



"STIGMA IN HEALTH": ADVOCATING FOR REACHING OUT FOR OBESITY MANAGEMENT

**Sydney
Moriangthem**

MD Assistant Professor of Psychiatry, National Institute of Mental Health and Neuroscience (NIMHANS), Bengaluru, India

KEYWORDS :

In the field of health care and delivery, stigma is a known offender. Throughout the history of medicine, stigma has imposed suffering on groups vulnerable to disease and impaired efforts to thwart the progression of those diseases. Disease stigma occurs when individuals or groups are blamed for their illnesses because they are viewed as immoral, unclean, or lazy. When African Americans were dying from tuberculosis at the beginning of the 20th century, rather than investing in prevention of the deadly scourge or treatment of tuberculosis, many cities' authorities issued warnings to its White citizens against commingling with or hiring African Americans. In 19th century America, immigrants from Ireland were held responsible for epidemic diseases because they were "filthy and unmindful of public hygiene." As large numbers of Irish-born immigrants died of cholera, many viewed their deaths as acts of retribution upon the "sinful and spiritually unworthy." Even the stigmatization of injection drug users and individuals with gonorrhea has been denounced as a barrier to actual testing and treatment. These examples have resulted in a broad understanding of the implications of stigma for public health. According to Herek, "Historical examples abound of stigma interfering with collective responses to diseases ranging from cholera to syphilis. In all of these cases, the social construction of illness incorporated moral judgments about the circumstances in which it was contracted as well as preexisting hostility toward the groups perceived to be most affected by it."

In the case of HIV (human immunodeficiency virus) infection and AIDS (acquired immunodeficiency syndrome), the detrimental role of stigma has become prominent that national and international health agendas explicitly identify stigma and discrimination as major barriers to effectively addressing the epidemic. As early as the mid-1980s, just a few years after the disease was initially identified, discrimination against those at risk for HIV/AIDS was identified as counterproductive, and early public health policies advocated protections for patients' privacy and confidentiality. As it became more apparent that stigma and discrimination were among the root causes of vulnerability to HIV/AIDS, the United Nations General Assembly Special Session on HIV/AIDS adopted the Declaration of Commitment in 2001, which pledged signatory states to "develop strategies to combat stigma and social exclusion connected with the epidemic." Subsequently, stigma and discrimination were chosen as the theme for the 2002–2003 World AIDS Campaign. In 2007, the Joint United Nations Program on HIV/AIDS issued the report, *Reducing HIV Stigma and Discrimination: A Critical Part of National AIDS Programmes*, which elaborates strategies for intense reduction of stigma and discrimination within national responses to the disease.

The stigma of obesity has not been addressed as a genuine concern that requires the attention of those working to combat obesity and is rarely discussed in the context of public health. In fact, weight stigma has been suggested by some as a method for obesity control. The lack of attention to weight stigma has persisted despite nearly several decades of scientific research documenting weight stigma and its consequences for obese individuals. Its absence was noted in the 1960s when stigma research was first emerging. In fact, in 1968, Cahnman published "The Stigma of Obesity," in which he explicated: Obesity is hardly ever mentioned in the writings of sociologists, and

not at all in the literature on social deviance. This omission is amazing... Clearly, in our kind of society, with its stress on affluence and upward mobility, being overweight is detrimental to health, a blemish to appearance, and a social disgrace.

This omission remains almost 50 years later. However, in a landmark endeavor, Dr. Kiran Panuganti of Texas Health Resources and Presbyterian Hospital in Denton, is putting a simple, straightforward message of dropping the barrier of stigma and approach medical help for diseases associated with public health deterrence. Through his webportal www.stigmainhealth.com, Dr. Panuganti is robustly advocating to reach out for medical help. In fact, the biggest emphasis the website is laying is on prevention of childhood obesity. Even as obesity rates have risen dramatically, weight stigma is rarely, if ever, afforded the same recognition or intervention as other disease stigmas. Although there is significant consensus that stigma undermines public health, this principle has generally not been applied to the obesity epidemic. Common societal assumptions about obesity, including the notion that obese individuals are to be blamed for their lack of self-control and high weight, contribute to the disregard of weight stigma and its impact on emotional and physical health. An examination of these assumptions in light of current evidence reveals that obesity stigma creates significant barriers in efforts to address the epidemic of obesity and deserves greater emphasis in the domain of public health agenda.

Societal attributions about the causes of obesity contribute significantly to expressions of weight stigma. Experimental research in psychology consistently demonstrates that obese persons are stigmatized because their weight is perceived to be caused by factors within personal control (e.g., overeating, lack of exercise). Weiner and his group assessed the relationship between perceptions of personal responsibility and stigmatizing conditions and found that conditions rated low on personal responsibility (such as Alzheimer's disease) were rated high on liking and elicited pity and intentions to help from others. However, individuals with stigmatizing conditions rated high on personal responsibility (e.g., obesity and drug addiction) were disliked, evoked little pity and high anger, and received low ratings of helping tendencies.

Research findings since that time have followed suit. In a study examining attitudes toward 66 different diseases and health conditions (including obesity), the attributed degree of personal responsibility for the disease predicted social distance and rejection by participants. Experimental research shows that providing individuals with information emphasizing personal responsibility for obesity increases negative stereotypes toward obese persons, whereas information highlighting the complex underlying basis of obesity (such as biological and genetic contributors) improves attitudes and reduces the preconceived stereotypes.

The view that obesity is a matter of personal responsibility is the prevailing message in the media. News coverage of the personal causes and solutions to obesity significantly outnumber other societal attributions of responsibility. Entertainment media also communicate anti-fat messages and reinforce perceptions that body weight is within personal control. The current societal

message is that both the cause and the solution for obesity reside within the individual. Thus, the pervasiveness of the “personal responsibility” message plays a key role in stigmatization and serves to justify stigma as an acceptable societal response.

However, this prevailing message does not accurately reflect the science. Many significant contributors to obesity are beyond the control of individuals. In addition to the important role of genetic and biological factors regulating body weight, multiple social and economic influences have significantly altered the environment to promote and reinforce obesity. As Seng Lee notes,

We have created a biology–environment mismatch, as the human weight regulation is unable to evolve fast enough to keep pace with the environmental change.

Advancements in workplace technology and reduction of manual labor have resulted in decreased energy expenditure. The built environment has decreased opportunities for healthy lifestyle behaviors through factors such as urban design, land use, public transportation availability, density and location of food stores and restaurants, and neighborhood barriers such as safety and walkability.

Significant changes have taken place in the food environment with increased accessibility of inexpensive foods. Prices of calorie-dense foods and beverages have decreased considerably in contrast to increasing prices of fresh fruits, vegetables, fish, and dairy items, contributing to increased consumption of unhealthy foods, especially as the portion sizes of these items have grown considerably larger. Significant marketing and advertising of unhealthy, energy-dense foods by the food industry contribute to excessive food consumption in important ways, especially for children, who are heavily targeted. Through another website www.thinkbeforefollowing.com, Dr. Panuganti is urging on avoiding cues for smoking cessation, another partner in the nexus of teenage depression and binge eating.

The complex societal and environmental conditions that have created obesity necessitate that we move beyond the narrow focus that targets the individual as both the culprit and the solution for obesity. Public health efforts must address the multiple forces contributing to the development and maintenance of obesity and recognize that individual behaviors are powerfully shaped by the obesogenic environment. As Cohen concludes, “a more accurate conceptualization of the obesity epidemic is that people are responding to the forces in their environment, rather than lacking in willpower and self-control.” There is increasing consensus that environmental change is essential to the solution of obesity.

There is also considerable scientific consensus about the challenge of significant long-term weight loss. A systematic review of 80 randomized clinical trials of weight-loss interventions with at least 1 year of follow-up (including interventions of diet, diet and exercise, exercise, meal replacements, very-low-calorie diets, and weight-loss medications) found the mean weight loss across studies to be 5% to 9% at 6 months, with a subsequent plateau across most interventions. These findings parallel a recent meta-analysis of 46 randomized controlled trials that revealed a maximum net treatment effect of approximately 6% of body weight lost at 1-year follow-up. Many other recent scientific reviews of multiple weight-loss trials and programs produced, on average, no more than 10% weight loss at 1- or 2-year follow-up.

As a result of these and other consistent findings demonstrating modest results of most weight-loss interventions, there is recognition in the scientific community that existing dietary programs and medications can produce no more than an average of 10% weight loss. This evidence has prompted agreement among expert panels and scientific groups (including the Institute of Medicine, World Health Organization, Preventive Task Force, Canadian Task Force of Preventive Health Care, and National Heart,

Lung, and Blood Institute) that health care providers should counsel patients to set a goal of 10% reduction in total body weight rather than struggle to attain ideal body weight. For obese individuals who want to lose body weight to improve their health (as opposed to individuals who want to obtain modest weight loss for aesthetic reasons only), a 10% weight loss means that many obese persons will remain obese and in fact, continue to be vulnerable to weight stigma.

The high rate of weight regain following weight loss is equally concerning. Most weight losses are not maintained, and individuals regain weight after completing treatment. Patients who have lost weight through lifestyle modification typically regain 30% to 35% of their lost weight during the year following treatment and regain most (if not all) of their lost weight within 5 years. The consistent findings in this area indicate that preventing weight regain is extremely challenging. As a result, experts in the obesity field have concluded that weight regain occurs in practically all dietary and behavioral interventions, and other researchers have asserted that “Dieters who manage to sustain a weight loss are the rare exception, rather than the rule. Dieters who gain back more weight than they lost may very well be the norm, rather than an unlucky minority.”

Despite weight regain, individuals can experience important improvements in health with modest weight loss of approximately 10%, including reductions in obesity-related health complications such as type 2 diabetes and hypertension and improvements in cardiovascular risk. However, even if modest weight loss improves some health indices, it is unlikely to significantly alter appearance or translate to a non-obese body mass index (BMI; weight in kilograms divided by height in meters squared) for most people and is doubtful to be sufficient to reduce weight stigma and discrimination.

Because weight-based stereotypes and prejudice so often emerge from attributions that obesity is caused and maintained by personal characteristics such as laziness or lack of willpower, there is a clear need for increased public awareness and education about the complex etiology of obesity and the significant obstacles present in efforts to achieve sustainable weight loss. The prevailing societal and media messages that reinforce blame on obese persons need to be replaced with messages that obesity is a chronic disease with a complex etiology, and a lifelong condition for most obese persons. It is essential for weight stigma to be addressed in obesity interventions, and for anti-stigma messages to be incorporated into obesity prevention campaigns. For example, interventions should focus on health as both the primary motivator and desired outcome for behavior change, rather than messages that emphasize achieving an ideal weight, which may perpetuate obesity stereotypes and chastise obese individuals. Dr. Panuganti has made a significant thoughtful step in this regard. Unhealthy eating behaviors, such as fast food and soda consumption, can be discouraged for all people, regardless of their body size. It may be especially important to incorporate anti-stigma messages in interventions for youths, because of the vulnerability of obese children to the negative emotional and physical health consequences of weight-based victimization. A 2005 report issued by the Institute of Medicine acknowledged the importance of considering weight-based stigmatization in obesity interventions for youths and recommended shifting the focus of prevention efforts to emphasize behaviors that promote health rather than appearance. Similarly, the Society for Nutrition Education also recommends that school-based obesity prevention programs include promotion of weight tolerance and school policies prohibit weight-based teasing and victimization. A range of stigma-specific recommendations for public health interventions for obesity have been proposed, including evaluation of the social impact of existing interventions on stigma, providing stigma-reduction training for health care professionals, screening public health communication messages for stigmatizing content, seeking perspectives from obese persons in efforts to identify solutions to stigmatizing programs, and ensuring consistent implementation of non-

stigmatizing messages.

Mental illness, intellectual disability and physical disability increase the risk of obesity. Obesity is more common in people with major depression, bipolar disorder, panic disorder and agoraphobia. The stigmatization of obesity is pervasive, damaging, and threatens core public health values. Rates of overweight and obesity are as high as 76% for some groups in the United States. By ignoring weight stigma, the public health community ignores substantial suffering of many Americans. To effectively address the obesity epidemic and improve public health, it is essential to challenge common societal assumptions that perpetuate weight stigma and prioritize discussions of weight stigma in the national discourse on obesity. Dr. Panuganti has taken a right and pioneering step in this direction for addressing issues of stigma relevant to global health.

References

1. Anderson DA, Wadden TA. Bariatric surgery patients' views of their physicians; weight-related attitudes and practices. *Obes Res* 2004;12(10):1587–1595.
2. Annis NM, Cash TF, Hrabosky JL. Body image and psychosocial differences among stable average weight, currently overweight, and formerly overweight women: the role of stigmatizing experiences. *Body Image* 2004;1(2):155–167.
3. Benas JS, Gibb BE. Weight-related teasing, dysfunctional cognitions, and symptoms of depression and eating disturbances. *Cognit Ther Res* 2008;32(2):143–160.
4. Cahnman WJ. The stigma of obesity. *Sociol Q* 1968;9:283–299.
5. Crandall CS, Moriarty D. Physical illness stigma and social rejection. *Br J Soc Psychol* 1995;34(Pt 1):67–83.
6. DeJong W. Obesity as a characterological stigma: the issue of responsibility and judgments of task performance. *Psychol Rep* 1993;73(3 Pt 1):963–970.
7. Fortenberry JD, McFarlane M, Bleakley A, et al. Relationships of stigma and shame to gonorrhea and HIV screening. *Am J Public Health* 2002;92(3):378–381.
8. Finkelstein EA, Ruhm CJ, Kosa KM. Economic causes and consequences of obesity. *Annu Rev Public Health* 2005;26:239–257.
9. Hebl MR, Heatherton TF. The stigma of obesity in women: the difference is black and white. *Pers Soc Psychol Bull* 1998;24(4):417–426.
10. Kraut AM. Silent Travelers: Germs, Genes, and the "Immigrant Menace." Baltimore, MD: The Johns Hopkins University Press; 1994.
11. Link BG, Phelan JC. Stigma and its public health implications. *Lancet* 2006;367(9509):528–529.
12. Institute of Medicine. Preventing Childhood Obesity Washington, DC: The National Academies Press; 2005.
13. Puhl RM, Latner JD. Stigma, obesity, and the health of the nation's children. *Psychol Bull* 2007;133(4):557–580.
14. US Department of Health and Human Services, The Advertising Council. Healthy Lifestyles and Disease Prevention Media Campaign: Take a Small Step to Get Healthy. [white paper]. 2004. Available at: http://www.smallstep.gov/pdf/obesity_whitepaperfinal_71205.pdf.
15. www.stigmainhealth.com
16. www.thinkbeforefollowing.com