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# Listening to children's voices in qualitative health research

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## Abstract

There is good deal of concern about the health of contemporary children particularly in terms of physical activity levels and nutrition behaviours. However, it is noteworthy that children's voices have been conspicuously absent within the decision making process associated with adult solutions to such perceived 'problems'. This paper utilises qualitative research to listen to children's voices in health research. Through rich descriptive narrative from children aged between 5 and 12 it provides a comprehensive understanding of the contemporary issues around physical activity, nutrition and the broader constructs of health among children. It also highlights the importance of using children's voices in qualitative research. It has been identified recently that the 'narrative turn' in qualitative research is now upon us. Bearing this in mind, the narrative should not be perceived as being the privilege of adolescence and beyond. This paper provides evidence that seeking and attaining rich descriptive narrative from children in early childhood and childhood is possible using the appropriate research methodology.

# Introduction

## *Listening to children's voices*

Children's constructions of health and what they perceive to be 'good nutrition' and 'good nutritional practices' differ considerably from one child to another depending on their life experiences. Varying factors may include socioeconomic status, living situation (dual or single parent household) and parents' level of education, which may influence a child's level of health literacy. Accessing children's voices through in-depth interviews around notions of health and appropriate nutrition assists researchers and health educators to develop an understanding of how children construct particular ideologies where health and nutrition are concerned. As this paper will identify, children's voices present a unique looking glass through which we can view broad aspects of health and nutrition, and provide important insights into factors that are perpetuated from one generation to another (Golan & Crow 2004; Wilson, Musham & McLellan 2004).

There is a significant body of knowledge pertaining to children's health, diet and physical activity. Childhood obesity and inactivity have become the focus of news media stories, government policy (Federal and State) and, if it is not too strong a term – 'community outrage'. Amos Hatch (1995) asserts that the plethora of research on children stems from a belief that working with children will have long-term benefits, and 'fix' society in general. However, while there is a great deal of research *on* children, there is very little that seeks to present their point of view, especially that of young children (Amos Hatch 1995; Darbyshire, Schiller & MacDougall 2005). Typically, research about children's health is presented through the lens of adult perceptions (Scott 2000).

Luus and Wells (1992) claim there exists an ideology within the research community that views children as less able to provide credible information than adults, possessing underdeveloped communicative and cognitive abilities (Smolak 2004; Spencer & Flin 1993). These perceived inadequacies are claimed to manifest as deficiencies in the reliability of children's memories, and a tendency to make egocentric judgments and exhibit suggestibility in their responses (Birbeck & Drummond 2005; Luus & Wells 1992). As a consequence, data collected from children is rendered less valuable in terms of its validity (Amos Hatch 1995).

Objective, empirical evidence suggests that if one engages children in research appropriately, they are able to make a significant contribution (Amos Hatch 1995; Scott 2000; Spencer & Flin 1993). However, it is important to recognise the need to adapt adult-centric methodologies in order to support the abilities of children if seeking to engage them in the research process (Darbyshire, Schiller & MacDougall 2005; Flin et al. 1992). Spencer and Flin (1993) conclude that, provided they are engaged in the information-gathering process appropriately, children should be regarded as competent research participants, with perceptions and thoughts of merit.

Children have the capacity to provide important information about their lives, particularly with respect to their eating habits and activities (Darbyshire et al. 2005).

Further, children can participate as research partners in meaningful ways if provided with an environment in which they feel safe, supported and valued (Amos Hatch 1995; Spencer & Flin 1993). It is also important to ascertain the reasons behind the responses children provide. This can be extremely difficult, as there is an ever-present danger that an adult researcher may assume understanding based on her/his own version of 'what makes sense' (Birbeck & Drummond 2005). Children report on what they see as important, which is not always congruent with adult interpretations (Luus & Wells 1992).

## *Understanding children's health*

Darbyshire, MacDougall and Schiller (2005) identify that in Australia, and internationally, children are becoming less fit and more obese. They claim that as activity is important for children's emotional and social health, one might expect that a decline in children's physical health status could lead to a corresponding decline in their emotional and social health (Darbyshire et al. 2005).

A significant body of knowledge exists dedicated to the importance of children's physical, emotional and social wellbeing and health. This body of knowledge is largely uncontested in the sense that there is a general acceptance that the health status of children has markedly diminished in the previous decade, particularly in relation to physical activity (Drummond, et al, 2008). What has not been contested to the same extent is the emphasis on health status as overwhelmingly being limited to physical health. Further, the voices of children as active participants in their own health are also missing (Birbeck and Drummond, 2005).

As an individual, one is taught that to be accepted by society, one must uphold the values of that society (Hesse-Biber 1996). Food industries, through advertising, instruct us to eat with little regard for health, and yet the exercise/health industries ask us to ration our consumption and slim down (Hancock et al. 2000a; Hesse-Biber 1996; O'Dea 1995). In addition to these competing agendas, individuals are encouraged to compare their bodies against the idealistic images portrayed in magazines and other media (Faludi 1999; Hesse-Biber 1996). This situation is exacerbated by the powerful and repetitive message of educational and health organisations: *if you exercise and lose weight you will feel better about yourself* (Hancock et al. 2000b; Hesse-Biber 1996). Too often we are quick to blame individuals for not adhering to health and nutrition messages, yet these messages are far from clear.

The American Academy of Pediatrics (2001) attributes the worsening health status of the general American society to a lack of activity and an increase in sedentary behaviours, particularly an increase in television viewing. Olds, Ridley and Dollman (2006) concur by claiming that excessive 'screen time', including television viewing, has been associated with a range of psychosocial disturbances and increasing pediatric obesity.

Burgard (2005) problematises the simplistic nature of examining body mass index (BMI) to determine health status by recognising the individual differences

between people, and contests the relationship between poor health and being slightly overweight**.** O'Dea (2004b), to an extent, supports the need for caution in this area of research, noting the relationship between extreme dieting cycles and adverse health consequences among people that have been diagnosed as overweight/obese.

Wilson, Musham & McLellan (2004) and Ogle & Damhorst (2003) assert a maternal relationship between dietary influences and health status for mothers and daughters, and attribute this to the cultural and familial influences within a family. Birbeck and Drummond (2006), in their study of body image with pre-pubescent boys and girls, evidenced some support for this conclusion. They found that children in their study cohort were aware of the dieting behaviours of their mothers and fathers. Further, not only were they aware, but they were able to communicate that they understood that losing weight was the purpose of dieting and being thinner was the desired goal.

One can find in the literature discourses regarding inactivity, poor diet, social pressures to conform, the role of the media – particularly television and magazines, pressures associated with schooling, lack of public play spaces, and parental concerns of children's safety. Some discourses argue that children in Western societies are becoming more obese despite pressure to be thin (O'Dea 2004a; Burgard 2005).

There is extensive literature reporting on studies of children's wellbeing by health professionals. Absent from this literature are the voices of the children themselves; the majority of studies in this area are *about* children and *on* children, but rarely *include* children. In contrast to the dominant adult discussions about children's health, this paper seeks to present the voices and opinions of children, some as young as five years of age, with as little adult interpretation as possible.

## Research and methodology

The data in this paper emerges from two separate research projects. However, the research methods in terms of participant cohort, data collection and analyses were identical. Both projects were established to develop a sense of understanding of how children construct their knowledge of health, using nutrition and physical activity as key points of discussion. Using familiar topics of discussion was crucial for the younger, early childhood cohort, enabling this group to focus on specific elements of health. Requiring the children to limit their memory recall to several points of focus around nutrition and physical activity enhanced the reliability of the data. Similarly, suggestibility was limited given that discussion was focused upon socially endorsed topics about which children were likely to have opinions.

For both research projects, ethics approval was obtained from The University of South Australia and the Department of Education and Children's Services (DECS) to undertake focus group interviews with children in South Australian Primary schools. Participating schools were selected from the inner and outer Adelaide metropolitan areas, thereby providing a mixture of sociodemographics.

Children were interviewed in focus groups of between 4–6 children per group. Given their age, the researcher felt it imperative that the children were interviewed with enough of their peers to feel supported, yet not in such a large group that they didn't feel comfortable to engage in free and open speech. While Patton (2002, pp. 385) states "the focus group interview is, first and foremost, an interview" he goes on to claim that it is *an interview* whereby each participant has the opportunity to hear others' views and opinions, thus establishing the most important issues for that group. Fontana and Frey (2000, p. 651) concur by claiming that the focus group interview is a technique for gathering rich, descriptive qualitative data in a systematic manner that "straddles the line between formal and informal interviewing". Finally, as Patton (2002, p. 386) aptly states, the object of the focus group "is to get high-quality data in a social context where people can consider their own views in the context of the views of others". In the current study, the interviewing techniques adopted successfully elicited open discussion around specific aspects of nutrition, physical activity and health, despite the fact that some of the participants were only 5–6 years of age.

The interviews lasted anywhere between 20 minutes for some of the early childhood cohort, to an hour with the students around 11–12 years of age. An interview guide was used in each of the focus group sessions, to assist the interviewer to adopt a specific line of enquiry. However, a phenomenological interviewing approach was taken in so far as the children's responses were further questioned and "teased out" to ensure that all aspects were fully explored. The interview guide was used to bring the interview back to a specific focus to ensure that all children were posed the same core questions, thereby enhancing research reliability. The interview guide was constructed through knowledge and awareness of contemporary literature in the area, as well as the researchers' extensive backgrounds in the field.

## Discussion: Themes

Data from the early childhood (5–8 years) and childhood (9–12 years) participants were analysed separately, to account for different levels of conceptualisation around health, nutrition and physical activity among the two age cohorts. Clearly, as the children move from early childhood into the childhood phase, their constructions of notions of health, along with their discourse, become increasingly sophisticated, elaborate and reflective. However, the voices of the younger children must also be taken into account if a well-rounded perspective is to emerge within the debate surrounding children's understandings of nutrition and physical activity in the context of health**.** Some of the themes to emerge amongst the two age groups were similar, despite significant differences in the discourse and how the children conceptualised them. Other themes were dissimilar. In the following sections, the dominant themes that emerged from the data for both age groups are identified and highlighted using rich descriptive quotes from the children.

### *Early childhood notions of health*

All the children interviewed, irrespective of age, had opinions about 'health'. Food and health appeared to be synonymous for the children in early childhood. When

invited to comment on "what is health?" unquestionably the majority of children expressed "it's food". When further questioned as to which types of foods they associated with health, the children typically identified apples, bananas, vegetables and salad. Even when the children related elements such as 'body strength' and 'getting stronger' to health, discussion inevitably implied food as being essential to those elements as well. For example, one boy claimed that:

> If you eat carrots it's good for your eyes, and you can see better and you could get strong.

Notions of health, and non-health, seemingly pervade much of contemporary Western culture through such outlets as television, radio and print media, as well as the internet. Children are susceptible to absorbing this broadcasted information, which often highlights the dire consequences of being overweight/obese, as well as discourse surrounding attempts to provide salient solutions to these oft-referred 'contemporary lifestyle diseases'. While it is arguable that very young childhood are at least picking up on the information they are exposed to, there is less evidence to suggest that they understand it and hence act on it. The following line of enquiry reflects some of the typical discourse surrounding nutrition and health in early childhood.

Q: What about you Tegan, what have you got in your lunch?

A1: I've got a sandwich with something on it. I don't know what it's called on it.

Q: And what would you love to have, what would you choose?

A1: The sandwich first and then other stuff.

Q: What other stuff?

A1: Mini custard, a packet of chips and that sort of stuff.

Q: What about you Will?

A2: I don't know what I have.

Q: What would you like to have?

A2: I'd like to have a lunch order.

Q: And what would you have in your lunch order?

A2: I'd have chips and chicken nuggets.

Q: What about you Josh?

A3: In my lunch box today I've got chips, fruit cup and Nutella sandwich, and a pear.

Q: What would you like to have in there if you choose?

A3: I'd like to have chocolate, biscuits and little dip-in teddies, they go in chocolate.

Importantly it must be noted that each of these children identified in earlier discussion that their favourite foods were cauliflower, bananas, apples, oranges and meat. Therefore it is arguable that while these children have heard the information around them highlighting the importance of 'good' nutrition, what they want is somewhat different and in opposition to their earlier claims.

The early childhood group appeared to have a very good understanding of the links between physical activity and health in so far as "physical activity and sport are good for you" (sport was a term used interchangeably with physical activity). It is this simplistic notion of the physical activity/health nexus that needs further exploration and analyses. Almost all of those in the early childhood cohort identified something akin to the concept of "sport and physical activity equals health". The problem once again is whether these children truly understand the relationship and act to implement physical activity in their lives based on this understanding, or whether the physical activity they currently undertake is simply a result of being very young children, who tend to engage in exploring body movements and space on a regular basis (Darbyshsire et al. 2005). Nevertheless, these young children were inextricably linking health to physical activity and sport, as the following representative discussion clearly emphasises:

Q: So what do you think healthy means?

A1: Like running.

A2: When I'm 7 I'm going to do basketball.

Q: Are you? That's fantastic. Do you do sports here at school?

A1: No we only do on sports day.

Q: Do you do any sports during the day?

A1: Yeah, we were running in the hall before.

A2: Yeah, we were playing over and under.

A3: Tennis.

Q: You play tennis?

A4: Yeah, cricket.

A1: I like to play cricket.

A2: Soccer

Q: What about running in the schoolyard?

A1: Yeah.

A4: I play basketball, that's running. You have to run.

A4: Walking is also healthy.

Q: Do you walk your dog?

A4: That's healthy.

A2: I wouldn't want to walk my dog. He's too big. He would growl at everyone.

## *"Water is healthy"*

Across the entire age spectrum and in every focus group, the importance of drinking water was addressed and closely aligned with the notion of health. A high proportion of schools involved in this research allowed students to have a water bottle alongside them at their table during class time, thereby constantly reinforcing the significance of hydration and normalising this important aspect of physical

functioning. The following extract from a discussion is representative of the type of conversation in the majority of focus groups.

Q: Some of you are mentioning drinks, who's mentioned drinks, what sort of things do you drink at home?

A1: I drink water.

Q: You drink water?

A1: We need to drink water.

A2: I've never drank big drinks of water.

A1: I forgot to say that.

A3: Water is healthy.

Q: Who knows anything about water?

A1: Me.

A4: Water is healthy.

Q: Do you drink water too?

A4: Yes.

A1: Yeah, at school I drink water, and in my lunch box I have fruit juice.

Q: So how much water do you drink?

A2: I drink 3 glasses a day.

Q: What about you Taylor?

A4: I drink 5 and 6.

Q: What about you there James, because you brought water up.

A1: 6.

Q: What about you Luke, how much water do you drink?

A5: I drink 100.

Q: What about you Tom?

A3: I have drunken 5 million thousand.

Q: Wow, that's a lot.

It appeared most of the older children, as expected, had a better understanding than the younger cohorts of the importance of water in terms of physical hydration, particularly where sport is concerned. As with the young children, the practice of keeping water bottles at their desks reinforced the notion that water, through the practice of hydration, is important for health, providing tangible physical benefits. The following commentary is from a year 6 class but was also typical of older class groups:

A1: After we get into class, at least 10 people have got water bottles on their desk, because we're only allowed to have drink bottles on our desk if it's filled with water. And everyone, basically everyone brings like, even an orange to eat, and apple, a slice of cheese or something like that.

Q: So what do you guys drink?

A1: I drink water most of the time, because I play like state soccer and that, and our coach tells us before training, he wants to see like, he wants to hear us ask to go to the toilet, so he knows that we've got our fluids up, and we keep our fluids into us.

Q: That's pretty out there. How do you like your class, because you didn't sort of get a chance to say what you were thinking?

Q: How much do you drink?

A2: I try to drink the, like some days I drink way over 6 glasses, and some days like, I feel a bit blah, and I don't have that much to drink.

Q: So do you drink anything else?

A2: Every now and then I'll have like that much coke or something. But like, when we have takeaway one night a month or something, I have a little of coke then.

A3: I know that I normally drink about 2 litres of water.

Q: A day?

A: A day.

Q: Wow.

A3: Because I'm also training up to go do the City to Bay (12km fun run) next year.

Q: That's why, yeah, that makes sense.

A3: And I have to admit, every now and again, I have some cordial in a bottle, and I barely ever have fizzy with my parents.

From a health educator's perspective, this commentary on the significance of water to these children is important to understanding their notions of health. That water has become a metaphor for health for these children may positively influence their consumption in the future.

## *TV/health: who's the Biggest Loser?*

Television plays a significant role in the construction of children's notions of health. A number of children in the early childhood cohort of this research, as young as five years of age, had television sets in their room to use at their own discretion. The numbers of children with personal television sets incrementally rose as the children moved towards year 7, around the age of 12. Not only does having a television in one's room send a message, through parental endorsement, that television viewing is to be encouraged as a passive pastime, but this practice means parents lose the capacity to supervise the programs being viewed by their children, along with the opportunity to discuss and explain events that present throughout the programs. This is arguably where a problem may arise.

Both early childhood and older students commented that programs such as 'The Biggest Loser' provide them with health information. The Biggest Loser is a 'reality-based' television program in which clinically obese individuals are pitted against one another in competing to lose the most weight. They must also participate in a series of challenges such as rigorous 'boot camp' exercises, as well as food challenges in which the contestants must make a decision to eat or abstain from a food, with the possibility of being voted off the program should they choose

inappropriately. The show has become a ratings success and its screening time of 7pm weeknights provides the ideal opportunity for young children to view it prior to going to bed. While it is possible to argue that there may be an element of health information within such programs, there are countless other aspects that require discussion with parents to ensure the children do not take away inappropriate messages relating to health whilst viewing. For example, the manner in which the physical bodies of the 'contestants' are derided and openly humiliated could have severe ramifications for large children watching the program. The program may also reinforce the cultural ideal of 'thin-looking' bodies being more socially acceptable than larger bodies, thereby perpetuating the thin = beauty myth. As one student claimed in response to her own dietary regime, "I don't like 'veggies' but they're good for you and I don't want to like, go on The Biggest Loser or anything".

Regardless of not wanting to appear on The Biggest Loser, there was a consensus among many students that, "I like The Biggest Loser". The fact that a program based on humiliation around individuals' weight is such a ratings success, and pervades the viewing practices of many Australian households, is alarming and requires a much more detailed assessment in terms of its normalising effect upon children. We have yet to see the influence of the current generation of The Biggest Loser viewers from early childhood through to adolescence and beyond – that is still a few years away. Certainly, immediate analysis is required.

While not all children in the current study claimed to watch The Biggest Loser every night, television did play a key role in providing aspects of health information to children of all ages in this research. Some of the information provided did have benefits, while other aspects of television could conceivably have negative effects if not accompanied by discussion with an informed adult. However, it was noted that some of the children did learn about cooking and healthy eating through specific nutrition-based programs, as evident in the following discussion:

Q: What about TV: Do you learn healthy things from TV?

A1: Oh, yeah.

A2: And books.

Q: And books? That's good.

A1: I watch the cooking shows.

A2: So do I.

A3: I never do.

A2: Yeah, 'Planet Cook'.

A4: I watch 'Ready, Set, Cook'. That's a really cool show and helps you learn how to cook stuff and eat healthy.

While these programs inspire children with ideas to think about and explore a variety of food options in the form of recipes, the food cooked is not necessarily healthy. Presenters sometimes create recipes with high fat, sugar and salt contents without any explanation or discussion. To suggest that these shows are health-oriented is misleading. However, in considering from a more rational perspective whether it is appropriate to allow children to watch such programs, these shows do

open children's (and possibly some parents') minds to embrace change where food and nutrition is concerned. The alternative is watching cartoons, where characters such as Homer Simpson normalise devouring excessive amounts of pizzas, hamburgers and donuts on a regular basis. An entire paper can be devoted to exploring the meaning of Homer Simpson's dietary patterns to children. That will come.

## Conclusion

This paper has attempted to highlight the importance of listening to children's voices where aspects of health are concerned. Irrespective of age, the perspectives of children can provide a salient basis for making recommendations, directing further exploration and constructing ideologies. Too often we are quick to dismiss children's voices, and in particular young children's voices, in qualitative research based on the misconception that what they have to say is not as important as older children, adolescents and adults. Clearly, as this research indicates, children's voices and perspectives can be captured in a rigorous manner given age-appropriate interviewing methodologies. Specifically where health is concerned, for both age cohorts in this study (early childhood and childhood), themes and issues were clearly articulated and consistently identifiable across a large number of focus groups. This provides evidence that, with consistent and rigorous research methods, reliable and valid data is attainable amongst all age cohorts of children from early childhood onwards.

Knowing where children of all ages attain their health information is crucial in contemporary Western society, with its rapidly evolving communication culture. How these children then interpret that information they are exposed to, and construct their notions of health, should be a serious consideration if health practitioners wish to stay abreast of practical means of health promotion and education where these age cohorts are concerned, and should inform future models of best practice. Surely we must base the needs of children regarding health promotion on what they think and say as a priority – otherwise we are not engaging in informed practice.

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