced several challenges that were reflected upon and aided the learning process. Firstly, Photovoice was a new methodology which I was inexperienced using. During the preparation process, I worked with my field supervisor (FS) who was trained in Photovoice and utilised the same instructions used in Hall and Noonan (2023). After my first interview, I was surprised that the participant had shared two images from online sources, which were copyrighted. After discussion, we acknowledged that this was not a typical interpretation of the instructions, which made explicit reference to taking photographs. My FS had not encountered this challenge before, neither was it cited in any available evidence. Therefore, after further contemplation, we collaboratively agreed to include the images and continue with the process, as this was still in line with the aims of Photovoice, which was to encourage a high level of control for participants over participants' expression (Wang & Burris, 1997; Budig et al., 2018). Additionally, I felt it was important to include as the participant had still gone to the effort to find an image to represent their experience. Therefore, although not constructing the photographs themselves, which may have compromised their co-researcher role (Wang & Burris, 1997), they still utilised their image to represent and recount personal lived experience.

Despite efforts being made to reduce participant burden through inviting participants to use their own device to take photographs (Foster et al., 2022) and employing a phenomenological approach in which the researcher led data analysis (Latz & Mulvihill, 2017), three participants did not take any of their own photographs and used online images. This made me consider the participant burden associated with the use of more abstract data collection methods such as Photovoice. For example, it requires technological skill and confidence (Paulus & Lester, 2021) and requires motivation and a level of critical and creative thinking (Lorenz & Bush, 2022), which could pose barriers to engagement. Indeed, this was reflected by three participants requiring technical support to access Microsoft teams and most participants questioning the requirements of the Photovoice task, asking for examples. However, providing examples was purposefully avoided to reduce the researcher's influence over the participants' choice of photographs. Therefore, it was difficult to facilitate creative thinking without being able to provide examples, which may have increased participant burden and anxiety.

Overall, these challenges highlighted how the prescribed methodology used in Photovoice may compromise participant engagement, if burden is deemed too high. For example, originally the Photovoice process provided a camera for participants to use and invited the group to meet multiple times to act as co-researchers throughout (Wang, 1999). However, my approach was more flexible (Latz & Mulvihill, 2017). Therefore, given that Photovoice is rooted in activism and social change, this may have implications for the desired collaboration and empowerment the methodology emphasises, as some images will not be able to be published due to copyright legislation. Therefore, I recognised the need for development of the integration of Photovoice with IPA analysis. It could be enhanced through the incorporation of the visual content into the interpretative layer of analysis and through inviting participants to co-analyse. Given the limited timeframe and scope for this project, I was not able to do this but identified how this may better centre the lived experiences of this population.

Secondly, during my interviews, I found it difficult to navigate my role as a clinician versus my role as a researcher. Given the challenges engaging caregivers of YPLwHW, I wanted to ensure I facilitated a trusting relationship with participants (Brock et al., 2021) and may have fell into a clinician role at times. After my first interview, I noticed that it was shorter than I anticipated, and I reflected upon my tendencies to offer multiple reflective summaries which I adopted to build rapport and trust (McCarthy & LaChenaye, 2017).

However, I noticed that this would encourage a closed response, of either agreement or disagreement of my understanding of the data. I found the use of a reflective diary helpful in acknowledging these summaries, in addition to noticing the increased use of empathic statements and validation. To overcome this, I utilised peer feedback and developed some further clarification questions which did not involve summarising such as “can you tell me about an example of that” or “can you tell me more about that”. Although this felt unnatural, this helped elicitation of richer data and meant that the participant was leading the discussion. I noticed the difference in the increased amount of data obtained when I started to employ these questions rather than summarising.

Ethical Issues

After several interviews, I recognised that participants had shared some discomfort about participating when the YP was in the house and could potentially overhear the interview. Therefore, we arranged a time when the YP was not present to maintain the participant’s confidentiality within the home (Self, 2021). A couple of participants had asked for verbal consent from their YP informally, and shared that they would give them the financial reward. After this, I started to question whether I should have asked for consent/assent from the YP whose caregivers were participants. In supervision, we acknowledged that the caregivers were contributing their own interpretations of experiences and were not acting solely as the YP’s proxy (Čolić, 2021). Therefore, although there was limited published ethical guidance for interviews with caregivers specifically, I focussed on maintaining the anonymity of the YP and ensuring the participant was in a safe space which did not risk a breach of confidentiality. To enhance insider anonymity (Saunders et al., 2015), I sought to omit identifiable information within the analysis and ensured quotes which were niche to the YP, were not included, specifically within the report; for example, specific diagnoses and demographics.

For some participants, I already had a pre-existing relationship and/or mutual connections with. Although acquaintance interviews can utilise the prior relationship as a resource for building rapport, special attention was paid to the ethical implications of this, such as ensuring confidentiality and anonymity (Roiha & Iikkanen, 2022). I sought to reassure the participant of the confidential nature of the interview and highlighted clearly that this information would not be shared to any mutual contacts, prioritising anonymity. Attention was paid to ensuring that participants did not feel coerced in any way to participate and they were reminded of their rights to withdraw throughout the research

Quality of Findings

To demonstrate the validity of findings, Yardley (2017)'s framework was used. This included evidencing sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Sensitivity to context was considered through the engagement with the literature and consultation of experts-by-experience in the development of the research proposal and materials used. I was reactive to any challenges that arose and adapted accordingly, for example, the wording of the advertisement discussed above. Commitment and rigour were considered through thorough data collection involving visual and narrative data, alongside appropriate engagement with the topic and methods used. Transparency was illustrated through providing evidence of coding and theme development, whilst importance was considered through the generation of novel insights and reflections which were relevant to clinical practice.

Throughout data collection and data analysis, I wanted to ensure I was accounting for my own biases which may have impacted the results (Pietkiewicz & Smith, 2014). I considered these within my reflective diary, exploratory noting and within supervision. For example, within one of the interviews, I questioned whether the participants' understanding of stigma was "correct" as they discussed weight management issues when asked about stigma. This differed to my expectations as I was anticipating explicit situations of stigma such as name-calling which was more prevalent in the literature. Following this, I discussed this interpretation with my supervisor during cross-checking and recognised that stigma for this participant was represented by a lack of support for their YP's weight management. Therefore, I was able to add an extra layer within the analysis to consider how participants found it easier to discuss weight management, as opposed to stigma. This may have led to results that neglected the participant's voice, therefore, bracketing my preconceptions reinforced the participants' voice to remain a focal feature within the analysis (Chan et al., 2013).

Within the SLR, quality of the findings were accounted for by completing the Critical Appraisal Skills Programme (CASP) tool. The studies included displayed consistency in many strengths including appropriate research design and providing a valuable contribution to the evidence-base. This was important as it meant that the research reviewed demonstrated commitment and rigour and impact and importance as per Yarley's (2017) framework. However, it should also be highlighted that the CASP tool may only accurately evaluate reporting as opposed to research quality; this is important to acknowledge as journal guidelines may lead to reporting restrictions (Long et al., 2020). Six out of the nine papers which were included, scored "no" for consideration of the relationship between researcher and participants and one scored "can't tell", thus could have contributed towards a bias in results.

However, the potential for researcher biases were accounted for within the inclusion criteria which ensured there were at least two supporting quotes for each theme included within the synthesis, to examine credibility. Furthermore, I reflected on my own misunderstandings of this requirement as I noted that most of the research tended to consider the impact of the researcher within data analysis, and not from the beginning, a common weakness in qualitative research (Chan et al., 2013). Therefore, I will seek to think about potential bias earlier on in the research process, for example, through delaying the literature review until after data collection and analysis (Hamill & Sinclair, 2010).

Clinical Implications & Future Research

I will discuss the clinical implications for clinical psychologists (CP) specifically, highlighting future research opportunities and reflect on my personal feelings towards the implications. Both papers highlighted the complexity underpinning the aetiology and maintenance of HW, particularly how weight stigma can contribute to this cycle through reduced psychological wellbeing (British Psychological Society [BPS], 2019; Westbury et al., 2023). Therefore, I recognised how important it is for CPs to understand this and advocate for a holistic and formulation-driven approaches when working with PLwHW (Johnston et al., 2023).

Indeed, within the literature, CPs roles are mainly discussed within the context of weight management services (Johnston et al., 2023; BPS, 2019) and not discussed in relation to working within typical mental health settings. This may be due to working with PLwHW being deemed ‘specialist’ knowledge (BPS, 2019) and I wondered whether this perspective could contribute to PLwHW feeling ‘othered’ as professionals may lack confidence in working with their potential “complexity” whereby they risk falling through the gaps. However, there is a higher prevalence of HW in mental health services (Afzal et al., 2021), and so CPs are more likely to work with many individuals with HW, yet clinical psychology training tends to neglect teaching about this client group (Brochu, 2018).

CPs are deemed valuable within the delivery of weight management interventions, yet their input is only offered for people with known mental health difficulties or when there are issues regarding engagement, thus may not be maximised due to reduced resource (Dandgey & Patten, 2023). Evidence cites that those who seek bariatric surgery have often experienced adverse childhood experiences, including abuse, trauma and family mental illness (Schroeder et al., 2021). This can contribute to complex mental health presentations including a higher likelihood for eating disorders, substance misuse and suicidality (Johnston et al., 2023). Therefore, the use of food can be seen as an emotional regulatory strategy as opposed to a biological explanatory mechanism for HW (Wiss & Brewerton, 2020).

Consequently, CPs can use formulation to understand these links and intervene accordingly, within their service and professional boundaries. Some key mechanisms underlying an individual's difficulties may involve reduced self-esteem and self-efficacy, unhelpful thoughts and beliefs, and emotional dysregulation (BPS, 2019). Given the limited resource and the lack of CPs working in weight management services, some patients fall through the gap of service provisions (Johnston et al., 2023). Therefore, CPs should be able to access appropriate training and seek close connections with weight management services to ensure an appropriate integration to better support this population (BPS, 2019).

Given the research regarding psychological interventions often focusses on weight loss as a main outcome (Tylka et al., 2014), behavioural treatments tend to be the first line intervention (NICE, 2025). However, it is difficult to compare therapeutic approaches due to the heterogeneous nature of the support programmes, thus it is unclear if behavioural interventions exceed the effectiveness of other interventions. Given stigma experiences and stigma internalisation show strong evidence mediating the relationship between HW and wellbeing (Hunger & Major, 2015), it may be an appropriate avenue to investigate. Indeed, NICE (2025) identified that the evidence in this area is limited and outcomes such as quality-of-life and stigma should be prioritised, with weight loss outcomes being secondary. Alternative interventions such as compassion-focussed therapy (Brenton-Peters et al., 2021) and acceptance and commitment therapy (Iturbe et al., 2022) show emerging evidence for effectiveness of improving psychological wellbeing and health behaviours, through addressing stigma internalisation, thus should be considered and continued to be researched for PLwHW.

Whilst the implications are important for CPs working within contexts involving PLwHW, I reflected on how more should be done at a societal level to address stigma, as this tends to act as a barrier to even receiving support (Puhl, 2023). I recognised how policy in the UK does not consider ‘obesity’ as a chronic disease of a relapsing nature, which has been considered in other countries (English & Vallis, 2023). Indeed, this is a challenge which may hinder translating research findings into practice as individual responsibility is emphasised, reinforcing negative attitudes toward PLwHW; thus top-down approaches are critical in enabling support interventions.

This made me feel quite hopeless and disempowered, which mirrored some of the participants’ feelings within both papers. However, I identified that CPs have a role in advocating for change on a wider level than the services they serve. For example, Bostock et al. (2021) suggest that CPs have a responsibility to embrace leadership that is politically informed which involves a recognition of systems that are failing people rather than their “poor choices” and influencing change at higher levels through lobbying, advocacy and challenging current practices and knowledge. Therefore, I have considered that I can influence change widely simply by sharing my knowledge and experiences of this topic and hopefully influencing others’ views within my professional and personal life.

Reflections on the Research Topic

My interest in this research stemmed from my curiosity of how mental health and the physical body interact. During my undergraduate research dissertation, I investigated stigma for transgender people and was influenced by the minority stress theory (Meyer, 2003). During this time, I was so appalled at the preventable nature of many health outcomes, if stigma was addressed at a societal level.

Additionally, I was interested in the application of this phenomenon within the context of PLwHW due to my personal/professional appreciation for physical activity as a therapeutic intervention and something I am passionate about endorsing within my clinical work. Therefore, I naively assumed that HW was strongly linked with lack of physical activity and excess calories. This could have been due to my Crossfit background and exposure to the health and fitness industry, which promotes this simplistic thinking.

However, throughout this journey, I have recognised that this simplistic assumption is one of the main contributors to weight stigma and is a belief held by the majority in society. Furthermore, this research has challenged these assumptions and supported me to recognise that there are many factors to consider for PLwHW such as co-morbid mental health difficulties, physical health issues and the role of stigma in maintaining HW through obesogenic coping strategies. Therefore, I believe this research has highlighted the need for targeted interventions to increase education and understanding of the aetiology of HW in paediatric and maternity settings but also beyond settings explored in my research. I believe this would be the most influential intervention to increase compassion for these populations.

Conclusion

Key reflections highlighted how research has to be conducted sensitively and thoughtfully to support engagement of this population. I also recognised the power of simplistic understandings towards HW, and how they can negatively impact support opportunities for PLwHW. Finally, I reflected on the implications for CPs, as they should feel more equipped with the knowledge and confidence to support this client group in mental health settings.

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Chapter Four: Ethics

Jess Doyle

Doctorate in Clinical Psychology

Faculty of Health and Medicine, Lancaster University

All correspondence should be sent to:
Jess Doyle
Doctorate in Clinical Psychology
Faculty of Health and Medicine
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Sir John Fisher Drive
Lancaster University
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LA1 4AT
Email: j.doyle4@lancaster.ac.uk

Application for Ethical Approval for Research

Research Ethics Application Form v1.9.8

Research Ethics Application Form v1.9.9.1 RECR

A Qualitative Exploration of Stigma Experienced by Young People Living with Obesity: A Caregivers Perspective - Approved

Information Regarding this Research Project

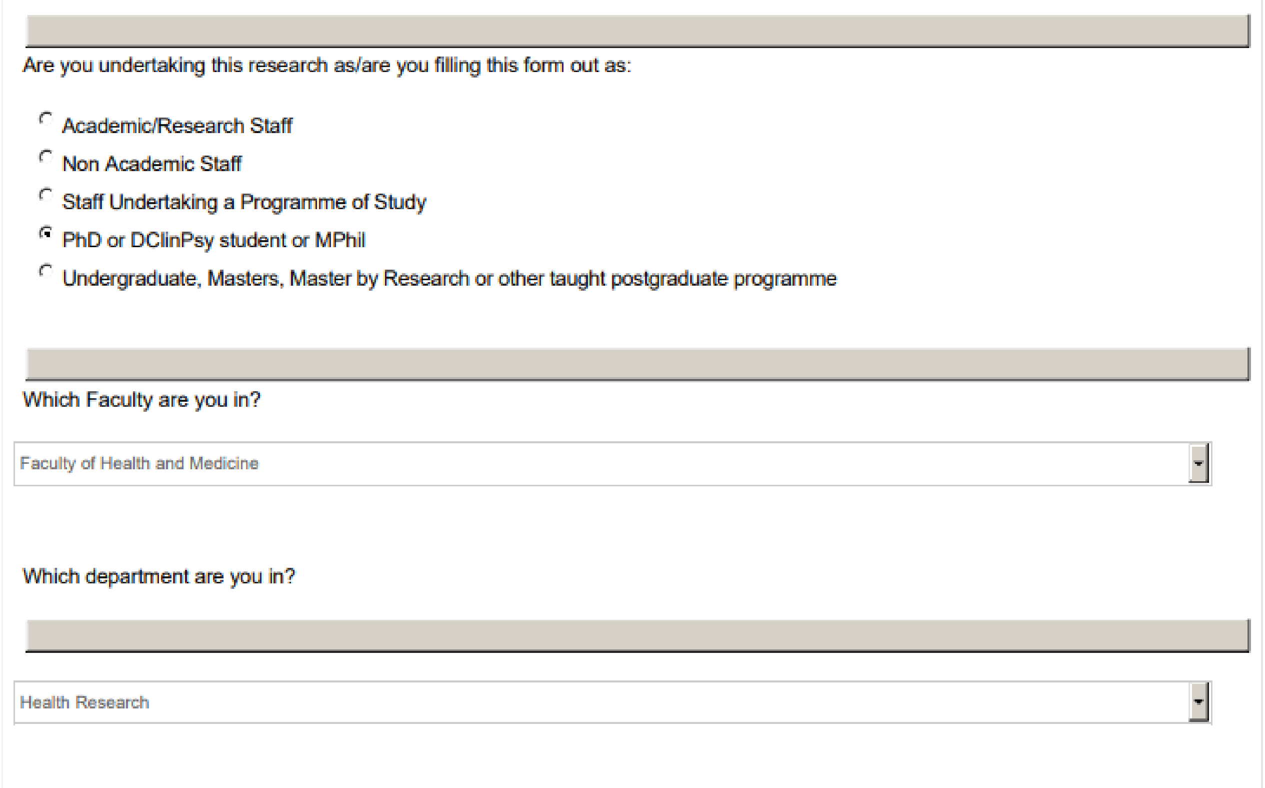
Are you conducting a research project?

(for more information on research projects please see our ethics pages)

● Yes ○ No

Does your research only involve animals?

○ Yes ● No



Are you undertaking this research as/are you filling this form out as:

○ Academic/Research Staff
○ Non Academic Staff
○ Staff Undertaking a Programme of Study
● PhD or DClinPsy student or MPhil
○ Undergraduate, Masters, Master by Research or other taught postgraduate programme

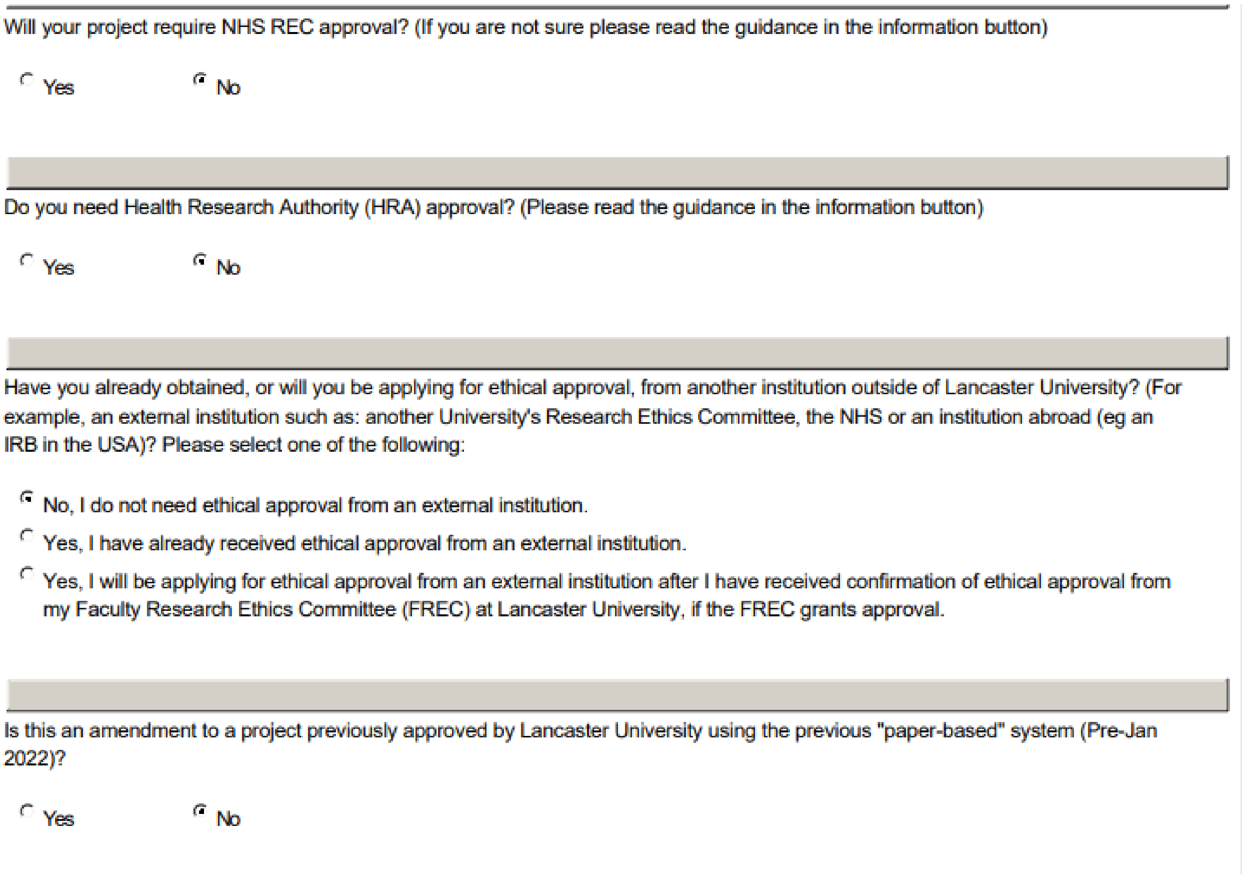
Which Faculty are you in?

Faculty of Health and Medicine

Which department are you in?

Health Research

ETHICS SECTION



Will your project require NHS REC approval? (If you are not sure please read the guidance in the information button)

○ Yes ● No

Do you need Health Research Authority (HRA) approval? (Please read the guidance in the information button)

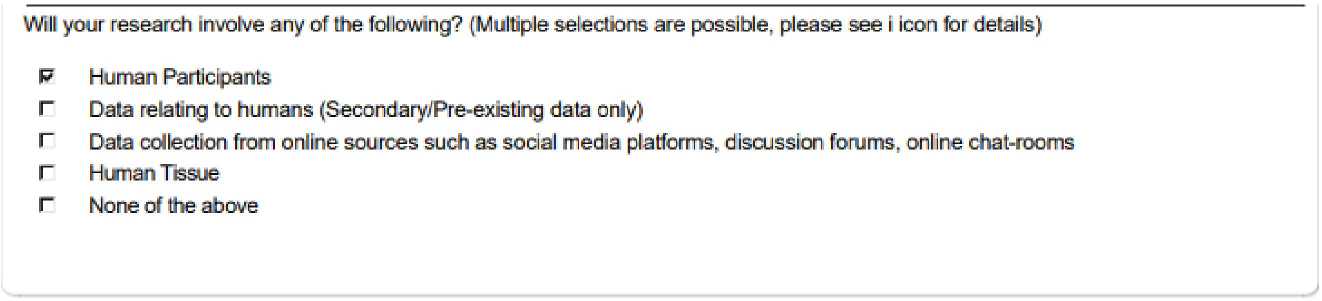
○ Yes ● No

Have you already obtained, or will you be applying for ethical approval, from another institution outside of Lancaster University? (For example, an external institution such as: another University's Research Ethics Committee, the NHS or an institution abroad (eg an IRB in the USA)? Please select one of the following:

● No, I do not need ethical approval from an external institution.
○ Yes, I have already received ethical approval from an external institution.
○ Yes, I will be applying for ethical approval from an external institution after I have received confirmation of ethical approval from my Faculty Research Ethics Committee (FREC) at Lancaster University, if the FREC grants approval.

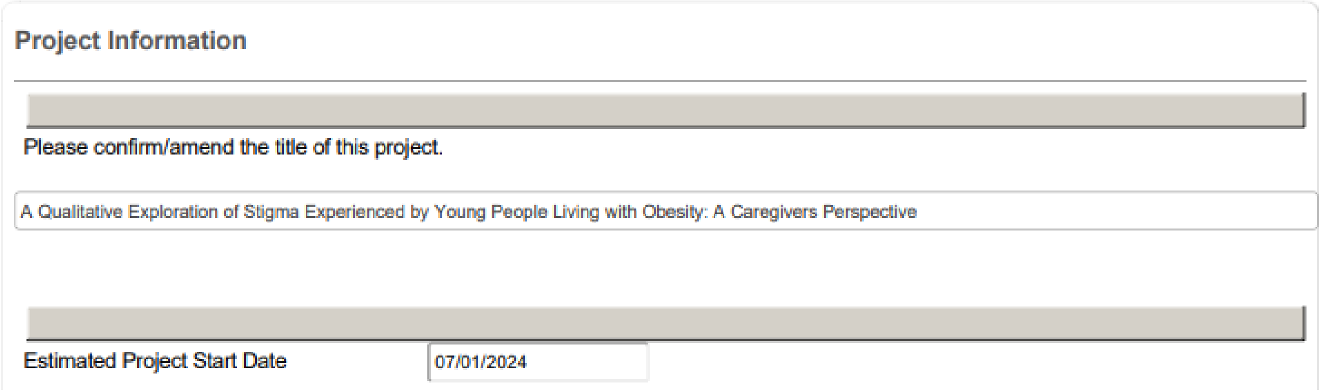
Is this an amendment to a project previously approved by Lancaster University using the previous "paper-based" system (Pre-Jan 2022)?

○ Yes ● No



Will your research involve any of the following? (Multiple selections are possible, please see i icon for details)

☑ Human Participants
☐ Data relating to humans (Secondary/Pre-existing data only)
☐ Data collection from online sources such as social media platforms, discussion forums, online chat-rooms
☐ Human Tissue
☐ None of the above

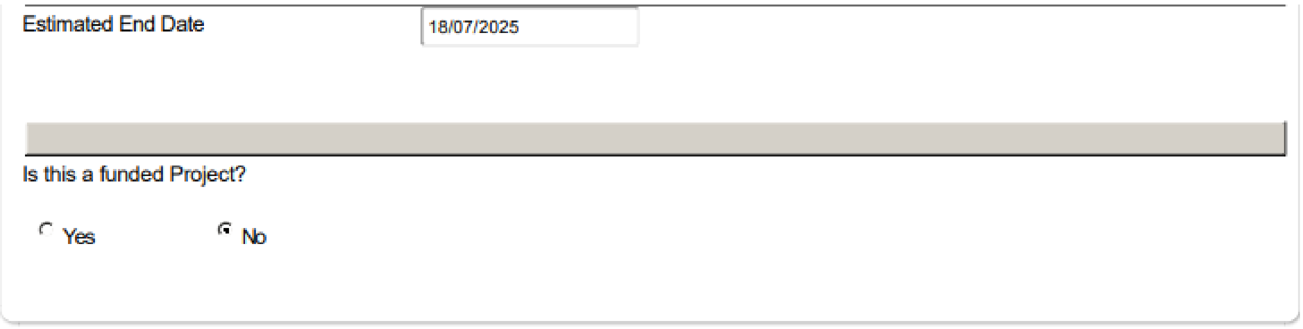


Project Information

Please confirm/amend the title of this project.

A Qualitative Exploration of Stigma Experienced by Young People Living with Obesity: A Caregivers Perspective

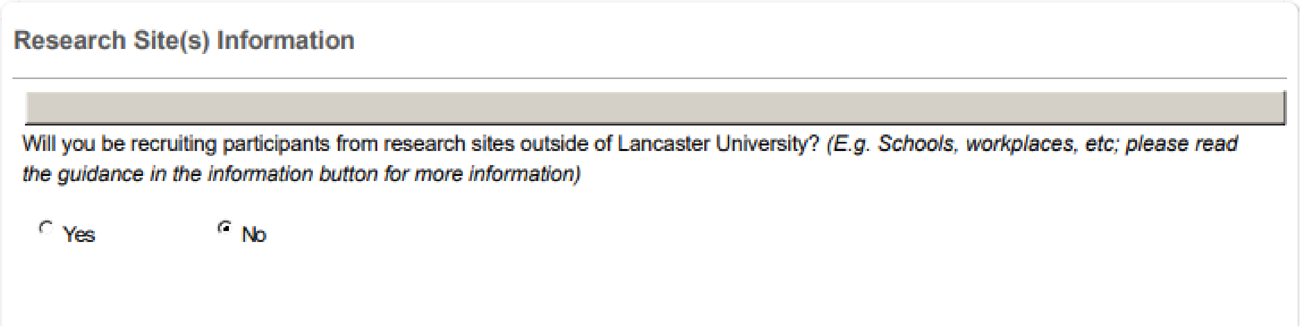
Estimated Project Start Date 07/01/2024



Estimated End Date 18/07/2025

Is this a funded Project?

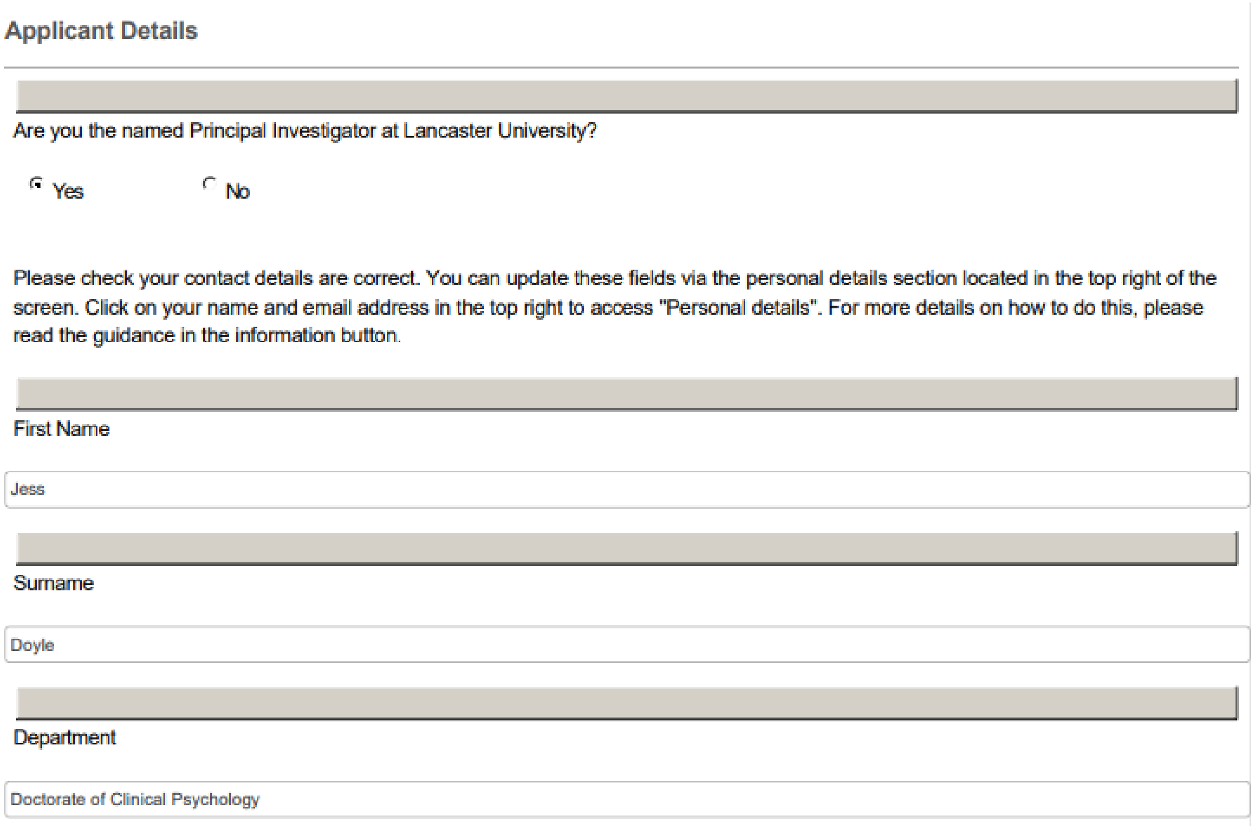
○ Yes ● No



Research Site(s) Information

Will you be recruiting participants from research sites outside of Lancaster University? *(E.g. Schools, workplaces, etc; please read the guidance in the information button for more information)*

○ Yes ● No



Applicant Details

Are you the named Principal Investigator at Lancaster University?

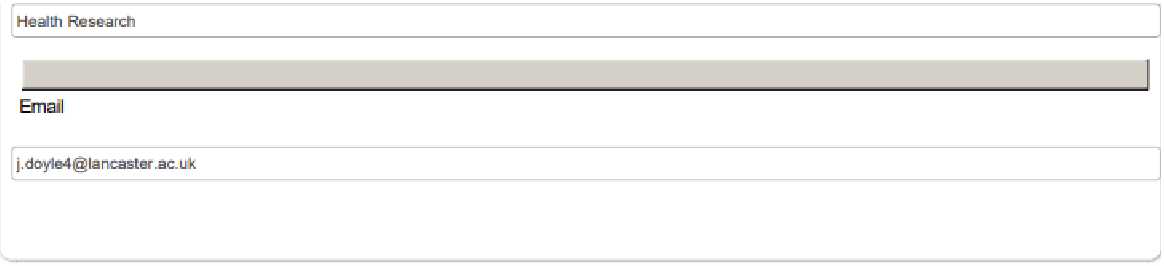
● Yes ○ No

Please check your contact details are correct. You can update these fields via the personal details section located in the top right of the screen. Click on your name and email address in the top right to access "Personal details". For more details on how to do this, please read the guidance in the information button.

First Name: Jess

Surname: Doyle

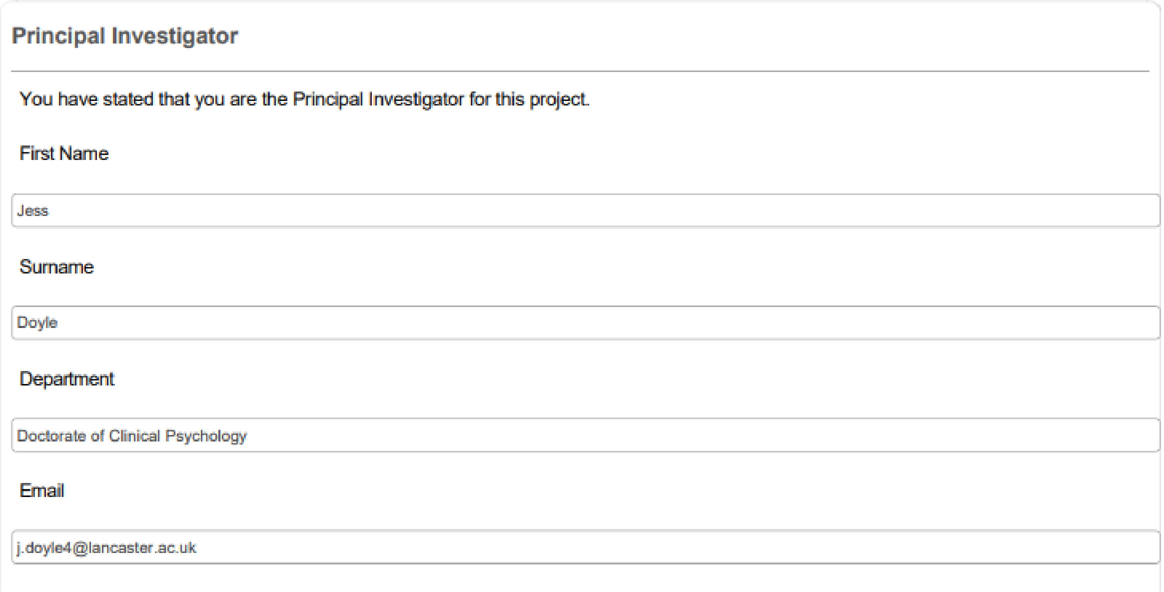
Department: Doctorate of Clinical Psychology



Health Research

Email

j.doyle4@lancaster.ac.uk



Principal Investigator

You have stated that you are the Principal Investigator for this project.

First Name

Jess

Surname

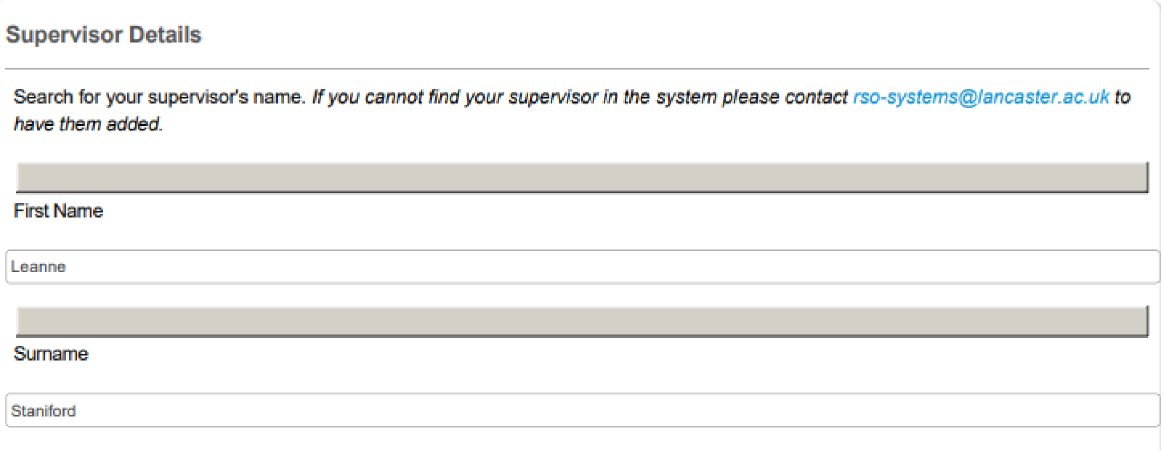
Doyle

Department

Doctorate of Clinical Psychology

Email

j.doyle4@lancaster.ac.uk



Supervisor Details

Search for your supervisor's name. *If you cannot find your supervisor in the system please contact rso-systems@lancaster.ac.uk to have them added.*

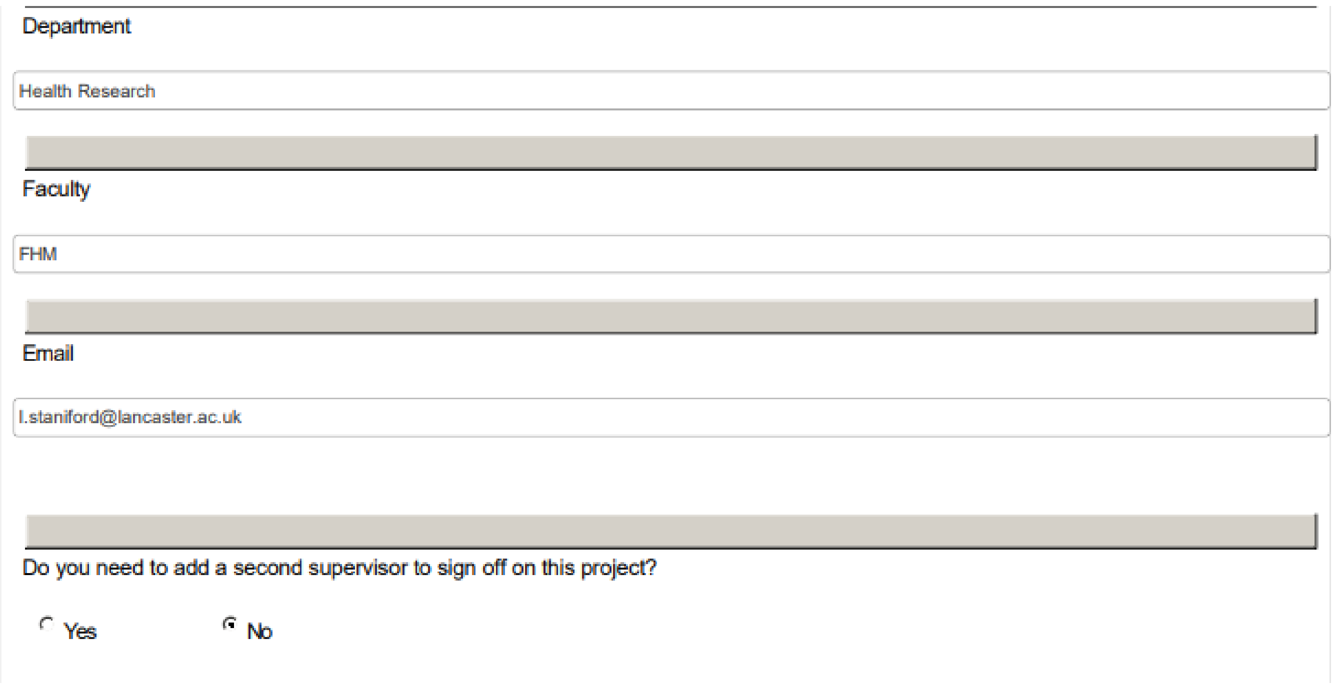
First Name

Leanne

Surname

Staniford

ETHICS SECTION



Department

Health Research

Faculty

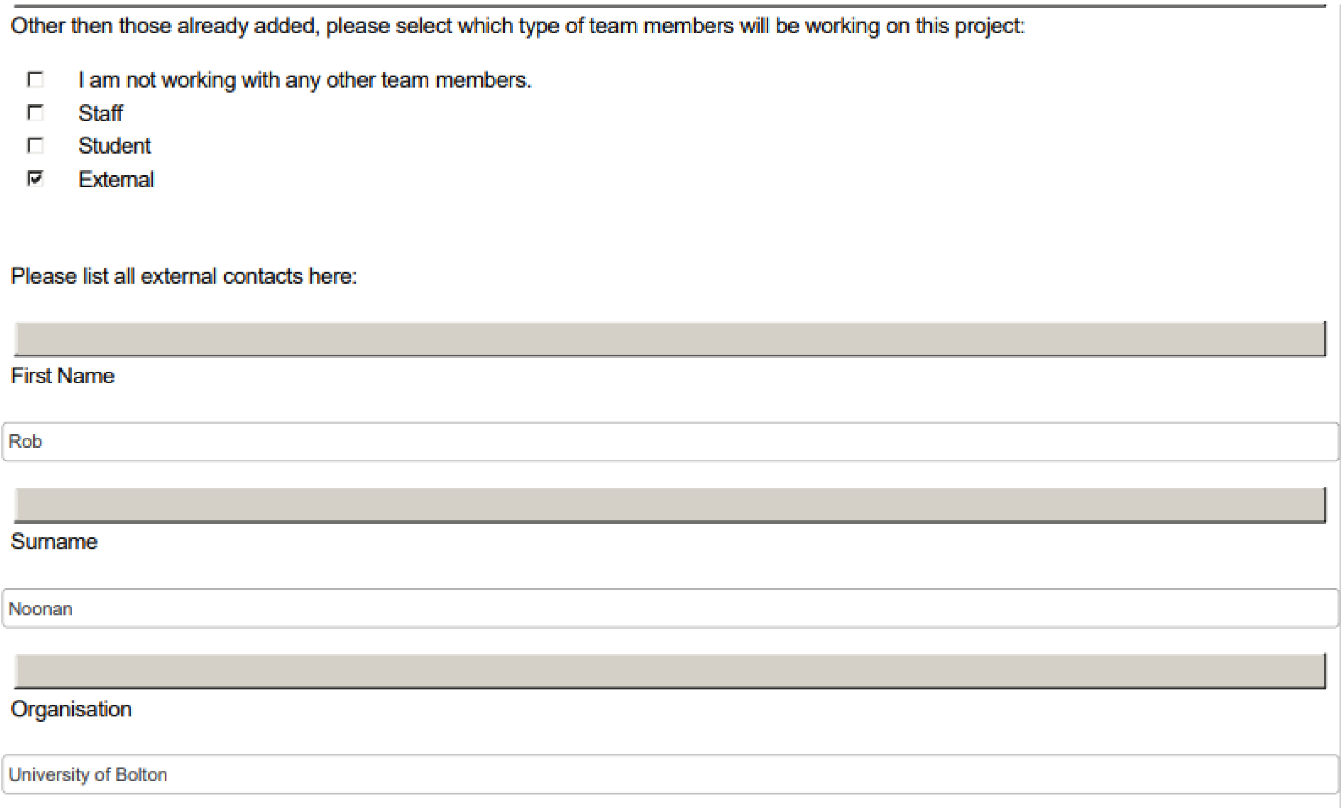
FHM

Email

l.staniford@lancaster.ac.uk

Do you need to add a second supervisor to sign off on this project?

○ Yes ● No



Other then those already added, please select which type of team members will be working on this project:

☐ I am not working with any other team members.
☐ Staff
☐ Student
☑ External

Please list all external contacts here:

First Name

Rob

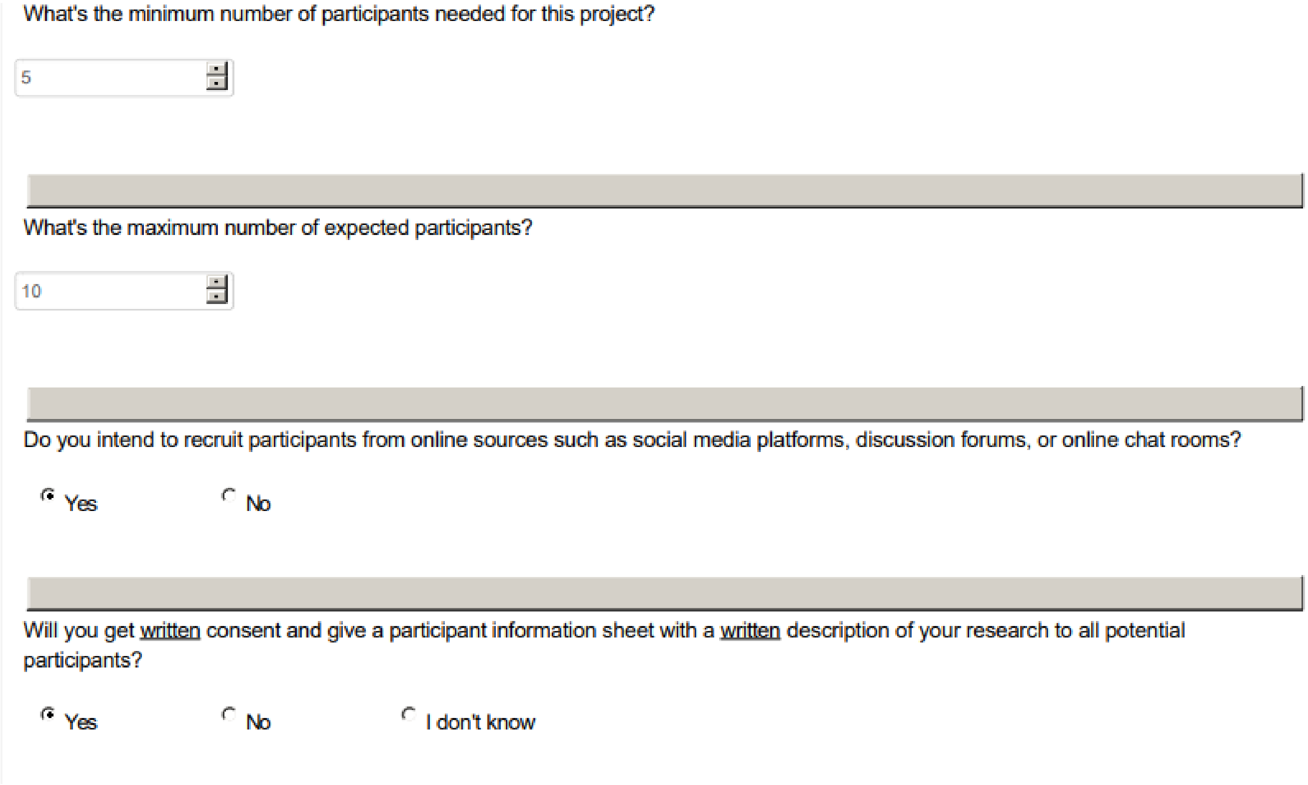
Surname

Noonan

Organisation

University of Bolton

ETHICS SECTION



What's the minimum number of participants needed for this project?

5

What's the maximum number of expected participants?

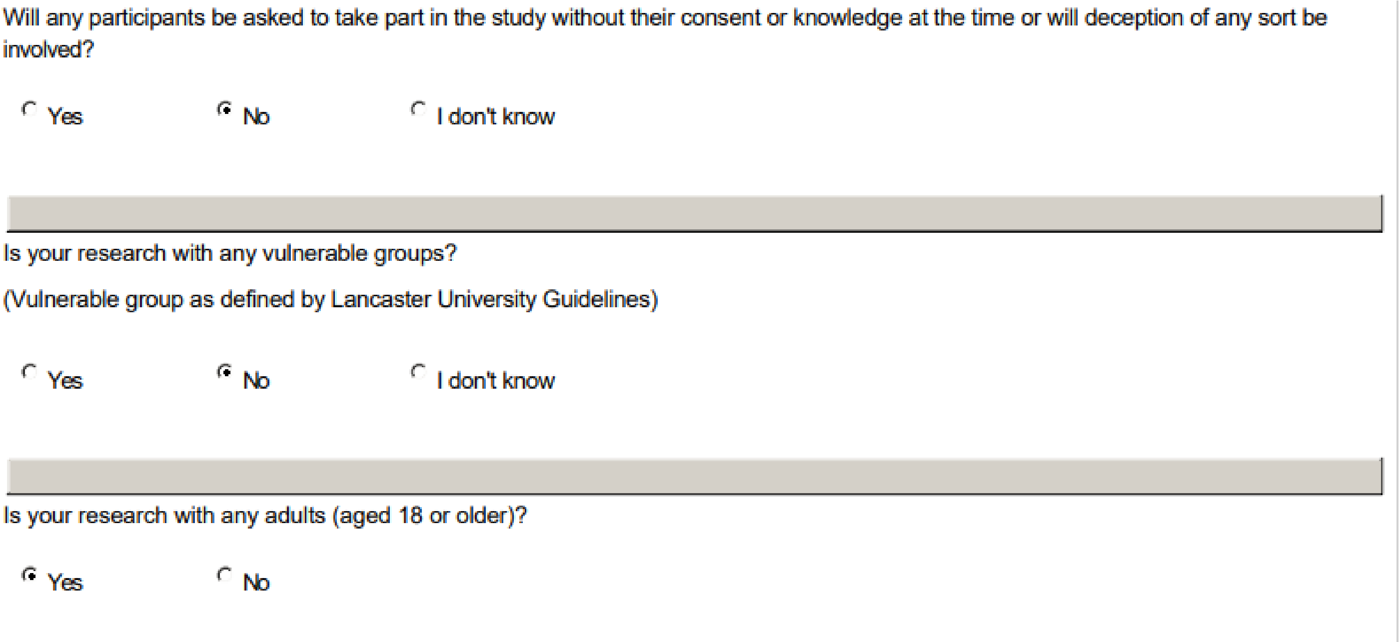
10

Do you intend to recruit participants from online sources such as social media platforms, discussion forums, or online chat rooms?

● Yes ○ No

Will you get written consent and give a participant information sheet with a written description of your research to all potential participants?

● Yes ○ No ○ I don't know



Will any participants be asked to take part in the study without their consent or knowledge at the time or will deception of any sort be involved?

○ Yes ● No ○ I don't know

Is your research with any vulnerable groups?

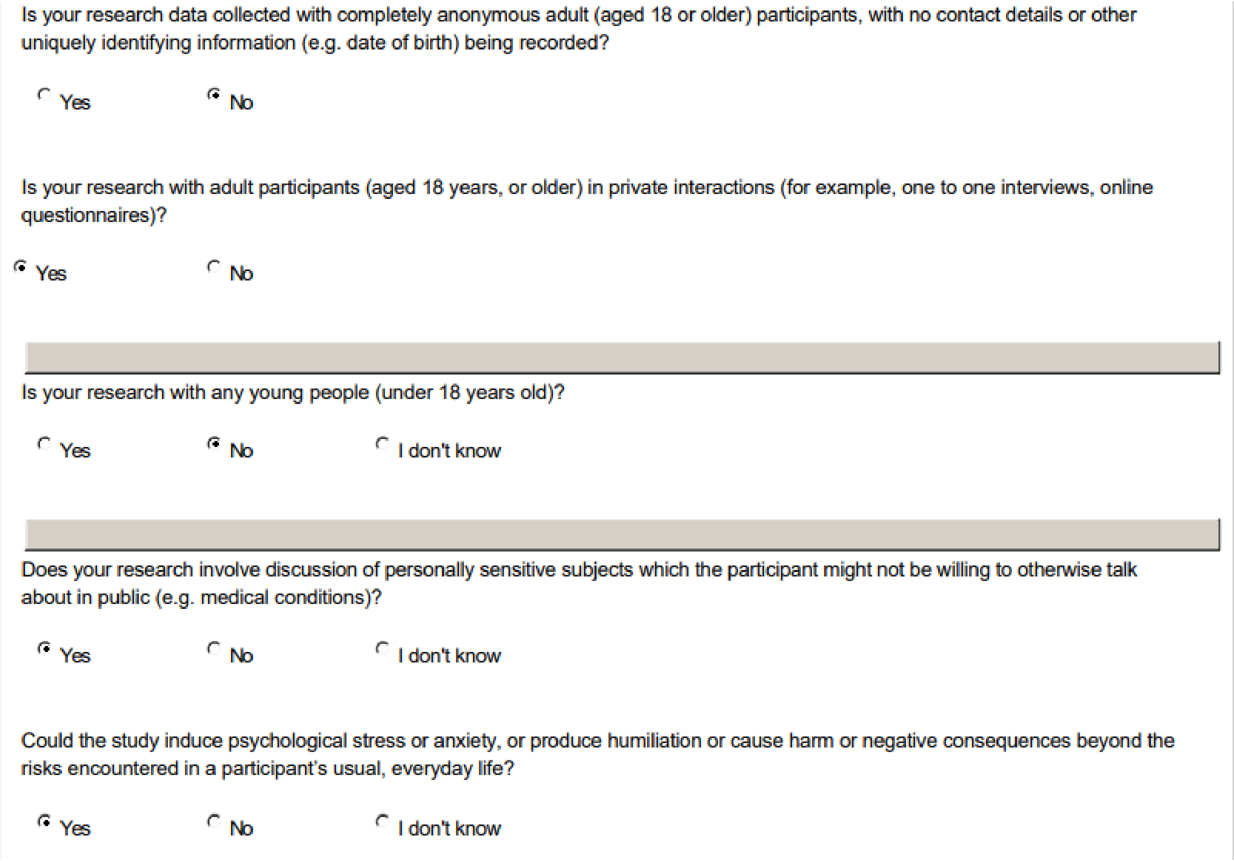
(Vulnerable group as defined by Lancaster University Guidelines)

○ Yes ● No ○ I don't know

Is your research with any adults (aged 18 or older)?

● Yes ○ No

ETHICS SECTION



Is your research data collected with completely anonymous adult (aged 18 or older) participants, with no contact details or other uniquely identifying information (e.g. date of birth) being recorded?

○ Yes ● No

Is your research with adult participants (aged 18 years, or older) in private interactions (for example, one to one interviews, online questionnaires)?

● Yes ○ No

Is your research with any young people (under 18 years old)?

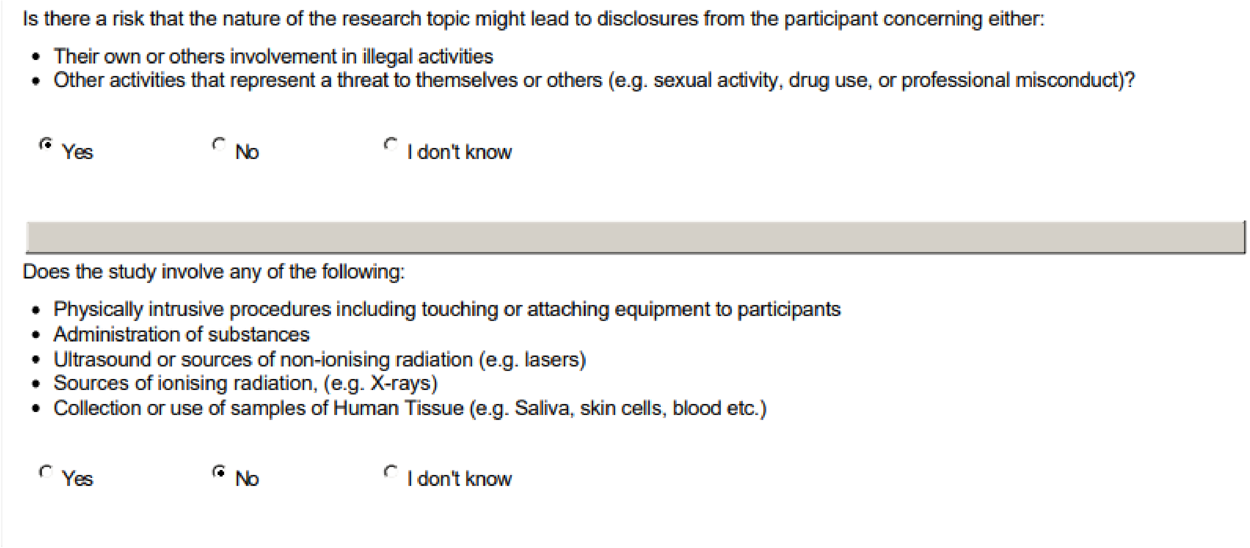
○ Yes ● No ○ I don't know

Does your research involve discussion of personally sensitive subjects which the participant might not be willing to otherwise talk about in public (e.g. medical conditions)?

● Yes ○ No ○ I don't know

Could the study induce psychological stress or anxiety, or produce humiliation or cause harm or negative consequences beyond the risks encountered in a participant's usual, everyday life?

● Yes ○ No ○ I don't know



Is there a risk that the nature of the research topic might lead to disclosures from the participant concerning either:

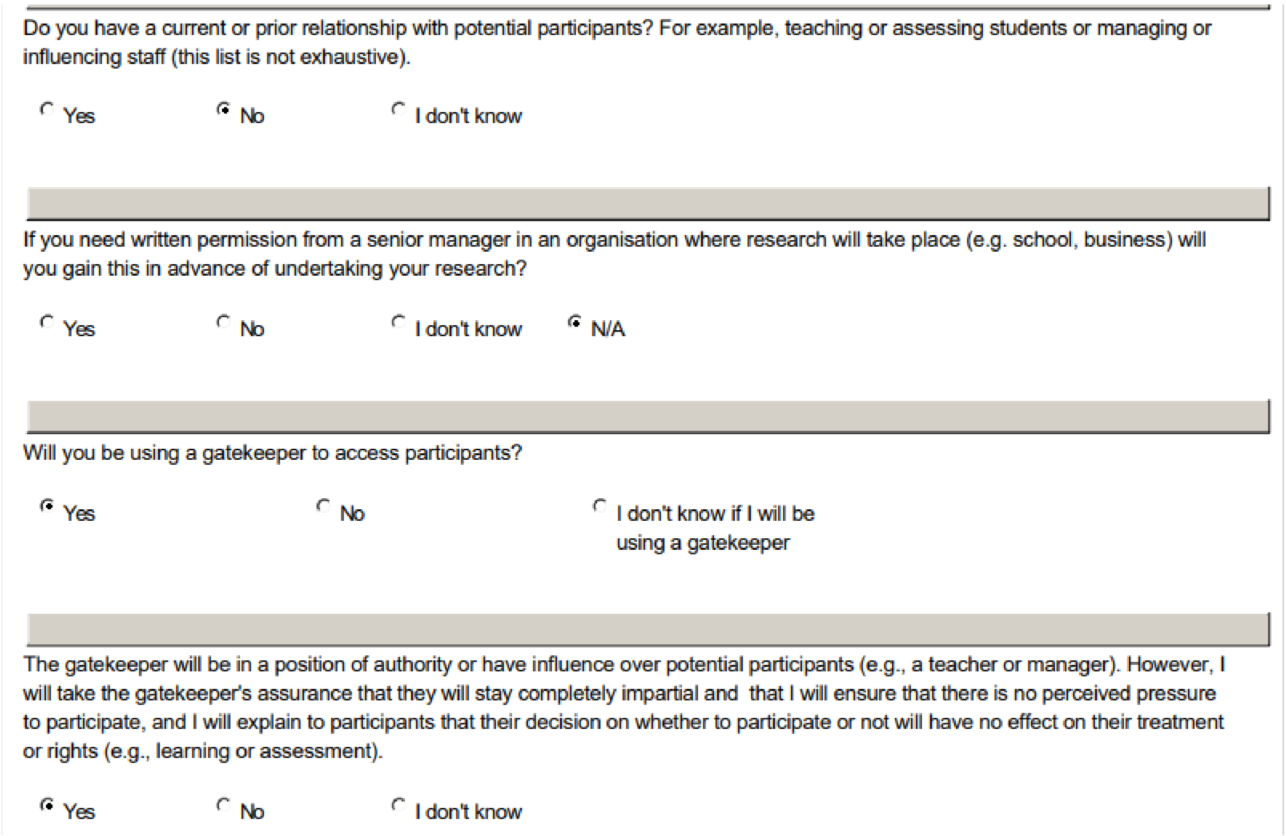
- Their own or others involvement in illegal activities
- Other activities that represent a threat to themselves or others (e.g. sexual activity, drug use, or professional misconduct)?

● Yes ○ No ○ I don't know

Does the study involve any of the following:

- Physically intrusive procedures including touching or attaching equipment to participants
- Administration of substances
- Ultrasound or sources of non-ionising radiation (e.g. lasers)
- Sources of ionising radiation, (e.g. X-rays)
- Collection or use of samples of Human Tissue (e.g. Saliva, skin cells, blood etc.)

○ Yes ● No ○ I don't know



Do you have a current or prior relationship with potential participants? For example, teaching or assessing students or managing or influencing staff (this list is not exhaustive).

○ Yes ● No ○ I don't know

If you need written permission from a senior manager in an organisation where research will take place (e.g. school, business) will you gain this in advance of undertaking your research?

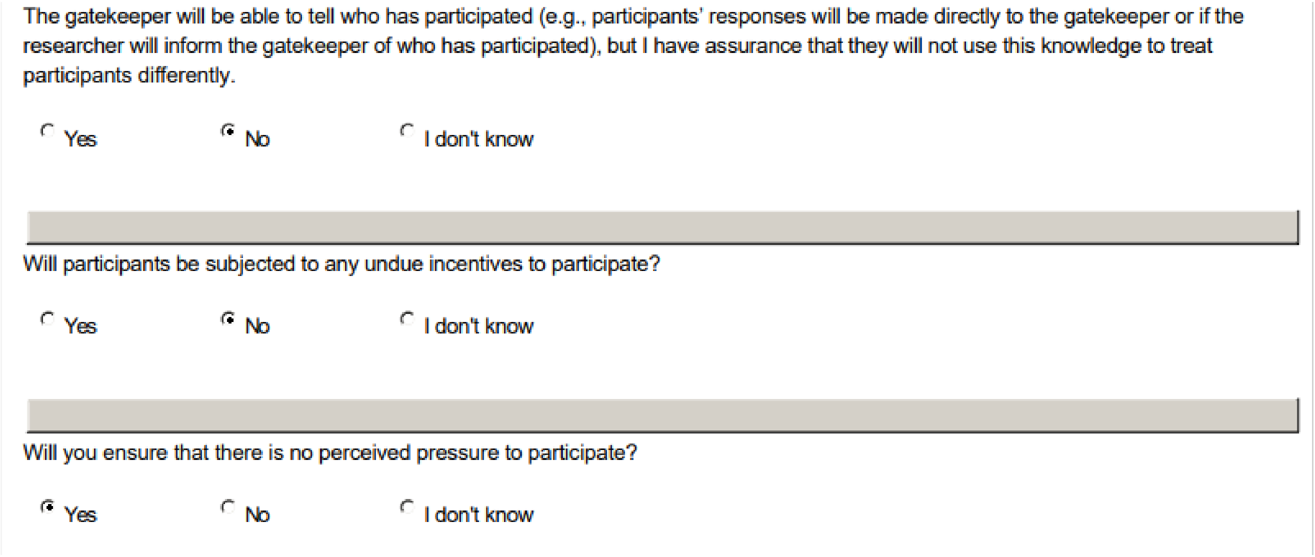
○ Yes ○ No ○ I don't know ● N/A

Will you be using a gatekeeper to access participants?

● Yes ○ No ○ I don't know if I will be using a gatekeeper

The gatekeeper will be in a position of authority or have influence over potential participants (e.g., a teacher or manager). However, I will take the gatekeeper's assurance that they will stay completely impartial and that I will ensure that there is no perceived pressure to participate, and I will explain to participants that their decision on whether to participate or not will have no effect on their treatment or rights (e.g., learning or assessment).

● Yes ○ No ○ I don't know



The gatekeeper will be able to tell who has participated (e.g., participants' responses will be made directly to the gatekeeper or if the researcher will inform the gatekeeper of who has participated), but I have assurance that they will not use this knowledge to treat participants differently.

○ Yes ● No ○ I don't know

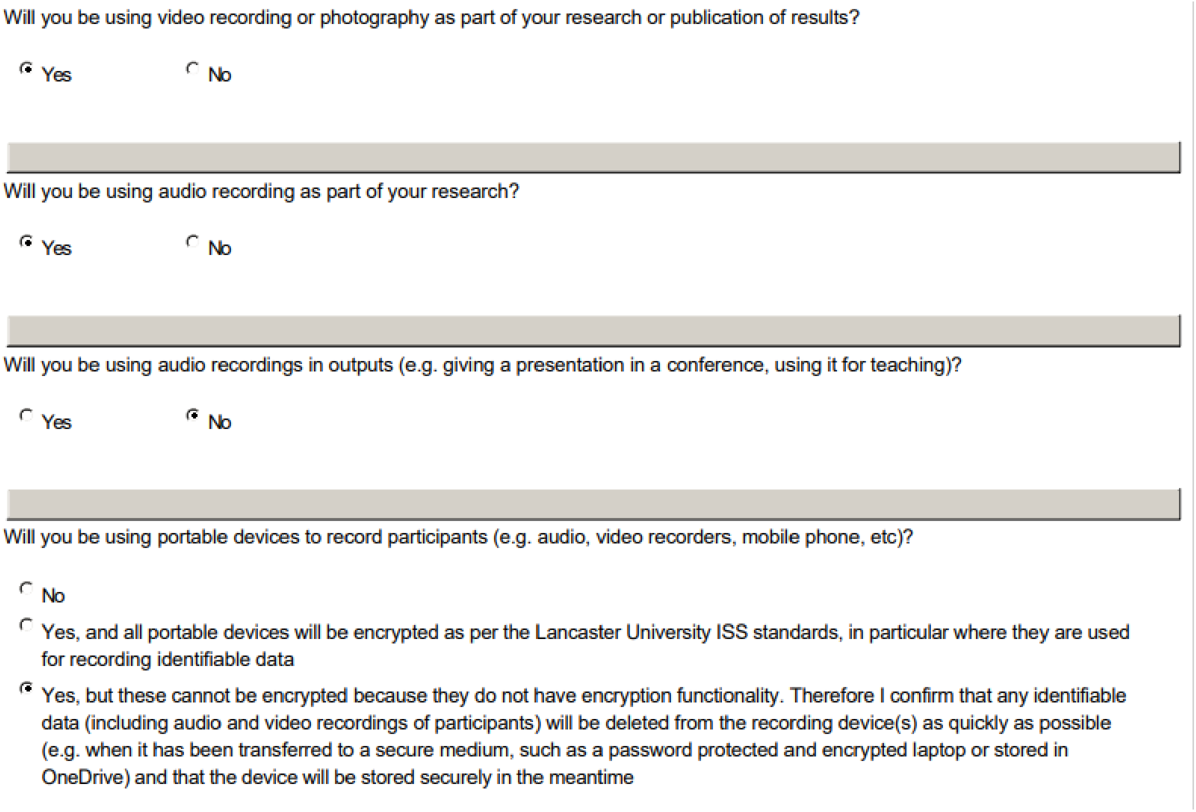
Will participants be subjected to any undue incentives to participate?

○ Yes ● No ○ I don't know

Will you ensure that there is no perceived pressure to participate?

● Yes ○ No ○ I don't know

ETHICS SECTION



Will you be using video recording or photography as part of your research or publication of results?

● Yes ○ No

Will you be using audio recording as part of your research?

● Yes ○ No

Will you be using audio recordings in outputs (e.g. giving a presentation in a conference, using it for teaching)?

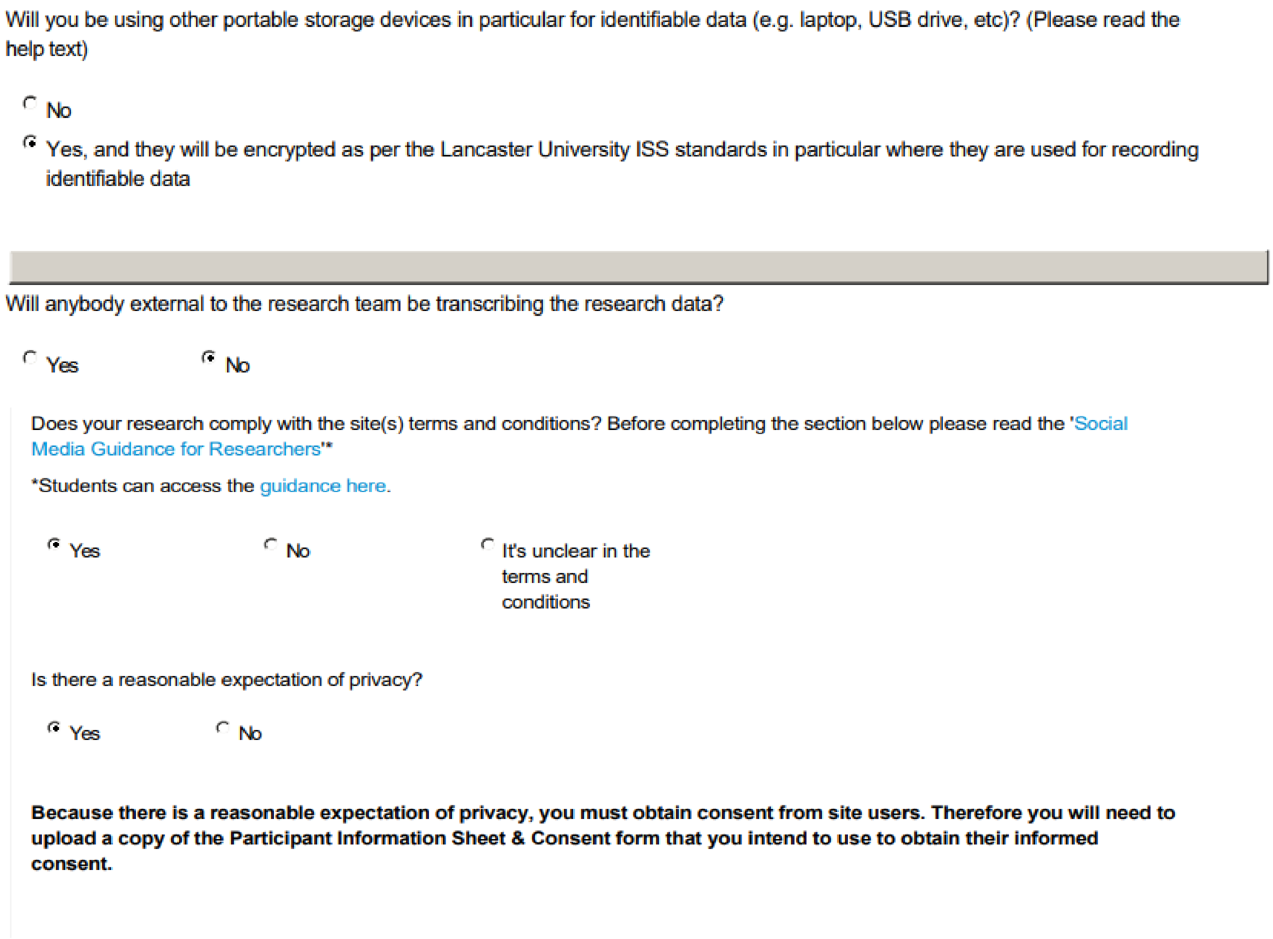
○ Yes ● No

Will you be using portable devices to record participants (e.g. audio, video recorders, mobile phone, etc)?

○ No

○ Yes, and all portable devices will be encrypted as per the Lancaster University ISS standards, in particular where they are used for recording identifiable data

● Yes, but these cannot be encrypted because they do not have encryption functionality. Therefore I confirm that any identifiable data (including audio and video recordings of participants) will be deleted from the recording device(s) as quickly as possible (e.g. when it has been transferred to a secure medium, such as a password protected and encrypted laptop or stored in OneDrive) and that the device will be stored securely in the meantime



Will you be using other portable storage devices in particular for identifiable data (e.g. laptop, USB drive, etc)? (Please read the help text)

○ No

● Yes, and they will be encrypted as per the Lancaster University ISS standards in particular where they are used for recording identifiable data

Will anybody external to the research team be transcribing the research data?

○ Yes ● No

Does your research comply with the site(s) terms and conditions? Before completing the section below please read the 'Social Media Guidance for Researchers'*

*Students can access the guidance here.

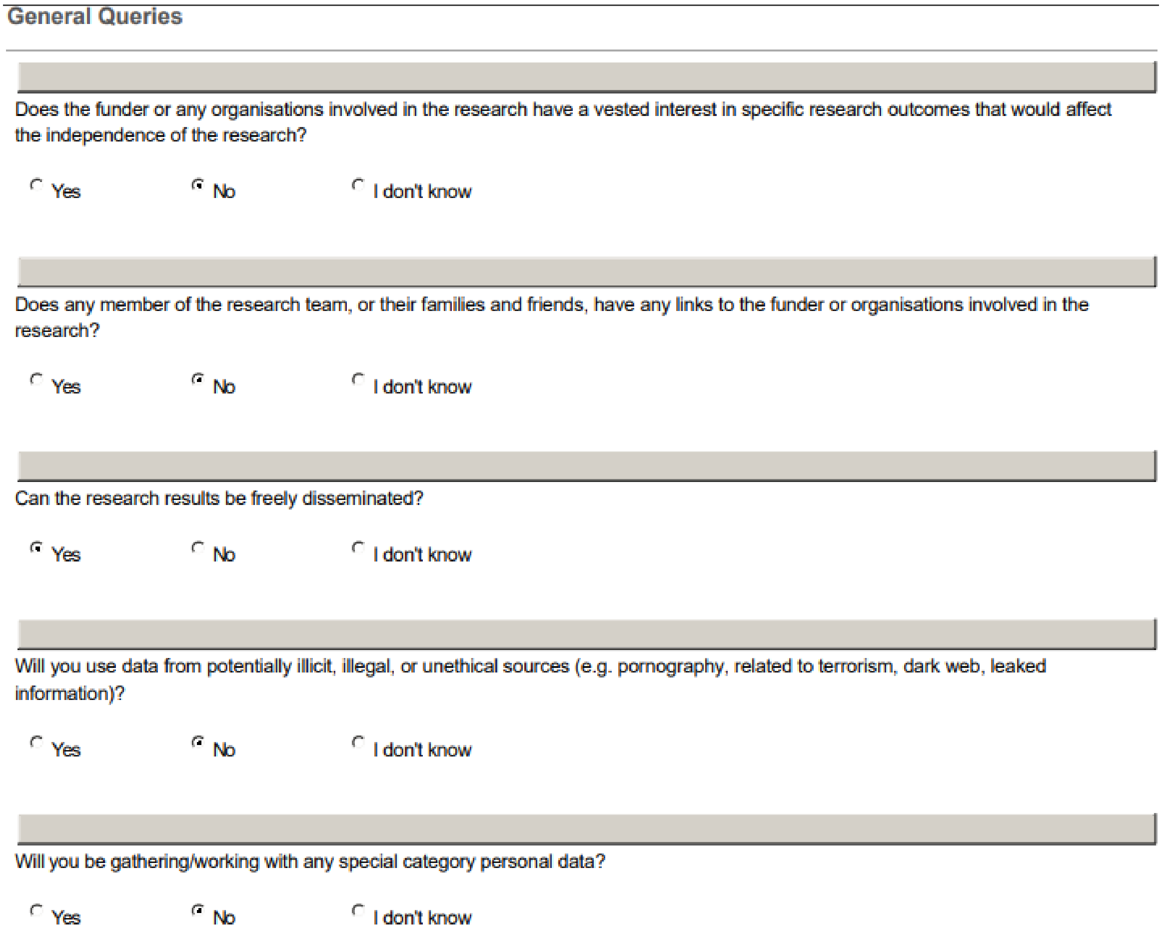
● Yes ○ No ○ It's unclear in the terms and conditions

Is there a reasonable expectation of privacy?

● Yes ○ No

Because there is a reasonable expectation of privacy, you must obtain consent from site users. Therefore you will need to upload a copy of the Participant Information Sheet & Consent form that you intend to use to obtain their informed consent.

ETHICS SECTION



General Queries

Does the funder or any organisations involved in the research have a vested interest in specific research outcomes that would affect the independence of the research?

○ Yes ● No ○ I don't know

Does any member of the research team, or their families and friends, have any links to the funder or organisations involved in the research?

○ Yes ● No ○ I don't know

Can the research results be freely disseminated?

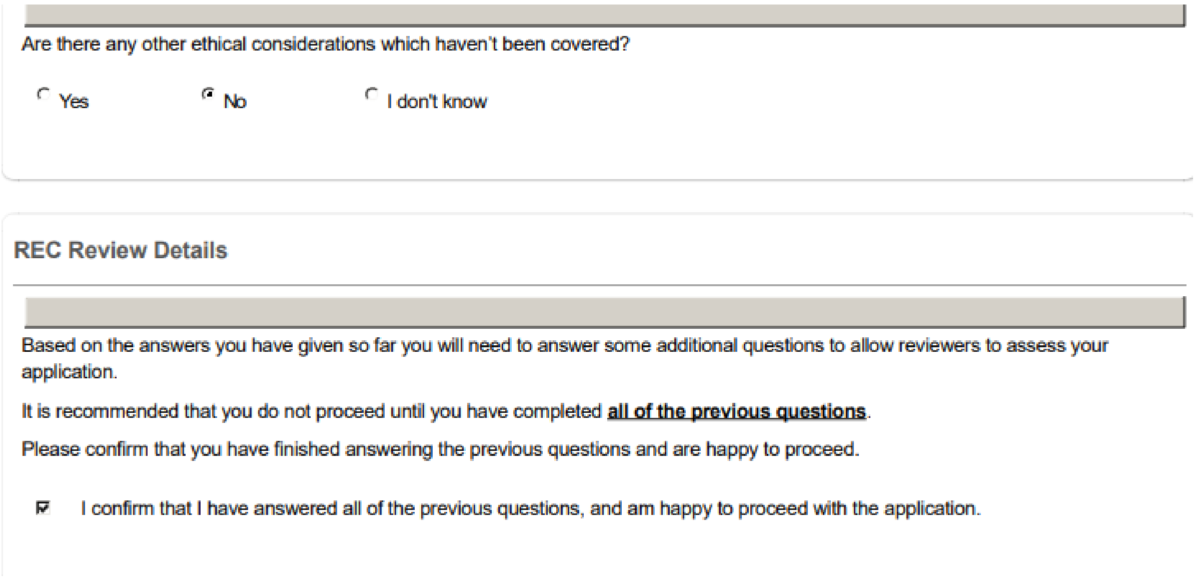
● Yes ○ No ○ I don't know

Will you use data from potentially illicit, illegal, or unethical sources (e.g. pornography, related to terrorism, dark web, leaked information)?

○ Yes ● No ○ I don't know

Will you be gathering/working with any special category personal data?

○ Yes ● No ○ I don't know



Are there any other ethical considerations which haven't been covered?

○ Yes ● No ○ I don't know

REC Review Details

Based on the answers you have given so far you will need to answer some additional questions to allow reviewers to assess your application.

It is recommended that you do not proceed until you have completed **all of the previous questions**.

Please confirm that you have finished answering the previous questions and are happy to proceed.

☑ I confirm that I have answered all of the previous questions, and am happy to proceed with the application.

Questions for REC Review

Summarise your research protocol in lay terms (indicative maximum length 150 words):

Research suggests that young people living with obesity and their families may experience stigma. These experiences of stigma may lead to worse mental health for the young person and influence behaviours that contribute towards the young person's obesity. It is important to explore the experience of stigma from a caregiver's perspective, ie. a person who provides primary support to the young person, as interventions which support weight management encourage the inclusion of caregivers, due to their influential position. Therefore, caregiver experiences may provide valuable insights on how best to support young people living with obesity. Approximately 5-10 caregivers will be recruited through social media. Caregivers will be able to participate if the young person they support is aged 5-16, has experienced stigma and is currently living with obesity. Participants will be asked to provide photographs representing their experiences of stigma, and will be interviewed about these photographs and experiences.

State the Aims and Objectives of the project in Lay persons' language

Due to the aims focussing on the experiences of stigma, the inclusion criteria specifies that the young person living with obesity has experienced stigma; therefore the aims and objectives are as follows:

Aims:

- To explore the experiences of stigma of young people living with obesity, from their caregiver's perspective
- To explore the potential experiences of stigma in caregivers of young people living with obesity
- To explore the potential consequences of experiencing stigma for young people living with obesity and/or their families
- To explore whether and/or how experiencing stigma impacts weight management of the young person living with obesity

Objectives:

- To contribute to our understanding of stigma in young people living with obesity
- To make recommendations on how best to support young people living with obesity and their families

Participant Information

Please explain the number of participants you intend to include in your study and explain your rationale in detail (e.g. who will be recruited, how, where from; and expected availability of participants).

Given that NICE guidance suggests a family-based approach is key to support Young People Living with Obesity (YPLwO) in managing their weight, the views of caregivers of YPLwO can offer valuable insights beyond that of the YPLwO alone. Caregivers can provide their views and experiences of direct and indirect forms of stigma that young people may not yet understand and experiencesof the impact towards the whole family. Furthermore, caregivers are central in supporting young people to engage in health-promoting behaviours, so their voices are valuable in the exploration of stigma experience. Given that a young persons' eating habits can be highly influenced by social contexts, it is important to go beyond the perspectives of parents alone as often many children may have multiple people involved in their day-to-day support and care. This may be even more prevalent currently due to many more families facing adversity (for example, the cost of living crisis), therefore, there may be more reliance on support networks for childcare in working parents. Therefore, participants will be individuals classed as a "caregiver" of YPLwO which may involve parents, grandparents, siblings, family friends etc. who take a primary role in supporting the young person's care. Therefore, this study seeks to extend findings from just parents to caregivers more generally.

Participants will be purposively recruited to allow the sample to include caregivers of YPLwO in line with the research question, aims and objectives. The target number will be between five to ten participants in order to obtain rich data (Smith & Osborn, 2015). Given that the sample of participants should be generally homogenous in terms of the experience, inclusion and exclusion criteria are outlined below:

Inclusion criteria

Primary caregivers (aged 18+) of young people who:

- Are aged 5-16 following Gorlick et al's (2021) rationale, whereby caregivers may be deemed more "responsible" for the weight of the young person during these ages, thus may be more vulnerable to stigma
- Are currently considered obese through caregiver self-report
- Have experienced stigma in relation to their weight

Exclusion criteria

- Participants who do not speak English
- Participants who do not live in the United Kingdom
- Participants who are currently under psychological home treatment services and present in acute psychological distress

How will they be recruited?

Participants will be recruited through visual advertisements given to relevant organisations and support groups to share on social media such as Association for the Study of Obesity (ASO), Obesity.org and Obesity UK. Furthermore, these advertisements will also be shared on Facebook, Twitter and LinkedIn, encouraging snowball sampling through relevant organisations. These organisations may include research networks such as (LORN and YORA) and charities/ local authority initiatives (e.g. FoodActive). It is hoped that relevant contacts will share the invite on to potential participants.

Specific communities will be targeted on Facebook through advertising in groups such as parenting groups (e.g. Health and Weight Loss Support for Kids), obesity groups (e.g. Overcoming Obesity, location based Obesity UK support groups) or local weight management groups such as 'Slimming World' or young people specific weight-loss/ healthy lifestyle communities (e.g. Active Lifestyles Sefton, Feeding Liverpool). Before joining/ posting in these groups, the researcher will seek out permission from the administrator of the group if not already outlined in the group rules.

Expected availability

Given my supervisor's previous experiences in this field, it is anticipated that it should be feasible to recruit the targeted number of participants. However, should utilising social media not be sufficient in attaining the targeted number of participants, other recruitment methods may involve linking in with the research supervisor's contacts in a preventative weight management clinic in Sheffield. If this method is utilised, we may use the clinic to advertise our study to recruit participants.

You have selected that the research may involve personal sensitive topics that participants may not be willing to otherwise talk about. Please indicate what discomfort, inconvenience or harm could be caused to the participant and what steps you will take to mitigate or manage these situations.

Content of topic

Asking participants about their experiences of stigma may initiate feelings associated such as shame and/or guilt, which could put the participant in psychological distress. To manage this, I plan to use my therapeutic skills within the interview to create an environment which promotes safety and a non-judgemental approach. The hope is that the use of Photovoice will enable the participant to share their initial reflections, so they feel more in control, which can help build rapport at the beginning of the interview. It will be made clear from the outset that the participant can refuse to answer a question, stop the interview, or withdraw from the research at any point if they feel uncomfortable or no longer wish to take part. Additionally, the participant will also be offered a comfort break in the interview. I will ensure to offer information to all participants regarding where they could seek support should the content bring up any distress that they later want to seek support for. Furthermore, I have developed a distress protocol and will receive regular supervision throughout the interview process. A debrief sheet has been developed signposting participants to general mental health support services and also more obesity-specific services/ family support services, and services to discuss any professional concerns, should this topic content have brought any distress up.

Language considerations

Language used within the interview may act as a source of stigma and therefore may cause discomfort or psychological distress. There is a lot of discussion in the literature and in non-academic sources about how we may refer to those of a higher BMI. Although the literature suggests that “living with obesity” is the most up to date term, there are fat acceptance movements whereby people prefer to be described using the term “fat” rather than medicalising the experience. To manage this, I have sought to consult with stakeholders/service-users to gain their insight alongside further research on the use of descriptive terms. Given that it is often a personal preference, there will there will be some brief demographic questions asked in the beginning of the interview, and within that it will ask the participant how they describe the young person they support’s weight status. Therefore, the researcher will check in with language at the beginning of the interview and ask their preference of how they would like me to refer to the young person they support. I will also discuss language in supervision and reflect on this throughout the interview process.

Confidentiality

There may be times whereby confidentiality may have to be breached if the participant discloses any significant malpractice or experiences whereby there is any risk to them or anyone else involved. This may cause psychological distress if participants did not understand the process before partaking in the interview. To manage this, I will ensure the participant is aware of the limits of confidentiality on the information sheet and verbally before we start the interview.

You have indicated that you will collect identifying information from the participants. Please describe all the personal information that you gather for your study which might be used to identify your participants.

Contact details

In order to participate, individuals are required to email the researcher to express their interest in the study. Therefore, the researcher will ascertain the participant’s contact details which will involve their name and email address and potentially their phone number, should they choose to be contact via this method initially. The participants are asked to return the consent form which will have their name on it. Within the interview, participants will be asked demographic questions such as their postcode, ethnicity, weight, height etc.

Photographs

Photovoice is a visual participatory research methodology that encourages participants to visually document, reflect upon, and communicate issues of concern (Wang & Burris, 1997). Therefore, it is an appropriate methodology to explore obesity stigma experiences and the meaning caregivers ascribe to it. Photovoice methodology will add depth to the qualitative interview data through exploring caregiver's perceptions and lived experiences of stigma, in relation to the young person they support. It is envisaged that the contextual information gathered from this qualitative study will provide novel insights into the meanings caregivers ascribe towards obesity stigma. The use of Photovoice allows the participants with more control over their expression, allowing time for them to reflect upon and articulate what is important to them. Furthermore, Photovoice may serve as a tool to build rapport before asking questions of a sensitive nature due to it emphasising more active and collaborative engagement between participant and researcher. Furthermore, prompts based on the commonly used SHOWeD technique (Wang, 1999) will be used to encourage participants to articulate their own meaning embedded within the photograph to give a richer insight towards their experiences. The visual data provided by Photovoice can be used to triangulate narrative data to enhance the credibility of photovoice research (Plunkett et al., 2013).

Participants are asked to submit photographs that they have taken prior to the interview.

Participants will be asked to take two photographs which represent:
1. What weight stigma means to you
2. The impact of weight stigma

Participants are not instructed to take photos of obesity and/or body parts; they are asked to represent the experience of weight stigma and the impact of stigma. Participants will not receive examples of potential photographs that they can take, in order to reduce the researcher’s influence over the participants’ choice of photographs. However, the ethical implications of individuals appearing in photographs will be discussed with participants. Participants will be instructed to not include the faces of any other individuals in photographs, although can include themselves if they wish to. After taking photographs participants will send the two photographs to the researcher via email. Any photographs that the participant does take of themselves that captures their face will be anonymised in any future publications. This is explicitly stated in the participant information sheet and consent form. Furthermore, the information sheet and consent form also outline that engagement in the photo-initiation task is not a condition of participation in the study and is useful in helping "to form a bigger picture". Therefore, participants can opt-out of this task if they choose to do so and can participate in just the interview. This is to support recruitment for those who may not be able to access photography for multiple reasons and ensure that the participants feel comfortable. Social media accounts Given that the adverts will be posted on social media, participants may try to contact via the social media platform and therefore their usernames may be visible to the researcher if they choose to direct message or ask questions via commenting.

Please describe how the data will be collected and stored

Contact details

The contact details and consent forms will initially be collected via email and will then be transferred and stored on encrypted files on a password protected laptop. The emails with these documents on will then be deleted. Only the student researcher will have access to the contact details. The data custodian and student researcher will have access to the consent forms as they will be stored for up to ten years, separate to the interview data. Contact details will also be separate to the study data and will only be retained if participants request to be informed about the results at the end of the study, which is addressed on the consent form. Demographic details will be stored on the secure drive which will also be separate to the transcript. The postcode will be deleted on the day once it is converted to a region and deprivation score, therefore will not be stored. Anonymity of the participants will be ensured by giving participants a unique identifier number which will be used in the storing of demographic data, consent forms, contact details, photographs and transcript data. There will be a separate document saved securely, with only the student researcher having access to this which will link the unique identifier number with the name of the participant.

Photographs

It is explained above the importance of the Photovoice methodology in gaining more in-depth data, in addition to building a rapport encouraging the participant to be in control before the interview. The photographs used in the study will be shared from the participant to the researcher via email. With regards to the transfer of photos via email from participant to researcher, the researcher will explain to all participants the opportunity to encrypt their data and the advantages of data encryption. For example, by encrypting each photo or by password protecting a Word document comprising their photos. However, it will also be explained to the participants that this is not a mandatory condition placed upon them with regards to participating in the project. The decision to encrypt shared data will be at the discretion of the participants. This is also addressed on the consent form. Once the researcher has transferred the photograph onto Lancaster University's secure drive on their password protected laptop, they will then delete the email sent by the participant.

Photographs will be stored alongside the anonymised transcription data for each participant to aid analysis, but separate to other documents using the unique identifier. Furthermore, if there are any identifiable features of the photograph, this will be anonymised by the researcher.

Social media accounts
The researcher will create research-specific social media accounts to maintain their privacy. The researcher will seek to contact potential participants via their university secure email as soon as possible and delete the messages from their social media account. The researcher will not record any social media contact details.

Please describe how long the data will be stored and who is responsible for the deletion of the data

Responsibility of student researcher- JD

If a potential participant expresses interest via email and does not return the consent form after a week, and they have not contacted the researcher to negotiate a timeframe, it will be assumed that the participant no longer wishes to participate in the study and their contact details will be deleted, in addition to their email correspondence. Contact details will be deleted after the participant has taken part in the interview, unless they wish to be informed of the results, this is asked in the consent form. Once results have been published and the findings have been disseminated to the participants, then the student researcher will delete the contact details of all participants. Demographic details will be stored separate to the transcripts utilising the unique identifier numbers to refer to if needed. The demographic information will be amalgamated into a table for all participants. The postcode will be converted to a location and deprivation score on the day of the interview, by the student researcher, therefore the postcode will not be stored.

Responsibility of supervisor- LS
The photographs will remain on the encrypted and secure drive until after the analysis. They will then be anonymised after the analysis (if there are any identifiable faces on them) and stored on the encrypted file on a password protected account. The anonymised photos will be stored with the transcript and identifiable using the participant's unique identifier number. The photos may be shared, if the findings are published, however, the participant is made aware of this on the information sheet and consent form. The anonymised photos will be stored for up to ten years alongside the transcript and consent forms, and my supervisor Dr Leanne Staniford will act as data custodian, deleting them after the timeframe.

You stated that the study could induce psychological stress or anxiety, or produce humiliation or cause harm or negative consequences beyond the risks encountered in a participant's usual, everyday life. Please describe the question(s) and situation(s) that could lead to these outcomes and explain how you will mitigate this.

Stigma content

Asking participants about their experiences of stigma may initiate feelings associated such as shame and/or guilt, which could put the participant in psychological distress. To manage this, I plan to use my therapeutic skills within the interview to create an environment which promotes safety and a non-judgemental approach. The interview schedule is arranged in a way to build rapport from the beginning through asking less emotive questions initially e.g. what things the participant likes to do with the young person they support and then the use of the Photovoice task early on. The Photovoice task will enable the participant to share their initial reflections, so they feel more in control, which can help build rapport at the beginning of the interview. It will be made clear from the outset that the participant can refuse to answer a question, stop the interview, or withdraw from the research at any point if they feel uncomfortable or no longer wish to take part. Additionally, the participant will also be offered a comfort break in the interview. Participants will be offered additional information regarding where they could seek support should the content bring up any distress that they later want to seek support for. Furthermore, I have developed a distress protocol and will receive regular supervision throughout the interview process. A debrief sheet has been developed signposting participants to general mental health support services and also more obesity-specific services/ family support services, and services to discuss any professional concerns, should this topic content have brought any distress up.

Language considerations

Language used within the interview may act as a source of stigma and therefore may cause discomfort or psychological distress. There is a lot of discussion in the literature and in non-academic sources about how we may refer to those of a higher BMI. Although the literature suggests that “living with obesity” is the most up to date term, there are fat acceptance movements whereby people prefer to be described using the term “fat” rather than medicalising the experience. To manage this, I have sought to consult with stakeholders/service-users to gain their insight alongside further research on the use of descriptive terms. Given that it is often a personal preference, there will be some brief demographic questions asked in the beginning of the interview, and within that it will ask the participant how they describe the young person they support’s weight status. Therefore, the researcher will check in with language at the beginning of the interview and ask their preference of how they would like me to refer to the young person they support. I will also discuss language in supervision and reflect on this throughout the interview process.

Confidentiality

There may be times whereby confidentiality may have to be breached if the participant discloses any significant malpractice or experiences whereby there is any risk to them or anyone else involved. This may cause psychological distress if participants did not understand the process before partaking in the interview. To manage this, I will ensure the participant is aware of the limits of confidentiality on the information sheet and verbally before we start the interview.

You have selected that you do not know if there is a risk that the nature of the research might lead to disclosures from the participant. What kind of information might participants disclose? How will you manage that situation?

Risk to self

If the content discussed causes acute psychological distress, then participants may disclose risk to themselves. The researcher will briefly check-in with the participant before starting the interview, asking whether they had any questions or concerns prior to starting the interview. The researcher may know if a participant is in psychological distress if their behaviours are suggestive of this e.g. shaking, crying or a general emotional response that is beyond what is expected, given the topic; the researcher will use their clinical skills to ascertain if they may need to pause the interview to check whether the participant can continue. If this happens I will follow the distress protocol attached. The steps I will take include stopping the interview, asking follow-up questions regarding safety and acting on these in line with the distress protocol. For example, if the participant is unable to keep themselves safe I would have to contact emergency services and/or their GP. I will ensure to remind participants of the limits of confidentiality within the information sheet and verbally before we begin the interview. I hope to mitigate these circumstances by excluding people who may already be in psychological distress and approaching the interview with empathy and sensitivity. I would also signpost participants to the charities/ support services on the debrief form if they are not at immediate risk.

Safeguarding/ risk to others

Given that the participants will be talking about the young person they support, they may disclose things that could be considered as safeguarding issues. If this was to happen, I would try to ascertain further information to ascertain the significance of this risk. I would try to tell the participant, where I could, that I was concerned that they had disclosed potential risk to others and that I would have to contact the relevant professionals. Firstly, I would contact my research supervisor to devise a plan and update the participant accordingly once a plan was confirmed. However, if this was an immediate concern I would act immediately. I will ensure to remind participants of the limits of confidentiality within the information sheet and verbally before we begin the interview.

Professional Malpractice

Given that the topic concerns stigma and that there is a prompt on the interview schedule concerning stigma from healthcare professionals, the participant may disclose significant professional malpractice. If this happened, I would ask further questions to ascertain the immediacy/ significance of the malpractice. I would inform the participant that I was concerned that this may cause harm to other people and that I may have to breach confidentiality to report this. I would ensure I spoke with my supervisor to develop a plan and contact the relevant professionals, as needed. I would update the participant accordingly in line with the plan. I have signposted the participant to complaint services if they wish to discuss any concerns further, should the interview initiate any reflections on this. I will ensure to remind participants of the limits of confidentiality within the information sheet and verbally before we begin the interview.

Participant Data

Explain what you will video or photograph as part of your project, why it is appropriate and how it will be used.

During the online interview, the researcher will record the interview on Microsoft Teams. This is so that the student researcher can then transcribe the data afterwards to ensure it is stored anonymously, as soon as possible. The use of Microsoft teams is appropriate for practicality reasons as the researcher may share their screen to remind participants of their photograph and to ask further prompts about it. This will also support data analysis as the participant can add context to their data source in the interview.

Photovoice is a visual participatory research methodology that encourages participants to visually document, reflect upon, and communicate issues of concern (Wang & Burris, 1997). Therefore, it is an appropriate methodology to explore obesity stigma experiences and the meaning caregivers ascribe to it. Photovoice methodology will add depth to the qualitative interview data through exploring caregiver's perceptions and lived experiences of stigma, in relation to the young person they support. It is envisaged that the contextual information gathered from this qualitative study will provide novel insights into the meanings caregivers ascribe towards obesity stigma.

The use of Photovoice allows the participants with more control over their expression, allowing time for them to reflect upon and articulate what is important to them. Furthermore, Photovoice may serve as a tool to build rapport before asking questions of a sensitive nature due to it emphasising more active and collaborative engagement between participant and researcher. Furthermore, prompts based on the commonly used SHOWeD technique (Wang, 1999) will be used to encourage participants to articulate their own meaning embedded within the photograph to give a richer insight towards their experiences. The visual data provided by Photovoice can be used to triangulate narrative data to enhance the credibility of photovoice research (Plunkett et al., 2013).

Participants are asked to submit photographs that they have taken prior to the interview.

Participants will be asked to take two photographs which represent:
1. What weight stigma means to you
2. The impact of weight stigma

Participants are not instructed to take photos of obesity and/or body parts; they are asked to represent the experience of weight stigma and the impact of stigma. Participants will not receive examples of potential photographs that they can take, in order to reduce the researcher's influence over the participants' choice of photographs. However, the ethical implications of individuals appearing in photographs will be discussed with participants. Participants will be instructed to not include the faces of any other individuals in photographs, although can include themselves if they wish to. After taking photographs participants will send the two photographs to the researcher via email. Any photographs that the participant does take of themselves that captures their face will be anonymised in any future publications. This is explicitly stated in the participant information sheet and consent form. Furthermore, the information sheet and consent form also outline that engagement in the photo-initiation task is not a condition of participation in the study and is useful in helping "to form a bigger picture". Therefore, participants can opt-out of this task if they choose to do so and can participate in just the interview. This is to support recruitment for those who may not be able to access photography for multiple reasons and ensure that the participants feel comfortable. These photographs will be sent to the researcher prior to the interview so the researcher can note down any of their reflections prior to the interview as advised by Papaloukas et al. (2017). The participant is given instructions not to include anyone else is the photograph although could involve their face if they chose to do so.

How will you gain consent for the use of video/photography?

The participant will be given the information sheet, and will have opportunity to ask questions before they consent to participating. During the consent process, the participant will complete the consent form and return to the researcher which addresses consenting to being recorded (and that it is not a requirement to be visible during the interview) and consenting to providing photographs (and participants can opt-out of this task if they choose to do so). Prior to the interview, the participant will be reminded of their consent form and offered the opportunity to provide verbal consent before commencing the Photovoice task and interview.

State your video/photography storage, retention and deletion plans and the reasons why.

The initial teams recording will be stored on a password-protected encrypted university drive, which only the student researcher will have access to. The researcher will require access to the online interview recording whilst transcribing the data. As soon as the data is transcribed, the interview recording will be deleted.

The photographs will be sent by the participant to the researcher via email. With regards to a framework for data collection and data use, we will adhere to the Photovoice.org statement of ethical practice (https://photovoice.org/wpcontent/uploads/2014/09/pvethicalpractice.pdf). Photovoice "safety" will be discussed prior to the participants completing the Photovoice task. Participants will be given explicit instructions about the type of photos that are appropriate for the study. The standardised instructions which will be emailed to participants ahead of the photovoice task have also been included in the participant information sheet. It is explicitly stated in the participant information sheet what photos are acceptable for the study. If photos are taken in a public space, it is acceptable for participants to include themselves in the photo but for the purpose of this study we will ask the participant to not take photos of any other person in these spaces, even the young person who they support.

With regards to the transfer of photos via email from participant to researcher, the researcher will explain to all participants the opportunity to encrypt their data and the advantages of data encryption. For example, by encrypting each photo or by password protecting a Word document comprising their photos. However, it will also be explained to the participants that this is not a mandatory condition placed upon them with regards to participating in the project, to reduce participant burden. The decision to encrypt shared data will be at the discretion of the participants and this is outlined in the consent form and information sheet. The photographs will be stored on the Lancaster University secure drive with the interview data. If the participant's face is visible in the photographs, they will be used in the analysis and then they will be anonymised for any future publications.

The approaches we will use are consistent with best practice evidence in the field and will follow PhotoVoice's ethical principles consisting of choice, creativity, partnership, sustainability and cultural sensitivity. A member of the team, Dr Rob Noonan has undertaken PhotoVoice training and has recent experience of using PhotoVoice with accompanying citations to support:

Hall, F. C, & Noonan, R. J. (2023). A qualitative study of how and why gym-based resistance training may benefit women's mental health and wellbeing. Performance Enhancement & Health, 11, 100254. Bhandel, J., & Noonan, R. J. (2022). Motivations, perceptions and experiences of cycling for transport: A photovoice study. Journal of Transport & Health, 25, 101341.

If a participant requests to invoke their ‘right to be forgotten’ or ‘right to erasure’ I will contact the Information Governance Manager, for advice. For more information about this please read the guidance here.

☒ I confirm that I will contact the Information Governance Manager.

Will you take all reasonable steps to protect the anonymity of the participants involved in this project?

☒Yes ☐No

Explain what steps you will take to protect anonymity.

Participants will have a choice in whether they have their camera on during the interview. During the interview recording I will not ask any questions which will yield any identifiable information. The recording of the interview will be stored securely with only the student researcher having access to it. The interview will be transcribed as quickly as possible so that the online interview data can be deleted. The transcription will be anonymised through deleting any information such as names, locations etc. Participants will have a choice in what photographs they take as part of the task. If they choose to include their face, this photo will be anonymised by blanking out their face for any future publications. The participant will be made aware of this on the information sheet and consent form. All data will be unidentifiable and will be referred to using a unique identifying number per participant.

Information about the Research
What are your dissemination plans? E.g publishing in PhD thesis, publishing in academic journal, presenting in a conference (talk or poster).

The findings will be communicated back to academics through the writing up of the thesis and hopefully with a publication in a relevant journal, alongside the presentation of the findings in final year. I hope to feed back to the charities that supported recruitment and to the participants through the use of an accessible summary, if they request. Further dissemination may be delivered using social media through the use of infographics.

Online Sources
You have indicated site users have a reasonable expectation of privacy and therefore you will need to obtain consent to use their data for this project. Please explain how you propose to obtain consent.

When in the recruitment stage, participants will be shared an advertisement for the study and can choose to opt-in to express their interest. When trying to recruit via Facebook, the researcher will send requests to join private groups. The researcher will be open and transparent about why they wish to enter the group e.g. they would like to post an ad for their research. If the administrator accepts the request from the researcher to join the private Facebook group, the researcher will ensure to follow the group rules and ask consent from the administrators, where necessary, to promote their study in the group. Individual members in the group will not be targeted and the ad will be shared for potential participants to opt-in. Once the participant has expressed interest via email to the student researcher, they will be asked a series of eligibility questions before being sent the information sheet and consent form to return within a week. If the researcher does not receive the consent form after a week, and the participant has not gotten in touch to discuss, the researcher will assume that the participant no longer wishes to take part. This is to ensure the participant does not feel pressured into participating in the study.

Data Storage

How long will you retain the research data?

The research data may be retained for up to ten years. Dr Leanne Staniford will act as data custodian and will be responsible in deleting the data.

How long and where will you store any personal and/or sensitive data?

Data such as contact details and consent forms from participants will initially be collected via email and will then be transferred and stored on encrypted files on a password protected laptop. Only the student researcher will have access to the contact details, and the student researcher and supervisor will have access to the consent forms. Both the contact details and consent forms will be separate to the study data. The contact details will only be retained if participants request to be informed about the results at the end of the study. For those who request to be updated about the outcome of the study, the contact details will be deleted after updating participants of the findings. The consent forms will be stored for up to ten years.

Demographic details will be stored on the secure drive separate to each transcript in the analysis process. The postcode will be deleted on the day of the interview, once it is converted to a region and deprivation score, therefore will not be stored. In the write up process, the demographic information will be amalgamated into a table for all participants, so that they are not identifiable, as soon as possible.

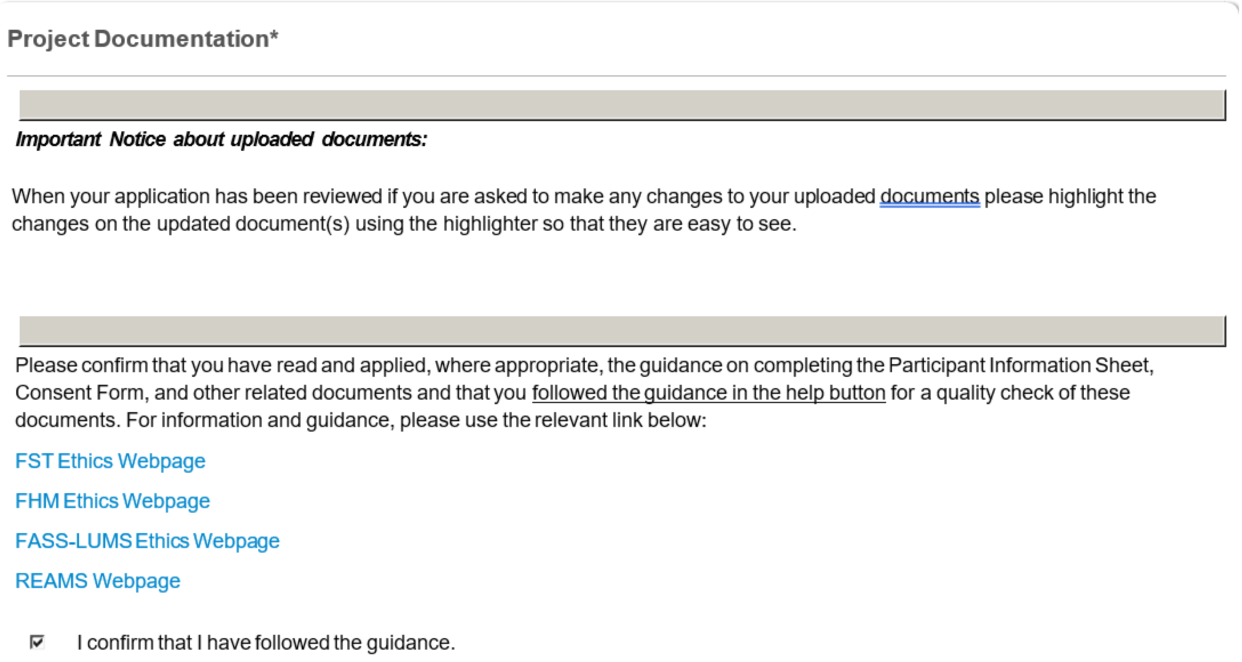
The photographs used in the study will also be shared via email, with participants being encouraged to encrypt their files should they wish to before sending them over. Once received, the researcher will transfer the photographs to a secure and encrypted University storage drive on a password protected laptop. The email of the photograph will be immediately deleted following the successful transfer onto the encrypted file. Photographs will be stored with the anonymised transcription data for each participant.

The initial online interview recording will be stored on a password-protected encrypted drive, which only the student researcher will have access to. The researcher will require access to the online interview recording whilst transcribing the data. As soon as the data is transcribed, the online interview recording will be deleted. The transcription will anonymised, along with the photographs and will be stored on the secure storage space, separately to the contact details and consent forms.

The interview data such as consent forms, anonymised transcriptions and anonymised photographs will be stored for up to ten years with Dr Leanne Staniford acting as data custodian and will be responsible for deleting this data in the given time frame.

Please explain when and how you will anonymise data and delete any identifiable record?

The data will be identified using a unique identifier number. There will be a separate document which links the names of participants to their numbers which only the student researcher will have access to. This will be stored on Lancaster University's secure drive. The photographs will be anonymised, if necessary, prior to submitting for publication. If the participant shows their face, the researcher will edit the photo ensuring their face is not identifiable, and the original photo will be deleted immediately. The recording of the interview will be stored securely with only the student researcher having access to it. The online interview recording will be transcribed as quickly as possible, during the data collection phase, so that the online interview data can be deleted. The transcription will be anonymised through deleting any information such as names, locations etc. and using pseudonyms. After the transcription has been completed, the online interview recording will be deleted.



Project Documentation*

Important Notice about uploaded documents:

When your application has been reviewed if you are asked to make any changes to your uploaded documents please highlight the changes on the updated document(s) using the highlighter so that they are easy to see.

Please confirm that you have read and applied, where appropriate, the guidance on completing the Participant Information Sheet, Consent Form, and other related documents and that you followed the guidance in the help button for a quality check of these documents. For information and guidance, please use the relevant link below:

FST Ethics Webpage

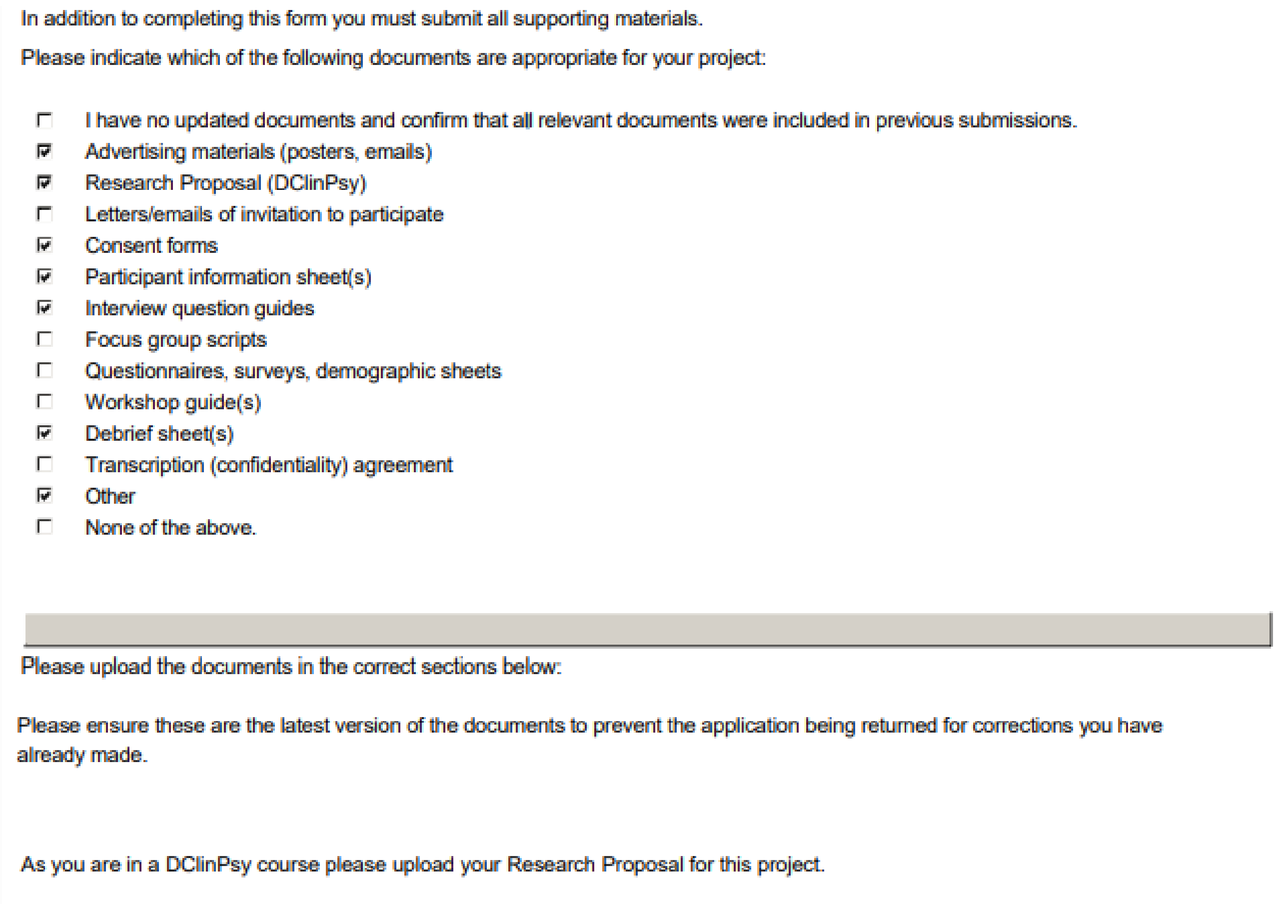
FHM Ethics Webpage

FASS-LUMS Ethics Webpage

REAMS Webpage

☑ I confirm that I have followed the guidance.

ETHICS SECTION



In addition to completing this form you must submit all supporting materials.

Please indicate which of the following documents are appropriate for your project:

- ☐ I have no updated documents and confirm that all relevant documents were included in previous submissions.
- ☑ Advertising materials (posters, emails)
- ☑ Research Proposal (DClinPsy)
- ☐ Letters/emails of invitation to participate
- ☑ Consent forms
- ☑ Participant information sheet(s)
- ☑ Interview question guides
- ☐ Focus group scripts
- ☐ Questionnaires, surveys, demographic sheets
- ☐ Workshop guide(s)
- ☑ Debrief sheet(s)
- ☐ Transcription (confidentiality) agreement
- ☑ Other
- ☐ None of the above.

Please upload the documents in the correct sections below:

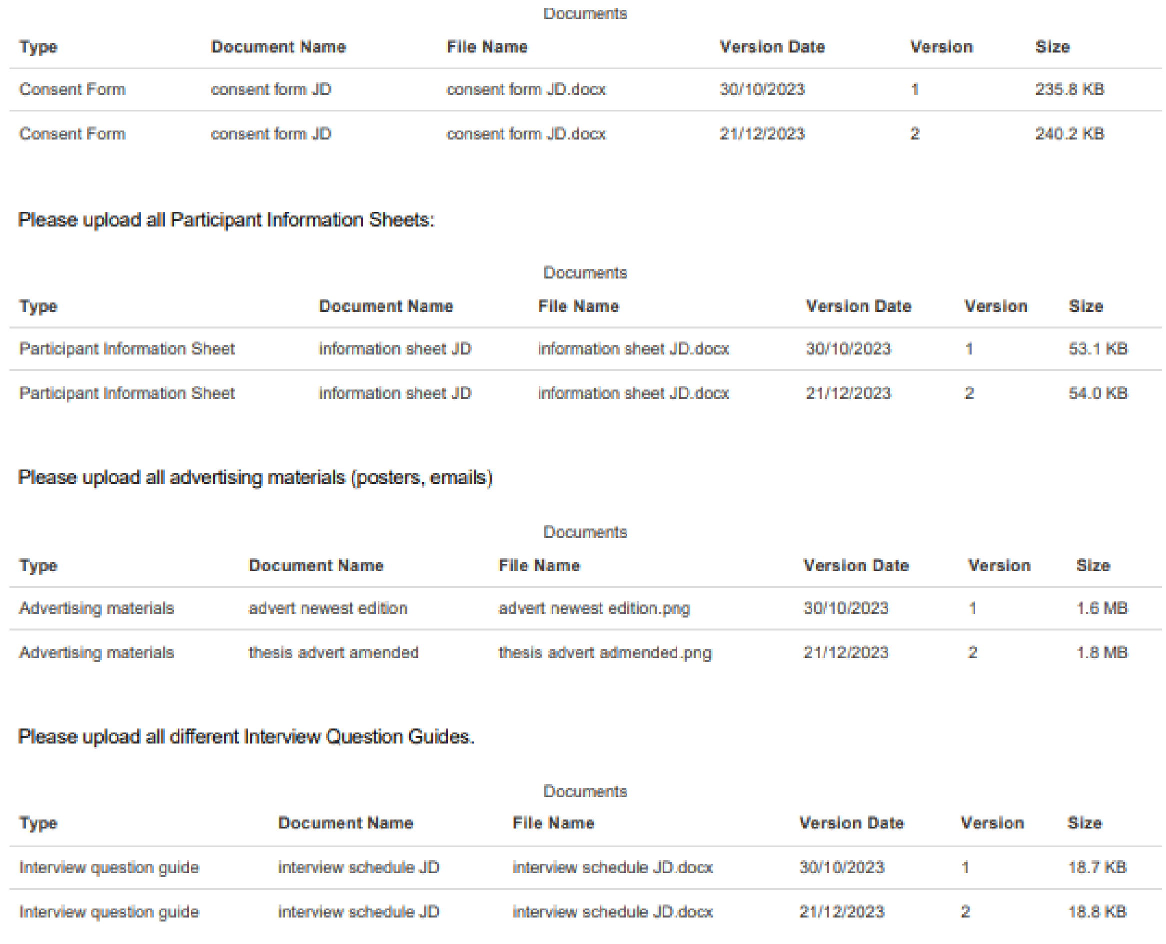
Please ensure these are the latest version of the documents to prevent the application being returned for corrections you have already made.

As you are in a DClinPsy course please upload your Research Proposal for this project.

As you are in a DClinPsy course please upload your Research Proposal for this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Research Proposal	Research ProtocolJessLS FB Sep 23 (1) (1)	Research ProtocolJessLS FB Sep 23 (1) (1).docx	30/10/2023	1	45.9 KB
Research Proposal	Research ProtocolJessLS FB Sep 23 (1) (1)	Research ProtocolJessLS FB Sep 23 (1) (1).docx	21/12/2023	2	48.8 KB



Documents

Type	Document Name	File Name	Version Date	Version	Size
Consent Form	consent form JD	consent form JD.docx	30/10/2023	1	235.8 KB
Consent Form	consent form JD	consent form JD.docx	21/12/2023	2	240.2 KB

Please upload all Participant Information Sheets:

Documents

Type	Document Name	File Name	Version Date	Version	Size
Participant Information Sheet	information sheet JD	information sheet JD.docx	30/10/2023	1	53.1 KB
Participant Information Sheet	information sheet JD	information sheet JD.docx	21/12/2023	2	54.0 KB

Please upload all advertising materials (posters, emails)

Documents

Type	Document Name	File Name	Version Date	Version	Size
Advertising materials	advert newest edition	advert newest edition.png	30/10/2023	1	1.6 MB
Advertising materials	thesis advert amended	thesis advert admended.png	21/12/2023	2	1.8 MB

Please upload all different Interview Question Guides.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Interview question guide	interview schedule JD	interview schedule JD.docx	30/10/2023	1	18.7 KB
Interview question guide	interview schedule JD	interview schedule JD.docx	21/12/2023	2	18.8 KB

Documents

Type	Document Name	File Name	Version Date	Version	Size
Debrief sheet	participant debrief form JD	participant debrief form JD.docx	30/10/2023	1	85.3 KB

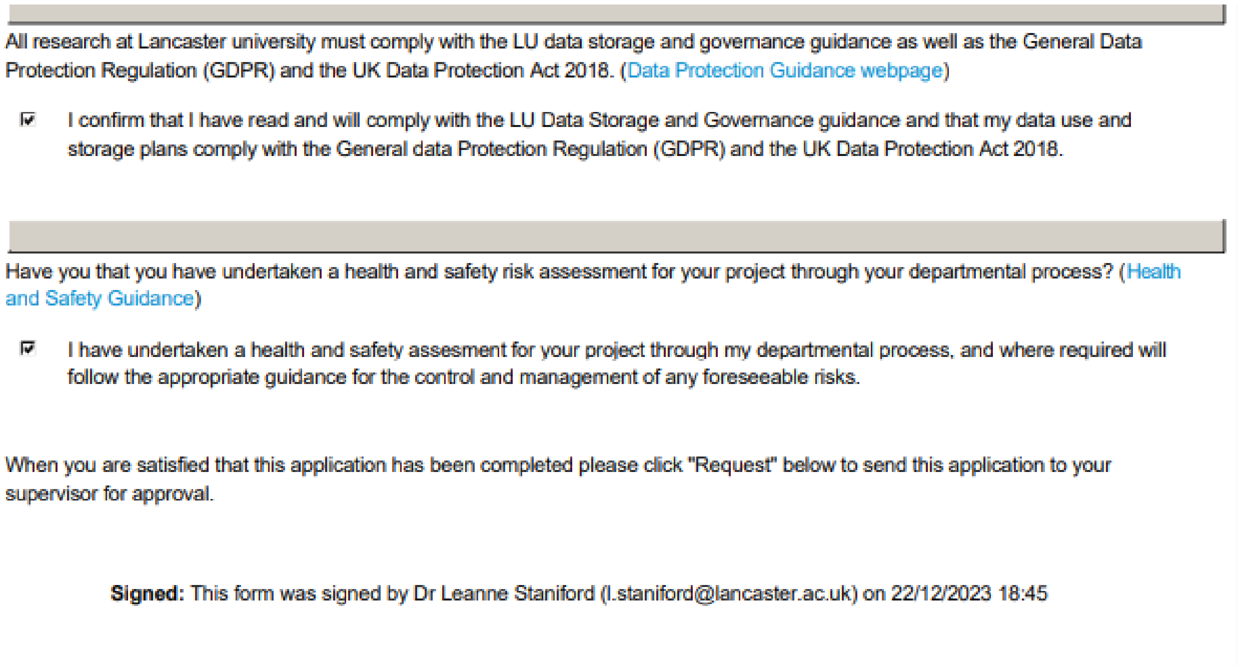
Please upload any other relevant documentation related to this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Other	Distress protocol 1 JD	Distress protocol 1 JD.docx	30/10/2023	1	46.2 KB
Other	Distress Protocol 2 JD	Distress Protocol 2 JD.docx	30/10/2023	1	44.2 KB
Other	Amendments ethics	Amendments ethics.docx	21/12/2023	1	18.3 KB

ETHICS SECTION

Declaration and Signatures



All research at Lancaster university must comply with the LU data storage and governance guidance as well as the General Data Protection Regulation (GDPR) and the UK Data Protection Act 2018. (Data Protection Guidance webpage)

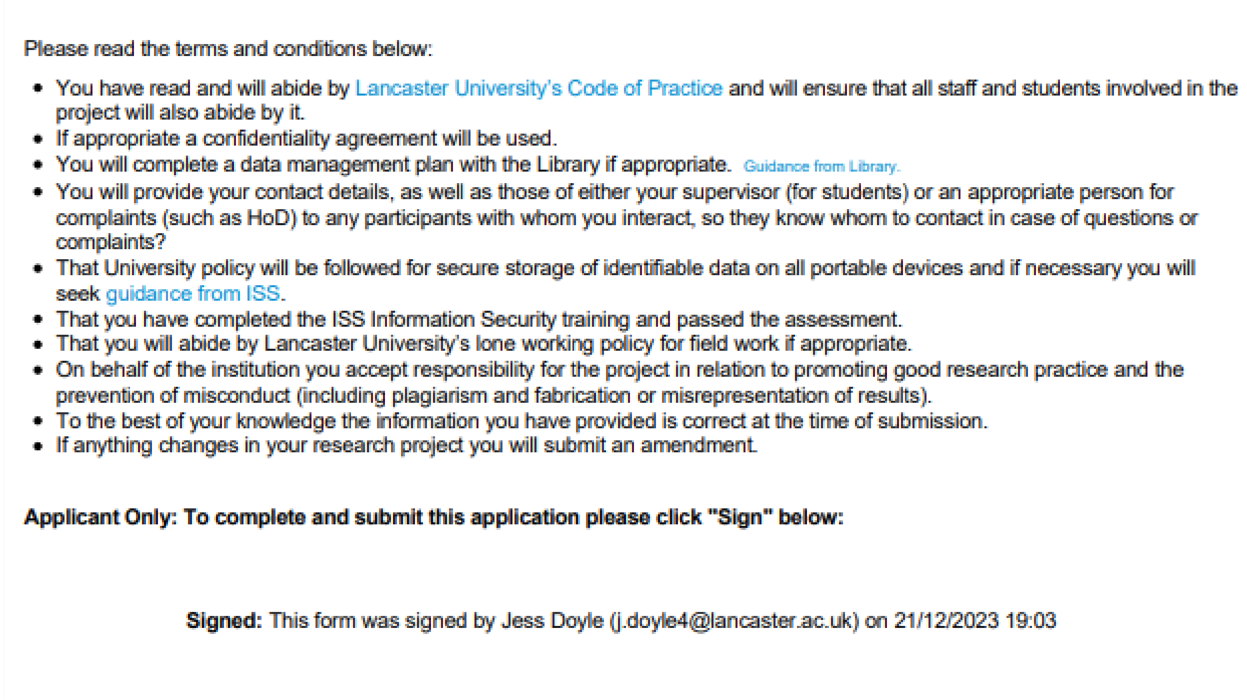
☑ I confirm that I have read and will comply with the LU Data Storage and Governance guidance and that my data use and storage plans comply with the General data Protection Regulation (GDPR) and the UK Data Protection Act 2018.

Have you that you have undertaken a health and safety risk assessment for your project through your departmental process? (Health and Safety Guidance)

☑ I have undertaken a health and safety assesment for your project through my departmental process, and where required will follow the appropriate guidance for the control and management of any foreseeable risks.

When you are satisfied that this application has been completed please click "Request" below to send this application to your supervisor for approval.

Signed: This form was signed by Dr Leanne Staniford (l.staniford@lancaster.ac.uk) on 22/12/2023 18:45



Please read the terms and conditions below:

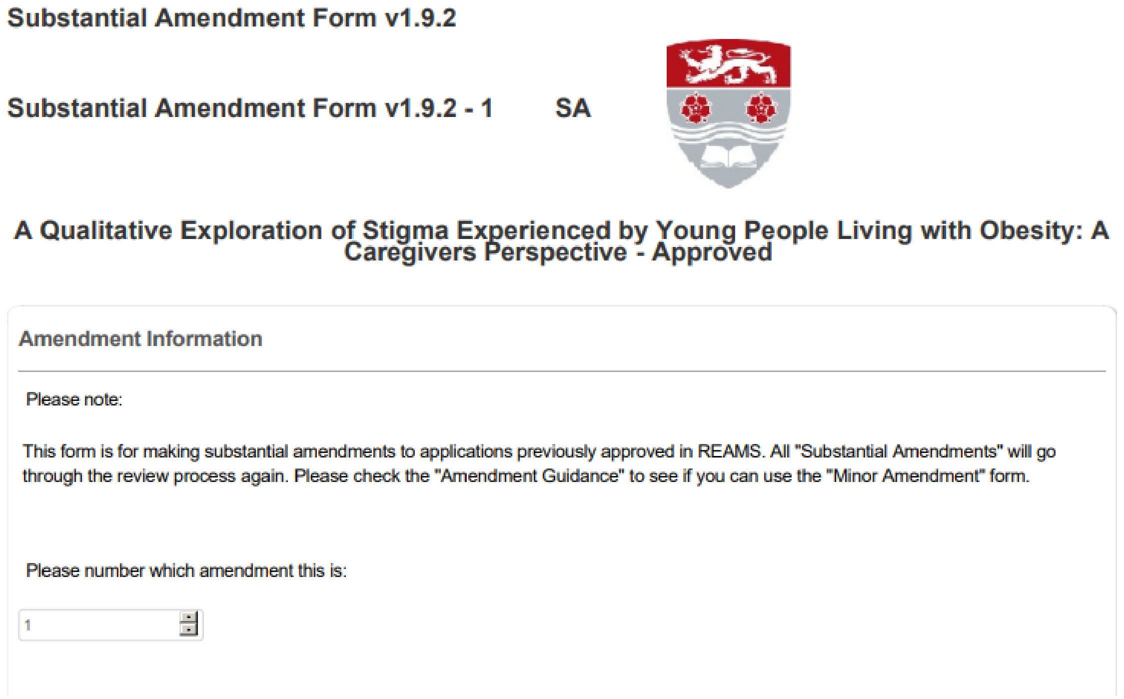
- You have read and will abide by Lancaster University's Code of Practice and will ensure that all staff and students involved in the project will also abide by it.
- If appropriate a confidentiality agreement will be used.
- You will complete a data management plan with the Library if appropriate. Guidance from Library.
- You will provide your contact details, as well as those of either your supervisor (for students) or an appropriate person for complaints (such as HoD) to any participants with whom you interact, so they know whom to contact in case of questions or complaints?
- That University policy will be followed for secure storage of identifiable data on all portable devices and if necessary you will seek guidance from ISS.
- That you have completed the ISS Information Security training and passed the assessment.
- That you will abide by Lancaster University's lone working policy for field work if appropriate.
- On behalf of the institution you accept responsibility for the project in relation to promoting good research practice and the prevention of misconduct (including plagiarism and fabrication or misrepresentation of results).
- To the best of your knowledge the information you have provided is correct at the time of submission.
- If anything changes in your research project you will submit an amendment.

Applicant Only: To complete and submit this application please click "Sign" below:

Signed: This form was signed by Jess Doyle (j.doyle4@lancaster.ac.uk) on 21/12/2023 19:03

Amendments to Ethics

Amendment 1



Substantial Amendment Form v1.9.2

Substantial Amendment Form v1.9.2 - 1 SA

A Qualitative Exploration of Stigma Experienced by Young People Living with Obesity: A Caregivers Perspective - Approved

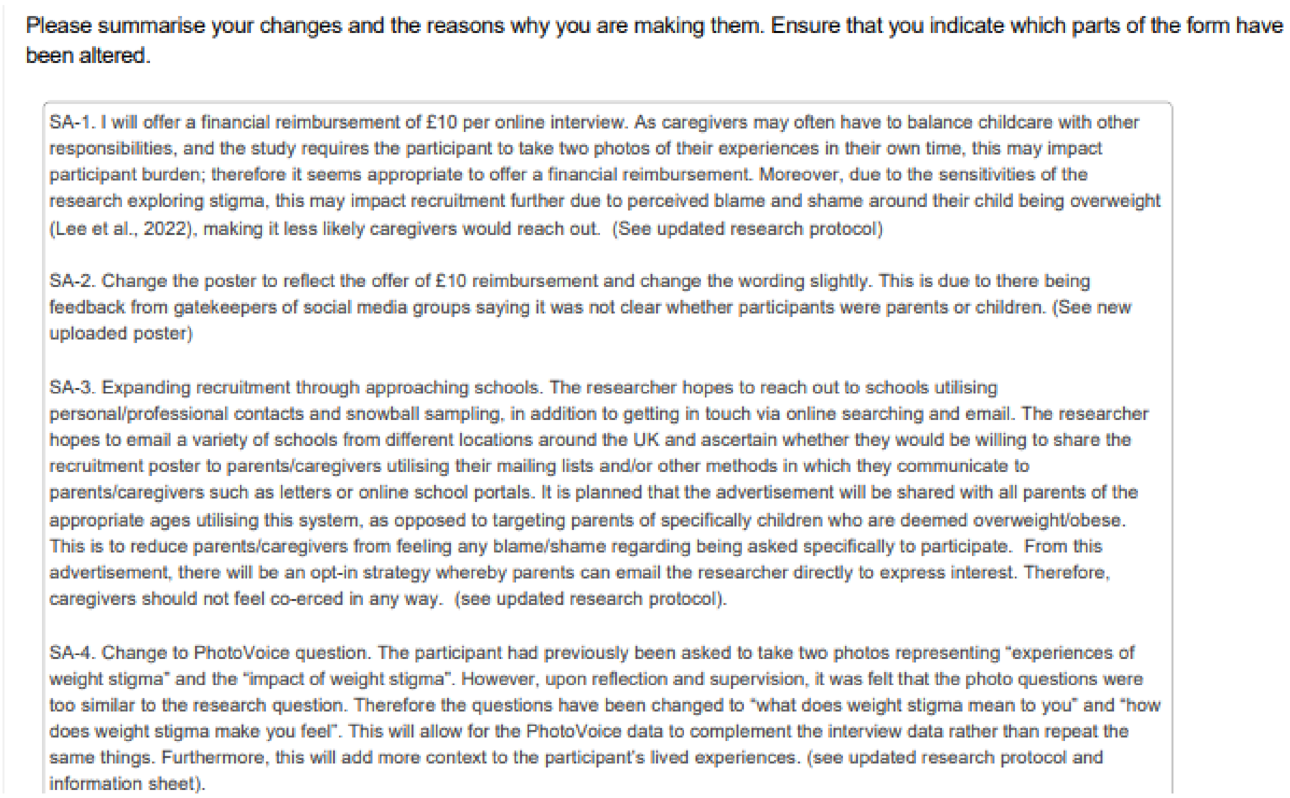
Amendment Information

Please note:

This form is for making substantial amendments to applications previously approved in REAMS. All "Substantial Amendments" will go through the review process again. Please check the "Amendment Guidance" to see if you can use the "Minor Amendment" form.

Please number which amendment this is:

1



Please summarise your changes and the reasons why you are making them. Ensure that you indicate which parts of the form have been altered.

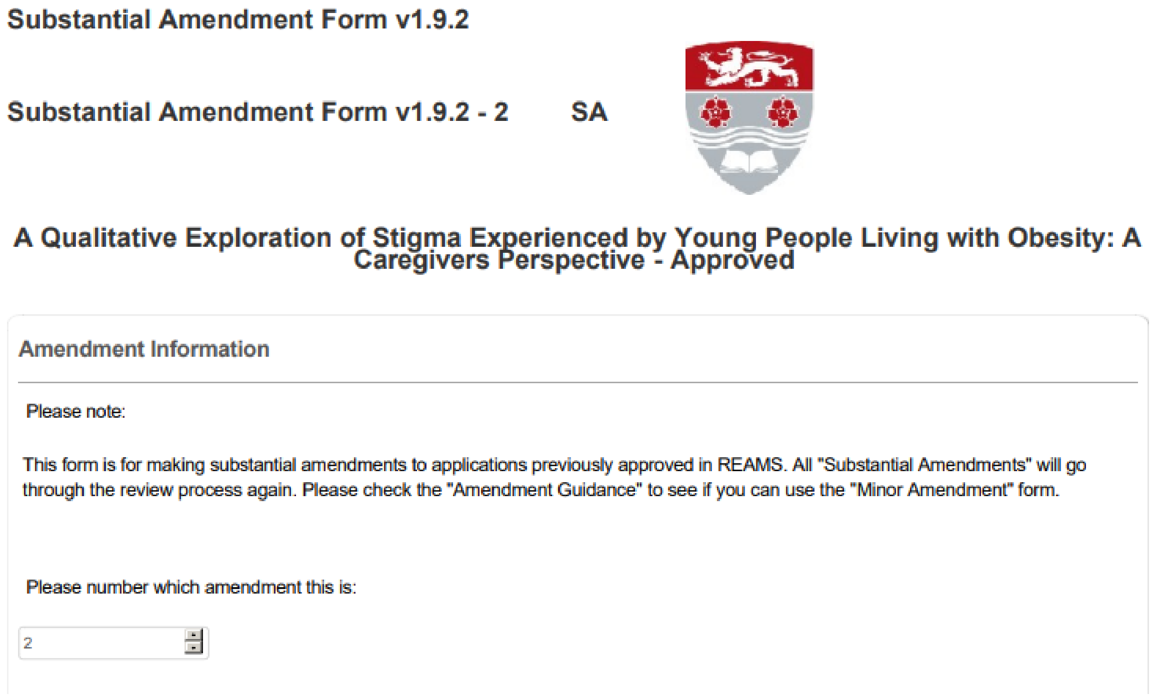
SA-1. I will offer a financial reimbursement of £10 per online interview. As caregivers may often have to balance childcare with other responsibilities, and the study requires the participant to take two photos of their experiences in their own time, this may impact participant burden; therefore it seems appropriate to offer a financial reimbursement. Moreover, due to the sensitivities of the research exploring stigma, this may impact recruitment further due to perceived blame and shame around their child being overweight (Lee et al., 2022), making it less likely caregivers would reach out. (See updated research protocol)

SA-2. Change the poster to reflect the offer of £10 reimbursement and change the wording slightly. This is due to there being feedback from gatekeepers of social media groups saying it was not clear whether participants were parents or children. (See new uploaded poster)

SA-3. Expanding recruitment through approaching schools. The researcher hopes to reach out to schools utilising personal/professional contacts and snowball sampling, in addition to getting in touch via online searching and email. The researcher hopes to email a variety of schools from different locations around the UK and ascertain whether they would be willing to share the recruitment poster to parents/caregivers utilising their mailing lists and/or other methods in which they communicate to parents/caregivers such as letters or online school portals. It is planned that the advertisement will be shared with all parents of the appropriate ages utilising this system, as opposed to targeting parents of specifically children who are deemed overweight/obese. This is to reduce parents/caregivers from feeling any blame/shame regarding being asked specifically to participate. From this advertisement, there will be an opt-in strategy whereby parents can email the researcher directly to express interest. Therefore, caregivers should not feel co-erced in any way. (see updated research protocol).

SA-4. Change to PhotoVoice question. The participant had previously been asked to take two photos representing "experiences of weight stigma" and the "impact of weight stigma". However, upon reflection and supervision, it was felt that the photo questions were too similar to the research question. Therefore the questions have been changed to "what does weight stigma mean to you" and "how does weight stigma make you feel". This will allow for the PhotoVoice data to complement the interview data rather than repeat the same things. Furthermore, this will add more context to the participant's lived experiences. (see updated research protocol and information sheet).

Amendment 2



Substantial Amendment Form v1.9.2

Substantial Amendment Form v1.9.2 - 2 **SA**

A Qualitative Exploration of Stigma Experienced by Young People Living with Obesity: A Caregivers Perspective - Approved

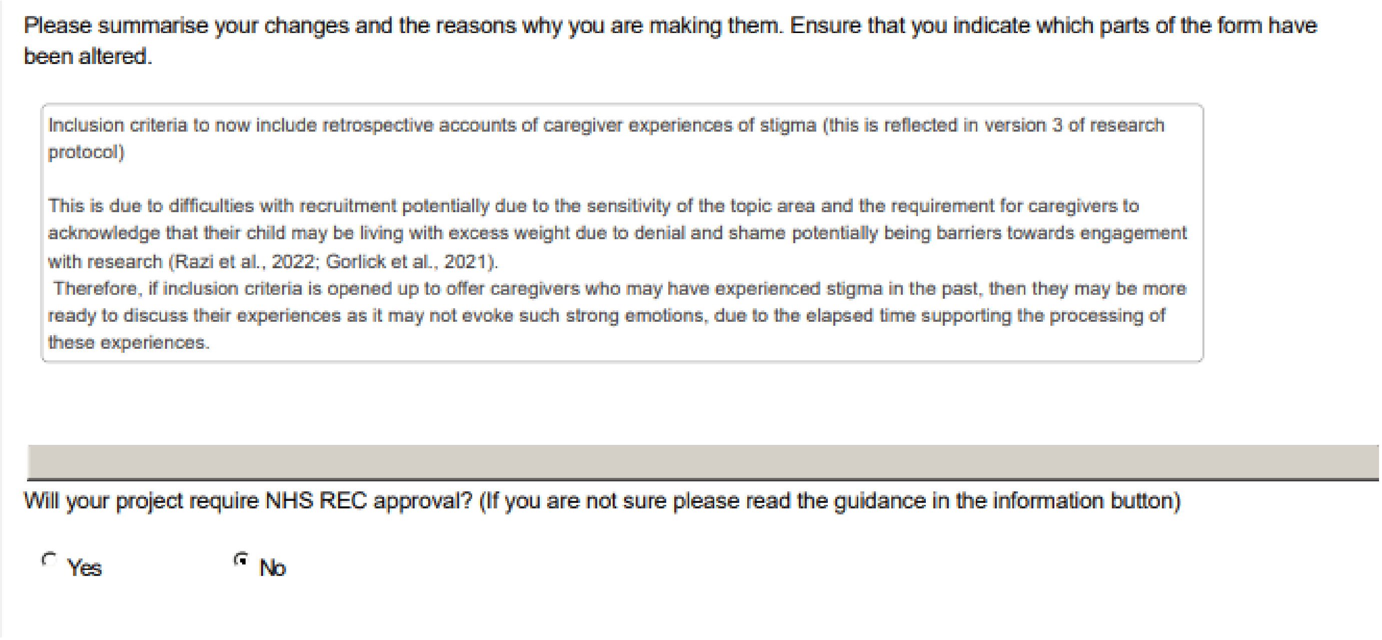
Amendment Information

Please note:

This form is for making substantial amendments to applications previously approved in REAMS. All "Substantial Amendments" will go through the review process again. Please check the "Amendment Guidance" to see if you can use the "Minor Amendment" form.

Please number which amendment this is:

2



Please summarise your changes and the reasons why you are making them. Ensure that you indicate which parts of the form have been altered.

Inclusion criteria to now include retrospective accounts of caregiver experiences of stigma (this is reflected in version 3 of research protocol)

This is due to difficulties with recruitment potentially due to the sensitivity of the topic area and the requirement for caregivers to acknowledge that their child may be living with excess weight due to denial and shame potentially being barriers towards engagement with research (Razi et al., 2022; Gorlick et al., 2021).
Therefore, if inclusion criteria is opened up to offer caregivers who may have experienced stigma in the past, then they may be more ready to discuss their experiences as it may not evoke such strong emotions, due to the elapsed time supporting the processing of these experiences.

Will your project require NHS REC approval? (If you are not sure please read the guidance in the information button)

○ Yes ● No

Appendices

Appendix 4-A: Research Protocol (last updated 20/06/24)

Trainee name	**Trainee number**
Jess Doyle	2232

Research Supervisor	**Field Supervisor**
Leanne Staniford	Dr Robert Noonan

Title of the primary research study
A Qualitative Exploration of Stigma Experienced by Young People Living with Obesity: A Caregivers Perspective

1. Background

What is known?

Within the United Kingdom (UK), 14.4% of young people aged 4-5 and 25.5% aged 10-11 are classified as obese (NHS Digital, 2021). A biopsychosocial framework considers the causes and maintenance of obesity as a complex interaction between biological, psychological, social and environmental factors (British Psychological Society [BPS], 2019). Given this, the National Institute for Health and Care Excellence (NICE, 2013) recommends a family-based multi-component approach towards weight management interventions for young people living with obesity (YPLwO). It is recognised that family involvement often contributes to the success in weight management for YPLwO due to family systems being integral for supporting young people.

People living with obesity (PLwO) may be deemed as “lazy” and “unmotivated” to improve their health, impacting their treatment within society (Puhl & Heuer, 2010). Weight stigma is most prevalent in the forms of teasing and bullying in young people (Puhl & Lessard, 2020; Van Geel et al., 2014). This stigmatisation can contribute to poor mental health and exacerbate obesity through maladaptive coping strategies such as binge eating and reduced physical activity (Haqq et al., 2021; Puhl & Suh, 2015). Therefore, it is important to address stigma in this context as it could be deemed a significant maintainer that is often ignored in weight management interventions.

Weight stigma experienced by the young person can be extended to caregivers (“courtesy stigma”) with an added sense of responsibility and blame for their child’s weight (Lee et al., 2022). Internalisation of stigma can contribute to poor mental health of the caregiver and can encourage negativity towards the young person (Gorlick et al., 2015). This can lead to caregivers trying to avoid stigma by limiting the young persons' engagement in health-promoting practices. Furthermore, caregivers can also be a source of stigma to the young person, evidence suggests that stigma from adults can be considered more distressing than that from peers (Magson & Rapee, 2022).

Given that NICE guidance suggests a family-based approach is key to support YPLwO in managing their weight, the views of caregivers of YPLwO can offer valuable insights beyond that of the YPLwO alone. Caregivers can provide their views and experiences of direct and indirect forms of stigma that young people may not yet understand. Furthermore, caregivers are central in supporting young people to engage in health-promoting behaviours. Given that a young persons' eating habits can be highly influenced by social contexts, it is important to go beyond the perspectives of parents alone as often many children may have multiple people involved in their day-to-day support and care.

Parental experiences of weight stigma have been examined in four qualitative studies to the best of the researcher's knowledge at present (Gorlick et al., 2015; Jackson et al., 2007; Hamlington et al., 2015; Roberts et al., 2021). These studies appear to be the only studies whereby stigma is explicitly explored as part of the research question. However, the former two studies are based on only mothers, one article is specific to young people with Bardet-Biedl syndrome, and the latter addresses parents and adolescents who are classified as "severely obese".

Therefore, this study will seek to make sense of caregiver's experiences of weight stigma and the associated consequences and implications for them and YPLwO in the United Kingdom. This study will add to the existing literature and extend the findings to explore the experiences of caregivers utilising a PhotoVoice methodology to increase active and collaborative engagement with the participants.

What is needed?

This research may indirectly impact YPLwO and their caregivers through contribution to the literature regarding how stigma may be experienced by families. Furthermore, this research seeks to discuss the interactions between stigma, its consequences and how it may further impact the weight management of the young person.

Despite there being lots of research into the field of obesity stigma, there are still misconceptions being published in the media from reputable sources, contributing to the stigmatising narratives (Yorkshire Obesity Research Alliance; YORA; 2023). Therefore, further research may be needed in a timely manner to raise awareness in the presentation of stigma and its consequences to many families.

This study will add to the evidence base through its explorations of the systemic impact of stigma, in addition to including the perspectives of non-parent caregivers, whose views are often unheard in the literature. This study is novel given its use of Photovoice methodology which will provide more context towards the meanings caregivers ascribe towards childhood obesity stigma.

What is the connection to clinical psychology?

The information from the study will help develop our understanding to facilitate a non-stigmatising approach when working with YPLwO and their families in clinical contexts. This research can help clinical psychologists (CPs) to take a trauma-informed and compassionate approach towards working with this client group. CPs may be able to support clients on an individual level through acknowledging stigma in formulation and intervention with young people and their families to try and reduce individual blame and develop effective coping strategies to protect against the potential negative psychosocial consequences (NICE, 2013). CPs can also support YPLwO through more systemic means such as being able to provide appropriate training, inputting towards service development and endorsing psychological perspectives throughout healthcare teams.

2. Aim and objectives

Due to the aims focussing on the experiences of stigma, the inclusion criteria specifies that the young person living with obesity has experienced stigma; therefore the aims and objectives are as follows:

2.1 Aims

Aims:

- To explore the experiences of stigma of young people living with obesity, from their caregiver's perspective
- To explore the experiences of stigma in caregivers of young people living with obesity
- To explore the potential consequences of experiencing stigma for young people living with obesity and their families
- To explore whether and/or how experiencing stigma impacts weight management of the young person living with obesity

2.2 Objectives

- To contribute to our understanding of stigma in young people living with obesity and their caregivers

- To make recommendations on how best to support young people living with obesity and their families

2.3 Research Question(s)

- What are the caregiver's experiences of stigma?
- What are the caregiver's perceptions of stigma experienced by the young people they support, living with obesity?
- What are the associated psychosocial consequences of experiencing stigma for the young person and their families?
- What are the associated weight management implications?

3. Method

3.1. Participants

Participants will be individuals classed as a "caregiver" of a young person living with obesity, who has also experienced stigma. Caregivers may involve parents, grandparents or family friends who take a primary role in supporting the young person's care.

Recruitment

Participants will be recruited through visual advertisements given to relevant organisations and support groups to share on social media such as Association for the Study of Obesity (ASO), Obesity.org, Obesity UK etc. Furthermore, these advertisements will also be shared on Facebook, Twitter and LinkedIn, encouraging snowball sampling through relevant organisations. These organisations may include research networks (e.g. LORN and YORA) and charities/ local authority initiatives (e.g. FoodActive). Specific communities will be targeted on Facebook through advertising in groups such as parenting groups (e.g. Health and Weight Loss Support for Kids), obesity groups (e.g. Overcoming Obesity, location-based Obesity UK support groups) or local weight management groups such as ‘Slimming World’ or young people specific weight-loss/ healthy lifestyle communities (e.g. Active Lifestyles Sefton, Feeding Liverpool). Before joining/ posting in these groups, the researcher will seek out permission from the administrator of the group if not already outlined in the group rules.

Should utilising social media not be sufficient in attaining the targeted number of participants, other recruitment methods may involve linking in with the research supervisor’s contacts in a preventative weight management clinic in Sheffield. If this method is utilised, we may use the clinic to advertise our study to recruit participants.

Recruitment Plan B

Given the limited response towards this research, to widen recruitment further, the researcher will approach schools around the UK in addition to financially reimbursing participants with £10 per interview (this has been approved by Research Director).

School Recruitment

The researcher hopes to reach out to schools utilising personal/professional contacts and snowball sampling, in addition to getting in touch via online searching and email. The researcher hopes to email a variety of schools from different locations around the UK and ascertain whether they would be willing to share the recruitment poster to parents/caregivers utilising their mailing lists and/or other methods in which they communicate to parents/caregivers such as letters or online school portals. It is planned that the advertisement will be shared with all parents utilising this system. From this advertisement, there will be an opt-in strategy whereby parents can email the researcher directly to express interest. Therefore, caregivers should not feel co-erced in any way.

Financial Incentive

As caregivers may often have to balance childcare with other responsibilities, it was deemed appropriate to offer a financial reimbursement for their time. Moreover, due to the sensitivities of the research exploring stigma, this may impact recruitment further due to perceived blame and shame around their child being overweight (Lee et al., 2022).

Participants will be purposively recruited to allow the sample to include caregivers of YPLwO in line with the research question, aims and objectives. The target number will be between five to ten participants in order to obtain rich data (Smith & Osborn, 2015). Given that the sample of participants should be generally homogenous in terms of the experience, inclusion and exclusion criteria are outlined below:

Inclusion criteria

Primary caregivers (aged 18+) of young people who:

- Are aged 5-16 following Gorlick et al's (2021) rationale, whereby caregivers may be deemed more "responsible" for the weight of the young person during these ages, thus may be more vulnerable to stigma
- Are currently considered obese/overweight through caregiver self-report
- Have experienced stigma in relation to their child's weight
- Caregivers who have met this criteria in the past and are able to retrospectively discuss their experiences

Exclusion criteria

- Participants who do not speak English
- Participants who do not live in the United Kingdom

- Participants who are currently under psychological home treatment services and present in acute psychological distress

3.2. Design

The approach taken will be a qualitative approach due to the nature of the research question requiring an in-depth exploration of experiences of stigma, and the impact it has had on caregivers and the young people in their care. The approach will utilise PhotoVoice method in addition to semi-structured interviews employing an IPA framework (Wang & Burris, 1994; 1997; Brunsden & Goatcher, 2007; Pietkiewicz & Smith, 2014).

Photovoice is a visual participatory research methodology that encourages participants to visually document, reflect upon, and communicate issues of meaning and concern with the view of stimulating social change (Wang & Burris, 1997). Participants will be asked to take two photographs illustrating:

1. What weight stigma means to you?
2. How does weight stigma make you feel?

The use of Photovoice allows the participants with more control over their expression, allowing time for them to reflect upon and articulate what is important to them. Furthermore, Photovoice may serve as a tool to build rapport before asking questions of a sensitive nature due to it emphasising more active and collaborative engagement between participant and researcher. Furthermore, prompts based on the commonly used SHOWeD technique (Wang, 1999) will be used to encourage participants to articulate their own meaning embedded within the photograph. The semi-structured interview will complement the narrative associated with the images and will allow for the participant to add novel perspectives on issues important to them, in addition to providing information prompted by the studies' aims and objectives. The interviews will take place online to allow more flexibility, due to caregivers' responsibilities.

The verbatim data initiated from the photo exercise and the interviews will be triangulated and analysed using Interpretative Phenomenological Analysis (IPA). By triangulating the two data sources researcher biases were limited and credibility can be enhanced.

IPA is the chosen method due to its effectiveness in investigating lived experiences of long-term conditions and its similar hermeneutic and phenomenological roots with PhotoVoice methodology (Brusden & Goatcher 2007; Smith, 2011). IPA seeks to explore 'lived experience' and how people make sense of it, via first person subjective accounts, whilst appreciating the context of the individual (Larkin et al., 2021). This leads the researcher into a double hermeneutic whereby they are making sense of an individuals' sense-making. Therefore, researchers need to acknowledge their own biases in the process, as the information is often sensitive and emotionally charged. Given there is no specific guidance in the analysis of PhotoVoice images, Papaloukas et al. (2017) suggest embedding the photographs within the transcript, in addition to "bracketing" any initial interpretations of the photographs prior to the interview, to ensure the participants' role as experiential experts are not compromised.

3.3. Procedure and materials

1. Advertisements are sent out to the relevant groups/ agencies
2. Participant responds to advertisement to express interest in participating in the study
3. Participant is asked a series of questions to identify their eligibility (are you over the age of 18? Do you care for a young person who lives with obesity who is aged 5-16? Has this

young person ever experienced any stigma? Do you live in the UK and speak English? Are you currently undergoing any immediate/crisis mental health treatment?)

4. If they are eligible, they are sent an information sheet and consent form and asked to return this within one week of receiving these. If they are not, their details are deleted. They are encouraged to contact the researcher if they have any further concerns/questions regarding participation. The individual is advised to return the consent form back within a week, and informed that after that timeframe, it will be assumed they no longer wish to participate. However, there is scope for negotiating this with the individual, if they feel as though they may need more time.
5. If the researcher has not heard back within the week, they will assume the individual no longer wants to participate in the study. If this is the case, contact details will be deleted.
6. If consent is obtained, the researcher will book them in for an online interview, at a suitable time. The participant can choose whether they would prefer an audio or video interview using Teams software.
7. The participant is also advised to send the researcher their photographs representing “what weight stigma means to you” and “the impact of weight stigma” prior to the interview. Participants can opt-out of this if they want to.
8. The participant is advised to encrypt these photos before sending them to the researcher, with instructions on the information sheet and being provided verbally by the researcher.
9. Participant attends online interview, verbal consent gained before starting. Participant will be asked to answer some brief demographic questions before completing the interview for approximately 30-40 minutes. The participant will be offered a break in the middle if needed and if the time goes over, will be offered the opportunity to book in for another time.
10. The transcriptions and photographs will be analysed in accordance with the IPA methods.

11. The participant can withdraw at any point up until the transcripts have been anonymised and amalgamated.
12. The academic supervisor, Dr Leanne Staniford will act as custodian for the data and keep it securely for 10 years and then it will be deleted/destroyed after this period of time.
13. During the dissemination of the data the photographs will be anonymised, and the original photographs will be deleted.
14. Contact details will be deleted after dissemination

Study materials required include: the interview schedule, advertisement, information sheet, consent form, debrief form and distress protocol. All of which will be developed under the supervision of my research and field supervisors.

Data Management Plan

Contact details/ identifiable information

The contact details and consent forms will initially be collected via email and will then be transferred and stored on encrypted files on a password protected laptop. The emails with these documents on will then be deleted. Only the student researcher will have access to the contact details. The data custodian and student researcher will have access to the consent forms as they will be stored for up to ten years, separate to the interview data. Contact details will also be separate to the study data and will only be retained if participants request to be informed about the results at the end of the study, which is addressed on the consent form. Demographic details will be stored on the secure drive which will also be separate. The postcode will be deleted on the day of the interview, once it is converted to a region and deprivation score, therefore will not be stored. Anonymity of the participants will be ensured by giving participants a unique identifier number which will be used in the storing of demographic data, consent forms, contact details, photographs and transcript data. There will be a separate document saved securely, with only the student researcher having access to this which will link the unique identifier number with the name of the participant.

Photographs

The photographs used in the study will be shared from the participant to the researcher via email. With regards to the transfer of photos via email from participant to researcher, the researcher will explain to all participants the opportunity to encrypt their data and the advantages of data encryption. For example, by encrypting each photo or by password protecting a Word document comprising their photos. However, it will also be explained to the participants that this is not a mandatory condition placed upon them with regards to participating in the project. The decision to encrypt shared data will be at the discretion of the participants. This is also addressed on the consent form. Once the researcher has transferred the photograph onto Lancaster University's secure drive on their password protected laptop, they will then delete the email sent by the participant. Photographs will be stored alongside the anonymised transcription data for each participant to aid analysis. Furthermore, if there are any identifiable features of the photograph, this will be anonymised by the researcher.

Interview data

The interview data will be recorded via teams and stored electronically on a password-protected laptop on an encrypted drive. Only the researcher will have access to the full recorded interview. Once the data has been transcribed and analysed, the audio/video recording will be deleted.

The transcription document will be anonymised by removing any identifying information including names, locations etc. and saved onto the password-protected laptop as an encrypted file. The transcripts will be identified using the unique identifier numbers.

Social media accounts

The researcher will create research-specific social media accounts to maintain their privacy. The researcher will seek to contact potential participants via their university secure email as soon as possible and delete the messages from their social media account. The researcher will not record any social media contact details.

3.4. Proposed analysis

IPA is an inductive approach and therefore the researcher is guided by the data. Once the data is transcribed, the analysis will be done alongside the transcript. The stages involve immersing oneself in the data through reading and re-reading, exploratory noting, experiential statements, searching for connections across experiential statements, naming the themes and organising them and developing group themes across cases (Larkin et al., 2021).

Given there is no specific guidance in the analysis of PhotoVoice images, Papaloukas et al. (2017) suggest embedding the photographs within the transcript, in addition to “bracketing” any initial interpretations of the photographs prior to the interview, to ensure the participants’ role as experiential experts are not compromised.

3.5. Practical/ Ethical Issues

- **Technology required** would involve the use of Microsoft Teams and the creation of research-specific social media accounts.

- **Research expenses:** to have two experts-by-experience (EbE) help with the development of the study materials to ensure they are not stigmatising. Each EbE would be paid £50 each for two hours work (reading through and providing feedback on the interview schedule, information/consent forms and advertisement).

- **Risk:** Asking participants about their experiences of stigma may initiate feelings associated such as shame and/or guilt, which could put the participant in psychological distress. To manage this, I plan to use my therapeutic skills within the interview to create an environment which promotes safety and a non-judgemental approach. The hope is that the use of Photovoice will enable the participant to share their initial reflections so they feel more in control which can help build rapport, at the beginning of the interview. It will be made clear from the outset that the participant can refuse to answer a question, stop the interview, or withdraw from the research at any point if they feel uncomfortable or no longer wish to take part. Additionally, the participant will also be offered a comfort break in the interview I will ensure to offer information to all participants regarding where they could seek support should the content bring up any distress that they later want to seek support for. Furthermore, I will develop a distress protocol and receive regular supervision to monitor this.

- **Language:** Language used within the interview may act as a source of stigma- There is a lot of discussion in the literature and in non-academic sources about how we may refer to those of a higher BMI. Although the literature suggests that “living with obesity” is the most up to date term, there are fat acceptance movements whereby people prefer to be described using the term “fat” rather than medicalising the experience. To manage this, it will be useful to consult with stakeholders/service-users to gain their insight alongside further research on the use of descriptive terms. Given that it is often a personal preference, there will be a brief demographic survey to complete prior to the interview, and within that it will ask the participant how they describe the young person they support’s weight status. Therefore, the researcher will check in with language at the beginning of the interview and ask their preference of how they would like me to refer to the young person they support.

- **Confidentiality:** There may be times whereby confidentiality may have to be breached if the participant discloses any significant malpractice or experiences whereby there is any risk to them or anyone else involved. To manage this, I will ensure the participant is aware of the limits of confidentiality on the information sheet and verbally before we start the interview. I will also discuss language in supervision and reflect on this throughout the interview process.

3.6. Ethics and Governance

I will need ethical approval from Lancaster University to do this research.

3.7. Patient and public involvement

Although there have been multiple attempts to involve stakeholders in the planning of this project. Unfortunately, the researcher was unable to recruit anyone within the timeframe for ethical approval. An advert has gone out to Obesity Voices however, there is no guarantee stakeholders would be interested. If I can secure an EbE to read through and provide feedback on my study materials I will seek to make an amendment to my ethical application, should there be any changes recommended.

4. Dissemination Plans

The findings will be communicated back to academics through the writing up of the thesis and hopefully with a publication in a relevant journal, alongside the presentation of the findings in final year. I hope to feed back to the charities that supported recruitment and to the participants using an accessible summary, if they request. Further dissemination may be delivered using social media.

5. Plain English Summary

Research suggests that young people living with obesity may experience stigma. Parents of these people may also experience stigma from being linked with them. Therefore, stigma may have an impact on the whole family. These experiences of stigma may lead to worse mental health. Experiencing stigma may also contribute to behaviours that influence obesity.

Therefore, this study aims to explore the experiences of stigma in caregivers of young people living with obesity. The aim is to find out what caregiver's experiences are of stigma and how stigma impacts the young person and their families. This study is original as it recognises that parents may not always be the main source of support for young people. Therefore, participants can include anyone who considers their role as significant in the young person's life. Furthermore, this study will use photographs and interviews to understand these experiences in more detail.

We hope to find between 5 and 10 participants through social media. We will use platforms such as support groups and charities to share this research. Participants will be asked to take photos which represent their experiences. They will then be asked questions about these photos. They will also be asked further questions related to the topic. The interviews will last about 30-40 minutes. They will later be written up and analysed alongside the photographs. The data will be studied to find themes across the participants. They will also find themes for each person alone.

6. References

British Psychological Society. (2019). *Psychological Perspectives on Obesity: Addressing Policy, Practice and Research Priorities.* Leicester: The British Psychological Society. https://cms.bps.org.uk/sites/default/files/2022-08/Psychological%20Perspectives%20on%20Obesity%20-%20Addressing%20Policy%2C%20Practice%2C%20and%20Research%20Priorities.pdf

Brunsden, V., & Goatcher, J. (2007). Reconfiguring photovoice for psychological research. *The Irish Journal of Psychology, 28*(1-2), 43-52 https://doi.org/10.1080/03033910.2007.10446247

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Appendix 4-B: Ethical Approval Letter

Dear Jess Doyle,
Please note that this is an automated e-mail (Please do not reply to this e-mail).
Name: Jess Doyle
Supervisor: Leanne Staniford
Department: Doctorate of Clinical Psychology
FHM **REC Reference:** FHM-2023-3742-RECR-2
Title: A Qualitative Exploration of Stigma Experienced by Young People Living with Obesity: A Caregivers Perspective
Thank you for submitting your ethics application in REAMS. The application was recommended for approval by the FHM Research Ethics Committee, and on behalf of the Committee, I can confirm that approval has been granted for this application.
As Principal Investigator/Co-Investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licences and approvals have been obtained.
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress).
- submitting any changes to your application, including in your participant facing materials (see attached amendment guidance).

Please keep a copy of this email for your records. Please contact me if you have any queries or require further information.
If you are experiencing any problems please contact your Research Ethics Officer.
Yours sincerely,
Professor Laura Machin
Chair of the Faculty of Health and Medicine Research Ethics Committee
fhmresearchsupport@lancaster.ac.uk

Appendix 4-C: Participant Information Sheet

Participant Information Sheet

A Qualitative Exploration of Stigma Experienced by Young People Living with Obesity: A Caregivers' Perspective

Name of Researchers: Jess Doyle (DClinPsy student), Dr Leanne Staniford (Researcher/Lecturer), Dr Rob Noonan (Researcher/Lecturer).

My name is Jess Doyle and I am conducting this research as a student completing a Doctorate in Clinical Psychology at Lancaster University. As part of my course, I will be conducting a study to explore the experiences of stigma towards young people living with obesity, from the perspectives of their caregivers.

What is the study about?

The purpose of this study is to explore experiences of stigma, the consequences of this stigma and the impact that these experiences may have on weight management for young people living with obesity, from the perspective of their caregivers. Stigma in this study refers to "a set of negative beliefs that a group of people have about something", and will be applied to an individual's weight.

Why have I been approached?

You have been approached because the study requires information from caregivers of young people aged 5-16 living with obesity, who have also experienced stigma. "Caregivers" refer to anyone who provides primary support to the young person such as parents, grandparents, aunties/uncles, siblings, family friends etc.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part.

What will I be asked to do if I take part?

If you decide you would like to take part, you will be expected to email me to let me know (j.doyle4@lancaster.ac.uk). I will then contact you using your preferred contact method to confirm whether you meet the criteria for the study. If you meet the criteria, you would be given this information sheet and then asked to sign a consent form.

You will be asked to **email your consent form** to me **within one week** from the date you receive the form. If I don't receive your form by this point, I will assume that you do not want to participate, and no further contact will be made from me. However, you are encouraged to contact the researcher if you require more time in making a decision and wish to discuss the study further.

After you have provided consent, we will arrange a convenient date and a time for the interview to take place. The online interview would take place via Microsoft Teams app which will be recorded with your consent (you can decide whether you want it to be a video interview or just audio).

Photo generation task

Prior to the interview taking place, you will be invited to take two photographs in your own time to represent:

1. What weight stigma means to you
2. How weight stigma makes you feel

If photos are taken in a public space, it is acceptable for you to include yourself in the photo, but for the purpose of this study we ask that you do not take photos of **any other person,** even the young person whom you support. Any photos that you do take of yourself that capture your face will be anonymised in any future publications.

Once you have taken your two photos, we would then invite you to email your two photos to me prior to the interview. Photos are not a condition of participation but will help to form a bigger picture of the research topic.

Although it is advised that you encrypt your photographs before sending them to the researcher, it is at the participant's discretion whether photos are encrypted. Encryption will ensure your data is secure when transferring it from your email to the researcher's. You can do this by putting them into a word document and adding a password to the document. You can then send this password on a separate email to the researcher. If you need any support with this, you can email the researcher to help with this j.doyle4@lancaster.ac.uk.

During the online interview, we will review your photos together and I will ask you some questions about your photos. You will also be asked some questions about the young person you support, the stigma that you/they have experienced and the impact it has had on you both. You will be provided with a debrief form afterwards.

You can withdraw from the study without giving a reason up until the point your data is anonymised and merged with other participants. You can do this by emailing me within 7 days of completing the interview, to ensure your data has not yet been anonymised and merged. If you do contact after the 7 day period, it may not be possible to withdraw your data from the study.

Will my data be identifiable?

Your contact details will be kept confidential and will be stored securely on a password-protected computer. I will be the only one with access to this information. Your contact details will only be retained if you request to be informed about the results at the end of the study (you are asked whether you would like to be contacted on the consent form). If you get in contact but decide not to participate, your contact details will be deleted after the week follow-up period.

You are advised to choose a quiet and private room during the online interview and not to have anyone overlooking or to leave your computer unlocked for a short break during the interview. Likewise, I will strictly follow the same security measures.

The online interview recordings will be stored securely and only I will have access to this data.

- Online interview recordings will be stored securely until the end of data analysis, after which, the recordings will be destroyed and/or deleted.

- The typed version of your interview will be made anonymous by removing information such as names, locations etc. and using pseudonyms. If you show your face in the photographs, these will be used within the analysis but then your face will be removed to anonymise the photo. Anonymised direct quotations from your online interview and the anonymised photos may be used in the reports or publications from the study.

- The files on the computer will be encrypted (that is no-one other than the researchers will be able to access them) and the computer itself, password protected. These will be kept by Lancaster University for 10 years. They will be destroyed at the end of this period.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this. Examples of this may be if you communicated significant risk to yourself throughout the interview or if you discussed significant professional malpractice within the interview, which would require reporting.

What will happen to the results?
The results will be summarised and reported in a thesis and may be submitted for publication in an academic or professional journal. The results will be disseminated to colleagues during the thesis presentation day.

Are there any risks?
There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?
Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?
This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher: Jess Doyle j.doyle4@lancaster.ac.uk

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Ian Smith: Tel: (01524) 592282, 07507857069
Research Director & Senior Clinical Tutor, email: i.smith@lancaster.ac.uk
Division of Clinical Psychology
Lancaster University
Lancaster
LA1 4YW.

If you wish to speak to someone outside of the DClin Doctorate Programme, you may also contact:

Dr Laura Machin Tel: +44 (0)1524 594973
Chair of FHM REC Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection.

Thank you for taking the time to read this information sheet.

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, you may contact your GP or the following resources may be of assistance:

Samaritans: A 24-hour telephone and email support for anyone who is worried, upset, or suicidal; 08457 90 90 90; email: jo@samaritans.org.

NHS Direct: a 24 hour helpline for health advice – you can call either 0845 4647 (depending on your area) or 111.
You can also use https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline to find a local crisis mental health service, relevant to your area.

Obesity UK. A website with useful resources and which signposts to different support groups relating to obesity. https://www.obesityuk.org.uk/

YoungMinds offers free confidential online and telephone advice and emotional support to anyone worried about a child or young person up to the age of 25.

- call the free parents' helpline on 0808 802 5544 from 9.30am to 4pm, Monday to Friday
- email parents@youngminds.org.uk and YoungMinds will respond within 3 working days

FamilyLives. A service providing Parenting and *family* support. It offers forums, an online chat via our live chat service, or support via email at askus@familylives.org.uk. You can also call on their helpline on 0808 800 2222 to speak to trained family support worker. There are resources regarding child weight on their website https://www.familylives.org.uk/advice/secondary/health-and-development/how-to-help-your-child-if-they-are-overweight?referer=/advice/secondary/health-and-development

Appendix 4-D: Consent Form

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CONSENT FORM

Project Title: A Qualitative Exploration of Stigma Experienced by Young People Living with Obesity: A Caregivers' Perspective

Name of Researchers: Jess Doyle (DClinPsy student), Dr Leanne Staniford (Researcher/Lecturer), Dr Rob Noonan (Researcher/Lecturer).

Email: j.doyle4@lancaster.ac.uk

Please read the following carefully:

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I withdraw within 7 days of the online interviews, my data will be removed. However if I contact the researcher after 7 days of completing the interview, my data will remain part of the study. ☐
3. I understand that taking part in the study involves taking two photographs relating to the experience and impact of stigma and participation in a subsequent online interview via Teams. ☐
4. I understand that although the photo initiation task is part of the study, I can opt-out and just participate in the interview. ☐
5. I understand that, if I choose to take part in the photograph activity, the photographs used for the study cannot contain images of any other person, including the young person I support. ☐
6. I understand that if participating in the photo-initiation task that it is my responsibility to encrypt the photos before sending them back, if I choose to do so. I understand that the researcher will provide me with instructions on how to do this and support me with this if required. I understand that once I have emailed my photographs, the researcher will store them securely on Lancaster University's secure drive. ☐
7. I understand that my online interview will be audio/video recorded and then made into an anonymised written transcript and stored securely on Lancaster University's secure drive. ☐
8. I understand that to protect my anonymity during the online interview, there is no requirement for me to show my face on screen, but the opportunity is available should I feel comfortable doing so. ☐
9. I understand that when interviewed, I can refuse to answer a question and ask to stop taking part at any time without having to give an explanation. ☐
10. I understand that any information given by me may be used in future reports, academic articles, publications or presentations by the researcher/s, but my personal information will not be included, and I will not be identifiable. ☐
11. I consent for my anonymised data including my photos to be used in future reports/ publications ☐
12. I understand that my name/my organisation's name will not appear in any reports, articles or presentation without my consent. ☐
13. I understand that any information I provide will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the researcher may need to share this information with their supervisor (Dr Leanne Staniford), or in the event of an emergency, emergency services such as the police. ☐

14. I understand that all data will be stored securely according to the University of Lancaster's guidelines for a minimum of 10 years after the end of the study. ☐

15. i) Do you wish to be contacted about the outcome of the study once it has been completed? **YES/NO**

    ii) IF YES: I understand that my contact details will be retained until the end of the study so the researcher can update me of the findings. I understand that after they have contacted me, my contact details will be deleted. ☐

16. I agree to take part in the above study. ☐

Name of participant:	**Date:**	**Signature:**

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Signature of Researcher/person taking the consent ______________________________

Date ____________________ DD/MM/YYYY

One copy of this form will be given to the participant and the original kept in the files of the researcher at Lancaster University

Appendix 4-E: Interview Schedule and Demographic Questions

Photovoice and Interview Schedule

Section One- Expectations and consent

Purpose and outline of today- Thank you so much for attending today's interview. The purpose of the interview is to understand more about stigma in young people living with obesity. We are hoping to understand this from a caregiver's perspective to understand the wider impact it may have to the young person and their support system. We are really keen to hear your perceptions and experiences on this. However, if there are any questions you do not wish to talk about, that is completely fine and you can refuse to answer any questions. There are two parts to this task, one where we will look at the photographs you have taken and I will ask you questions on these, and then from that we will proceed with the general interview. We expect this interview may take 30-40 minutes and you will be offered a break in between.

Confidentiality – This interview will remain confidential between ourselves and the two researchers involved in this project. However, confidentiality may have to be breached if there are any concerns raised in this interview such as risk to yourself or any risk to/from someone else. If there is anything that seems concerning, I may have to contact the appropriate professionals to escalate this.

Do you have any questions or concerns about this or any other aspect of the interview before we proceed?

Are you still happy/ feel able to go ahead with today's interview?

Section Two- Getting to know you

Before we complete the interview, I would like to ask you some questions about you and the young person you support. Please could you answer the following questions to the best of your knowledge and if you do not wish to answer specific questions that is fine.

Gender:
Age:
How would you describe your ethnicity?
In what region do you live? What is your postcode? (we use this to calculate a deprivation score- once the deprivation score is worked out, this will be deleted)
What is the highest level of education you have completed? E.g. post grad, university, GCSEs etc
What is your current employment status?
What is your height and weight?
If you do not know your height and weight, how would you describe your weight status?

Section Three- Getting to know the young person

What is their first name?
What is their gender?
What is your relation to them?
How old are they?
Could you provide an estimate of their weight and height?
How would you describe their weight status?

Can you tell me a bit about the young person you support?

- What do you like to do together? (anything you have done recently?)
- What are their hobbies/interests?
- What are they like to be around?
- What is your relationship like?

Section Four- Photo Initiation task

When you agreed to take part in this study, we asked whether you could take two photographs to represent the following:

1. What weight stigma means to you
2. The impact of weight stigma

Prompts for each photograph
SHOWED questions to discuss images
S… What do you SEE here?
H… What's really HAPPENING here?
O… How does this relate to OUR lives?
W…WHY does this problem or situation exist?
E… How could this image EDUCATE others (the community, policy makers, etc.)?
D… What can we DO about the problem or situation?

Section Five- Interview about stigma (for YP, participant, impact)

1. **Can you tell me a bit about the YP's journey with their weight?**

- Can you tell me a bit about their journey with their weight?
- Can you tell me a bit about your role in their weight journey?
- How have they experienced this journey with their weight?

2. **Can you tell me about any stigma the young person you support has experienced?**

- Has anyone close to you ever said anything about the YP's weight? If yes, what do they say? How do you feel when they say these things?
- Have any medical professionals ever said anything about the YP's weight? If yes, what types of things have they said to you about their weight? How did you feel when they said these things?
- Has any other adult ever said anything about the YPs weight? If yes, what have they said? How does that make you feel?
- Have there been any indirect experiences of stigma?
- What are the drives to weight stigma?

3. **Can you tell me about your experiences of stigma in relation to the YPs weight?**

- Has anyone similar to the above ever said anything to you about the Yp's weight?
- Have you had any indirect experiences of stigma?
- Some people think that caregivers are to blame when a child is overweight. How does that make you feel?
- Do you think that other people blame you for the YP's weight?
- What makes you think that?
- What are the drives to your experience of weight stigma?

- **How has experiencing weight stigma impacted the young person you support?**
- Mental health?
- School?
- Friendships?
- Family?
- Eating behaviours?

4. **How have these experiences impacted the relationship you have with the YP?**

5. **How have these experiences impacted you?**

- Mental health?
- Work?
- Friendships?
- Family?
- Eating behaviours?

6. **How have these experiences impacted yours or the YP's perspective on weight management?**

Appendix 4-F: Recruitment Poster

Have you experienced stigma due to your child's weight?

Have your say!
and earn £10 for your time

Who can take part?

Parents or caregivers of young people who:

- are aged **5-16**
- are considered as **over their ideal weight** (either through self-report or through their BMI being highlighted in school or healthcare)

What will I need to do?

- Take a couple of photos representing what stigma means to you
- Take part in a 30 minute online interview to discuss the photos you took and your experiences of weight stigma

How do I get involved?

Please email
j.doyle4@lancaster.ac.uk

Appendix 4-G: Participant Debrief Sheet

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Participant Debrief Form

A Qualitative Exploration of Stigma Experienced by Young People Living with Obesity: A Caregivers' Perspective

Researchers: Jess Doyle (DClinPsy Student), Dr Leanne Staniford (Researcher/ Lecturer), Dr Rob Noonan (Researcher/ Lecturer)

Thank you for taking the time to take part in this research project.

The research project aimed to explore experiences of stigma, the consequences of this stigma and the impact that these experiences may have on weight management for young people living with obesity, from the perspective of their caregivers.

If you would like any further information about this research project or would like to be informed of the results, then please feel free to get in touch with me at j.doyle4@lancaster.ac.uk

If you wish to withdraw, please inform the researcher within 7 days after participating in the online interview. As mentioned on the information sheet, we cannot withdraw data once it has been anonymised and merged with other participants.

If any of the issues in this study were distressing and you feel you need additional support, please contact your GP and/or one of the organisations below for help:

Samaritans: A 24-hour telephone and email support for anyone who is worried, upset, or suicidal; 08457 90 90 90; email: jo@samaritans.org.

NHS Direct: a 24 hour helpline for health advice – you can call either 0845 4647 (depending on your area) or 111.
You can also use https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline to find a local crisis service, relevant to your area.

Obesity UK. A website with useful resources and which signposts to different support groups relating to obesity. https://www.obesityuk.org.uk/

YoungMinds offers free confidential online and telephone advice and emotional support to anyone worried about a child or young person up to the age of 25.

- call the free parents' helpline on 0808 802 5544 from 9.30am to 4pm, Monday to Friday
- email parents@youngminds.org.uk and YoungMinds will respond within 3 working days

FamilyLives. A service providing Parenting and *family* support. It offers forums, an online chat via our live chat service, or support via email at askus@familylives.org.uk. You can also call on their helpline on 0808 800 2222 to speak to trained family support worker. There are resources regarding child weight on their website https://www.familylives.org.uk

Concerns about Malpractice

If the content of this interview has made you consider a health professional's practice you can contact the following organisations for further guidance:

Patient Advice and Liaison Service (PALS): specific to NHS professionals https://www.nhs.uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service/

General Medical Council- specific to doctors in the UK. You can contact 0161 923 6602 to discuss concerns further.

Citizens Advice Bureau- can be a great source of advice and support if you want to complain about the NHS, social services or local authorities.

You can find your local Citizens Advice Bureau on its website: www.citizensadvice.org.uk

Thank you again for your participation!

Appendix 4-H: Distress Protocol

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Distress

- Participant indicates distress within interview
- OR
- Exhibits behaviours suggestive of distress within the interview such as shaking or crying.

Stage 1 Response

- Stop the interview/discussion
- Allow time to recuperate or regulate emotions
- Assess mental state to determine whether emotional response is beyond what may be expected within an interview regarding a sensitive topic

Review

- If participants feels able to continue; resume interview
- If participant is unable to continue; go to stage 2

Stage 2 Response

- Stop recording online interview
- Ask if participant would like to call someone for support (GP, a friend or relative, a crisis service)
- Provide participant with relevant crisis services as well as support services relevant to their difficulties
- The researcher can also offer, with participant consent, for a member of the research team to contact services on their behalf
- If in imminent danger, the researcher can do this without consent from the individual if their is a serious risk to their safety

Follow up

- If the participant consents, follow up with a courtesy call

List of services

General crisis services

Samaritans: A 24-hour telephone and email support for anyone who is worried, upset, or suicidal; 08457 90 90 90; email: jo@samaritans.org.

NHS Direct: a 24 hour helpline for health advice – you can call either 0845 4647 (depending on your area) or 111.
You can also use https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline to find a local crisis mental health service, relevant to your area.

Specific for obesity support/ young person mental health

Obesity UK. A website with useful resources and which signposts to different support groups relating to obesity. https://www.obesityuk.org.uk/.

YoungMinds offers free confidential online and telephone advice and emotional support to anyone worried about a child or young person up to the age of 25.

- call the free parents' helpline on 0808 802 5544 from 9.30am to 4pm, Monday to Friday
- email parents@youngminds.org.uk and YoungMinds will respond within 3 working days

https://www.youngminds.org.uk/

FamilyLives. A service providing Parenting and *family* support. It offers forums, an online chat via our live chat service, or support via email at askus@familylives.org.uk. You can also call on their helpline on 0808 800 2222 to speak to trained family support worker. There are resources regarding child weight on their website https://www.familylives.org.uk/advice/secondary/health-and-development/how-to-help-your-child-if-they-are-overweight?referer=/advice/secondary/health-and-development