

## DEBATE

# Obesity, stigma and public health planning

**LYNNE MACLEAN<sup>1\*</sup>, NANCY EDWARDS<sup>2</sup>, MICHAEL GARRARD<sup>5</sup>,  
NICKI SIMS-JONES<sup>5</sup>, KATHRYN CLINTON<sup>3</sup> and LISA ASHLEY<sup>4</sup>**

<sup>1</sup>Community Health Research Unit, <sup>2</sup>Nursing, Epidemiology and Community Medicine, Community Health Research Unit, <sup>3</sup>Institute of Population Health, Community Health Research Unit and

<sup>4</sup>Community Health Research Unit, School of Nursing, Nursing Best Practice Research Unit, Canadian Nurses Association, University of Ottawa, Ottawa, Canada and <sup>5</sup>Maternal Child Health Program, First Nations and Inuit Health Branch, Health Canada, Canada

\*Corresponding author. E-mail: lynne.maclean@uottawa.ca

---

### SUMMARY

*Given the rise in obesity rates in North America, concerns about obesity-related costs to the health care system are being stressed in both the popular media and the scientific literature. With such constant calls to action, care must be taken not to increase stigmatization of obese people, particularly of children. While there is much written about stigma and how it is exacerbated, there are few guidelines for public health managers and*

*practitioners who are attempting to design and implement obesity prevention programs that minimize stigma. We examine stigmatization of obese people and the consequences of this social process, and discuss how stigma is manifest in health service provision. We give suggestions for designing non-stigmatizing obesity prevention public health programs. Implications for practice and policy are discussed.*

**Key words:** obesity; stigma; public health planning

---

### INTRODUCTION

According to many, an obesity epidemic has taken hold in North America. Concerns about obesity-related costs to the health care system are being stressed in both the popular media and the scientific literature. However, calls to action (Brownell, 2005; Saguy and Riley, 2005) may potentially increase stigmatization of obese people. While there is much written about stigma and how it is exacerbated, there are few guidelines for public health managers and practitioners who are attempting to design and implement obesity prevention programs that minimize stigma.

In this paper, we will examine stigmatization of obese people and the consequences of this social process, and discuss how stigma is manifest in health service provision. We then discuss

approaches for designing non-stigmatizing obesity prevention public health programs.

### BACKGROUND: OBESITY, STIGMA AND PUBLIC HEALTH INTERVENTION

#### Stigma and its effects on health

Stigma links individuals to a negative stereotype, one that leads others to discount them, seeing them as tainted or shameful (Goffman, 1963). Groups holding a stigma have been the victims of prejudice and discrimination which 'are believed to be important contributors to the production of health disparities' (Stuber *et al.*, 2008, p. 351). Stigmatized conditions may be associated with other forms of marginalization, such as poverty, disability, racial or cultural discrimination resulting in the experience of

layered stigma (Mill *et al.*, 2007). Green distinguished between enacted stigma that is discriminatory behaviour and sanctions at individual and collective levels; and felt stigma, that is the fear of enacted stigma (Green, 1995). Felt stigma may result in avoidance of health care environments and providers.

For people with stigmatized conditions, stress from anticipating hostile reactions in others exists independent of the reaction, and they carry that stress with them internally, persisting as chronic stress. Stigma can also be internalized and its messages become part of the person's self concept. It has been suggested that children are especially vulnerable to this impact. Such internalized oppression has been linked to ultimately constricted social networks, compromised quality of life, poor self-esteem, depression, unemployment and income loss and poor health outcomes (Stuber *et al.*, 2008).

### Obesity and stigma

It is generally agreed that being obese, or even being overweight, is a highly stigmatized condition. There is a considerable discussion in the literature on the stigma of obesity and the way that obese people are treated in western society, from childhood teasing and bullying (Vaidya, 2006), avoidance by others (Latner and Schwartz, 2005), discriminatory hiring practices (Stuber *et al.*, 2008) and misplaced humour (Brownell, 2005). Rogge *et al.* used the term 'civilized oppression' to describe the pervasive pattern of ongoing, daily denigration and condemnation that constitutes living as an obese person (Rogge *et al.*, 2004).

Stigma may worsen obesity through dynamics such as fear of going out, fear of ridicule while exercising, cycles of emotional eating and the development of eating disorders (Schwartz and Brownell, 2007). Further, stigmatization is correlated with significant health problems such as depression, hypertension, coronary heart disease and stroke (Major and O'Brien, 2005; Stuber *et al.*, 2008). Thus, stigma itself may independently contribute to the health risks associated with obesity.

### How health programs and services become stigmatizing

Stigmatizing beliefs about obesity are pervasive, and their influence on the emphasis of health

service programs strong, despite flawed attributions about obesity characteristics and causes. For example, although 'one simply cannot explain high rates of obesity by biology or by positing a systematic, worldwide decline in [personal] responsibility' (Brownell, 2005, p. 960), there remains a heavy emphasis on behavioural (lifestyle) approaches to obesity prevention both in health sciences curricula and in health service programs. These approaches focus on the individual as the locus for change, making the client's personal responsibility for all aspects of their situation, as opposed to more environmental or socio-ecological approaches. Health practitioners are exposed to the same stigmatizing beliefs about obesity as the general public and this influences their approach to care. Fabricatore *et al.* detailed decades of biased behaviours and attitudes about obesity among physicians, nurses and nutritionists, along with inaccurate knowledge about its causes and effects (Fabricatore *et al.*, 2005). Examples include overestimation of the actual caloric intake of the majority of obese people (Robinson and Bacon, 1996); lack of awareness of the metabolic and other biologic functions which predispose and perpetuate obesity (Friedman, 2004; Vaidya, 2006); and 'anachronistic preconceptions' (Friedman, 2004, p.563) that weight is easily controlled through decisions at the individual level to exercise more and eat less, despite findings that show very little long-term success for any treatment approach focusing on individually focused 'boot-strap' approaches (Szwarc, 2004–2005).

As a health construct, being obese has often been framed as a risky behaviour with poor lifestyle choices, whereas being thin has often been framed as a product of good lifestyle choices (Saguy and Riley, 2005). The professional training of health providers and obesity researchers have led to expectations that, while it may be challenging to exercise and eat well under difficult environmental conditions such as poverty and living in high crime areas, losing weight is essentially about self-discipline and focus. Thus, the emphasis of many obesity prevention programs has been individual behaviour changes rather than structural changes in social and physical environments (Saguy and Riley, 2005).

Beyond the modification of medical office equipment to meet the needs of larger patients, both the stigmatizing effect of current medical language and the pathologization of 'fatness' may lead to strong negative responses by

patients (Saguy and Riley, 2005). Stigmatized care provider attitudes are picked up by patients, and in the case of children, by their parents (Edmunds, 2005).

Direct clinical interventions are not the only channels for stigma. Mass media reporting of research findings and broad-based public health interventions can have an impact. According to Saguy and Riley (Saguy and Riley, 2005), 'medical research on obesity has ballooned since 1995 and has preceded a subsequent increase in mass media reporting on obesity' (p.875). Similarly, obesity prevention initiatives for children often inappropriately label large numbers of children as overweight or 'fat' (Szwarc, 2004–2005). Such initiatives may 'result in unprecedented levels of body hatred, unhealthy and inappropriate weight loss attempts, fears of food, increased susceptibility to media messages, eating disorders, nutritional deficits, and weight discrimination' (Szwarc, 2004–2005, p.97).

Recent public marketing campaigns to 'denormalize' tobacco use through legislation, taxes and fines have led some researchers to debate whether the benefits of a mildly stigmatizing approach, in moderated degrees, might outweigh its negative impacts (Bayer, 2008). However, we would agree with Burris (Burris, 2008) that this approach crosses the line from positive public health into stigmatization and is both unkind and ineffective '...stigma is a barbaric form of social control that relies upon primitive and destructive emotions. And chances are it won't work anyway' (p.475). There is little evidence that stigma works, or works any better than positive approaches, such as, in the case of drunk driving, systematic law enforcement (Burris, 2008). He suggests that '...rather than asking whether the amount of shame is proportionate to the risk, the ethical practitioner is watching for any sign that people who smoke are becoming a pariah group, are being stereotyped, are suffering status loss, or are beginning to shamefully punish themselves' (p.475). We would contend that much the same concerns can be applied to the stigmatization of obesity and the practitioner would contribute substantially to de-stigmatizing interventions through attending to these emergent issues.

### **De-stigmatizing: environmental approaches**

Alongside a growing understanding of how more distal determinants influence obesity have

come many recent calls for obesity prevention approaches that target the wider environment rather than individual behaviour change (Alderman *et al.*, 2007; Schwartz and Brownell, 2007). Emerging evidence is pointing to the effectiveness of these approaches. For example, in a policy-focused review of the literature, Thomas *et al.* (Thomas *et al.*, 2004) concluded that multi-faceted approaches are more effective than single interventions; that resources need to be made available for implementing such programs; and that government, the private sector and others need to work together to provide more rigorous evaluation of environmental and systems-based interventions. Working to address the environmental determinants of obesity over system levels and sectors, with multiple interventions may be required for multi-faceted obesity intervention. These system approaches hold promise as de-stigmatizing approaches to obesity prevention (Wang and Brownell, 2005).

Interventions that focus on environmental approaches may be less stigmatizing, more effective and more supportive of health for all over a longer time period as they deal with the population level determinants that affect health. A more universal approach should be less stigmatizing as all people are considered as beneficiaries of an intervention, and specific groups are not 'targeted' for 'fixing'. However, the decision of whether or not to use a universal approach also has other implications for treatment. As Solomons (Solomons, 2005) points out, the decision whether to target groups or provide more universal intervention has implications for cost-efficiency versus potential discrimination/stigmatization. Universal approaches may or may not be more cost-effective, depending on the circumstances.

Universal approaches also need to fully consider special needs related to interactions of social determinants resulting in stigmatized health problems. For stigmatized conditions such as obesity that are correlated with other forms of marginalization, such as poverty, disability, racial or cultural discrimination, many people experience a 'layering' of stigma (Mill *et al.*, 2007). Such people have to cope with multiple stigmas, for example being poor and from a visible ethnic minority, as well as being obese. While environmental level interventions may indeed work towards removing some barriers causing stigma (e.g. more walkable

environments attempting to increase activity and reduce obesity), other barriers must be addressed at the same time (e.g. accessible and affordable alternatives for food). Policy makers must also carefully consider whether a universal program that helps a targeted group and is expected not to benefit everyone else, does not inadvertently harm yet a third group. In order to monitor programs and policies across population groups at different levels, communication and evaluation systems must be synchronized.

Congruence with culture and multi-disciplinary approaches across sectors is also important in obesity treatment and prevention (Henson, 2005). As well as differential distribution across subpopulations, there are different impacts of obesity in different groups. For example, the impact of stigmatization on self-esteem appears to vary by gender and by culture (Latner and Schwartz, 2005) partly depending on protective factors in subgroups, as well as on the combined negative impacts of multiple layers of stigma. Further, different groups have different needs in terms of accessibility and cultural competence of health services, which needs to be attended to.

## STIGMA-SPECIFIC IMPLICATIONS FOR PRACTICE

Beyond the general de-stigmatizing impact of environmental, system-focused approaches, there are stigma-specific recommendations necessary for public health planning, regardless of intervention focus. Public health program planners and practitioners need to do the following.

- Evaluate for stigma. Interventions, both universal and targeted, should be evaluated for their impact on stigma (Lang and Rayner, 2005; Lobstein and Baur, 2005). Examples include school-based programs which monitor self-esteem changes, by measuring self-esteem or body image before and after intervention, for all weight categories of children (Foster *et al.*, 2008).
- Be aware of the potential impact of separating out the overweight/obese for targeted interventions at any intervention level. Think through when this might be helpful (e.g. there might be specific exercise needs for very obese people, plus less self-consciousness justifying fitness programs just for them), and

when this could be stigmatizing ('Oh, you have to go to "that" class'). Stigma might be particularly impactful for children and teens.

- Provide training across sectors for professionals such as nurses, doctors, nutritionists, educators and social workers about stereotyping, as well as accurate information about obesity and obese people.
- Screen public health mass communication messages for stereotyping, blaming and misinformation. Consider provision of messaging focused on positive self images and stereotype reduction for obese people. Buffers must be put in place to ensure that health policies and interventions carry appropriate messaging, including self-esteem building components, which may be especially helpful for children. This can be done throughout jurisdictional levels and across sectors.
- Include programming efforts to prevent stigma in all interventions. Providing positive coping strategies for obese people to improve accurate assessment of their social rejection and to develop a sense of a strong identity have been found to be useful in mitigating the mental and physical health effects of stigma (Reyna, 2000; Major and O'Brien, 2005).
- Bring stakeholders to the table. This means meaningful involvement of obese and overweight people and, also, in the case of children, their parents, in finding solutions to stigmatizing program and policies. Such stakeholder involvement has, in the past, proven to be very important in keeping stigma-reduction on the table. Saguy and Riley (Saguy and Riley, 2005) discuss an example of how having respected members of the obesity community on task forces has led to shifts in focus from weight-based to health-based approaches. Stakeholders would be important contributors, not just at program planning, but throughout interventions, as part of coalitions or committees.
- In programs crossing system levels and sectors, each segment of programming needs to be examined for coherence and consistency with non-stigmatizing messages and approaches. As with any multiple intervention programming (Edwards *et al.*, 2006), monitoring for program coherence needs to happen in an ongoing fashion. It would not do, for example, for municipal public health services to be providing programs promoting

active and positive lifestyles, while school and community sport and exercise programs are made accessible only to elite athletes, or, if mass media campaigns pushed personal responsibility as the key to overcoming activity in unwalkable neighbourhoods. Each sector needs awareness of stereotyping and its impact, and of inaccurate information about obesity. Maintaining the non-stigmatizing integrity of intersectoral policies requires agreement on a strong, underlying mission, goals and objectives supporting any non-stigmatizing policy directives.

- Layering of stigma must be considered. Fortunately, the strength of system-level approaches is that they are less likely to end up blaming the poor and minority groups for health issues due to socio-economic structural issues (Saguy and Riley, 2005). This is because they take into account determinants of population health. Still, the complexity of system-level approaches, potentially over large population groups, require special attention to the issues of layering of stigma as well as equitable treatment and meeting needs of all, without stigmatizing individuals or groups. Policy is not inherently equitable, even if policy reach is universal (Canadian Institutes of Health Research, 2004). Policies directed at obesity prevention may inadvertently stigmatize sub-populations. For example, a tax on unhealthy food has a disproportionate financial impact on the poor who may also be using such foods as a cheap source of high caloric intake. The purchasing behaviour itself may come to be stigmatized, through the process of taxation, and come to suggest irresponsible purchasing of food above their means, as well as being the purchase of unhealthy food.

## POLICY IMPLICATIONS

Awareness of stigma in overweight/obesity programs and policy is not enough. Once programs are in place, evaluating the social impact of current approaches to the obesity epidemic is critical to the physical and mental health of our society. The need for a clear message from health policy levels across sectors and over jurisdictions is called for, as health practice aimed at obesity prevention and intervention escalates in speed and intensity.

## CONCLUSION

Stigma related to obesity is pervasive. Although environmental approaches to prevent obesity are promising because they move away from the individual as the source of the problem, they are not without stigmatizing risks. As we move into the era of multi-level policy interventions targeting obesity, it is important that we pay close attention to their stigma-reinforcement and stigma-reduction potential.

## ACKNOWLEDGEMENTS AND AUTHOR NOTES

The authors wish to gratefully acknowledge the assistance of Martha Pinheiros with the review of the literature for this paper.

## FUNDING

The work reported here was supported by the Ontario Ministry of Health through a System-Linked Research Grant to the Community Health Research Unit. The opinions expressed here are those of the authors. Publication does not imply any endorsement of these views by either of the participating partners of the CHRU, or by the Government of Ontario.

## REFERENCES

- Alderman, J., Smith, J. A., Fried, E. J. and Daynard, R. A. (2007) Application of the law to the childhood obesity epidemic. *The Journal of Law, Medicine, and Ethics*, **35**, 90–112.
- Bayer, R. (2008) Stigma and the ethics of public health: not can we but should we. *Social Science and Medicine*, **67**, 463–472.
- Brownell, K. D. (2005) The chronicling of obesity: growing awareness of its social, economic, and political contexts. *Journal of Health Politics, Policy and Law*, **30**, 955–964.
- Burris, S. (2008) Stigma, ethics and policy: a commentary on Bayer's 'Stigma and the ethics of public health: not can we but should we'. *Social Science and Medicine*, **67**, 473–475.
- Canadian Institutes of Health Research (CIHR). (2004) *Addressing Childhood Obesity: The Evidence for Action*. Canadian Institutes for Health Research (Institute of Nutrition, Metabolism and Diabetes), CAPHC, and PCC, Ottawa.
- Edmunds, L. D. (2005) Parents' perceptions of health professionals' responses when seeking help for their overweight children. *Family Practice*, **22**, 287–292.

- Edwards, N., MacLean, L., Estable, A. and Meyer, M. (2006) *Multiple Intervention Program Recommendations for MHPSG Technical Review Committees*. University of Ottawa, Community Health Research Unit, Ottawa.
- Fabricatore, A. N., Wadden, T. A. and Foster, G. D. (2005) Bias in health care settings. In Brownell, K. D., Puhl, R. M., Schwartz, M. B. and Rudd, L. (eds), *Weight Bias: Nature, Consequences, and Remedies*. The Guildford Press, London, pp. 29–41.
- Foster, G. D., Sherman, S., Borradaile, K. E., Grundy, K. M., Vander Veur, S. S., Nachmani, J. *et al.* (2008) A policy-based school intervention to prevent overweight and obesity. *Pediatrics*, **121**, 794–802.
- Friedman, J. M. (2004) Modern science versus the stigma of obesity. *Nature Medicine*, **10**, 563–569.
- Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity*. Simon and Schuster, New York.
- Green, G. (1995) Attitudes towards people with HIV: are they as stigmatizing as people with HIV perceive them to be? *Social Science and Medicine*, **41**, 557–568.
- Henson, K. E. (2005) Childhood obesity in the United States of America with a special focus on Native American reservation dwelling youths: the problem, the treatments, and how psychology can help. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, **66**, 554.
- Lang, T. and Rayner, G. (2005) Obesity: a growing issue for European Policy? *Journal of European Social Policy*, **15**, 301–327.
- Latner, J. D. and Schwartz, M. B. (2005) Weight Bias in a Child's World. In Brownell, K. D., Puhl, R. M., Schwartz, M. B. and Rudd, L. (eds), *Weight Bias: Nature, Consequences, and Remedies*. The Guildford Press, London, pp. 54–67.
- Lobstein, T. and Baur, L. A. (2005) Policies to prevent childhood obesity in the European Union. *European Journal of Public Health*, **15**, 576–579.
- Major, B. and O'Brien, L. T. (2005) The social psychology of stigma. *Annual Review of Psychology*, **56**, 393–421.
- Mill, J., Austin, W., Edwards, N., Jackson, R., Leonard, L., MacLean, L. *et al.* (2007) *The Influence of Stigma on Access to Health Services by Persons with HIV Illness*. Canadian Institutes of Health Research, Ottawa, unpublished manuscript.
- Robinson, B. E. and Bacon, J. G. (1996) The 'if only I were thin...' Treatment Program: Decreasing the stigmatizing effects of fatness. *Professional Psychology: Research and Practice*, **27**, 175–183.
- Reyna, C. (2000) Lazy, dumb, or industrious: when stereotypes convey attribution information in the classroom. *Educational Psychology Review*, **12**, 85–110.
- Rogge, M. M., Greenwald, M. and Golden, A. (2004) Obesity, stigma, and civilized oppression. *Advances in Nursing Science*, **27**, 301–315.
- Saguy, A. C. and Riley, K. W. (2005) Weighing both sides: morality, mortality, and framing contests over obesity. *Journal of Health Politics, Policy and Law*, **30**, 869–923.
- Schwartz, M. B. and Brownell, K. D. (2007) Actions necessary to prevent childhood obesity: creating the climate for change. *The Journal of Law, Medicine and Ethics*, **35**, 78–89.
- Solomons, N. W. (2005) Programme and policy issues related to promoting positive early nutritional influences to prevent obesity, diabetes and cardiovascular disease in later life: a developing countries view. *Maternal and Child Nutrition*, **1**, 204–215.
- Stuber, J., Meyer, I. and Link, B. (2008) Stigma, prejudice, discrimination and health. *Social Science and Medicine*, **67**, 351–357.
- Szwarc, S. (2004–2005) Putting facts over fears: examining childhood anti-obesity initiatives. *International Quarterly of Community Health Education*, **23**, 97–116.
- Thomas, H., Ciliska, D., Micucci, S., Wilson-Abra, J. and Dobbins, M. (2004) *Effectiveness of Physical Activity Enhancement and Obesity Prevention Programs in Children and Youth*. Effective Public Health Practice Project, Hamilton.
- Vaidya, V. (2006) Psychosocial aspects of obesity. *Advances in Psychosomatic Medicine*, **27**, 73–85.
- Wang, S. S. and Brownell, K. D. (2005) Public policy and obesity: the need to marry science with advocacy. *Psychiatric Clinics of North America*, **28**, 235–252.