Chapter 2
Language, Stigma

Terminology

Use of the term 'obesity'

2.1 The importance of language when describing the problem, or developing programs that attempt to tackle overweight and obesity, was highlighted throughout the inquiry. Even the language used for this inquiry was questioned as it potentially generates fear among individuals. These descriptions then permeate to the level of the individual with negative connotations.[1]

2.2 The committee deliberated on whether the term 'obesity' itself should be used in any context. It is a medical term meaning excess weight that is likely to be detrimental to health. The general usage of the term covers all aspects of the condition from description, to prevention, to intervention. It is a term understood and used universally among stakeholders.

2.3 However, the committee agreed that in certain circumstances the term is not helpful. As discussed throughout this chapter, there is a high degree of stigma associated with the term, which can cause those most in need of assistance to shy away from accessing help, or being influenced by messaging that contains it. The example cited below, of the Nepean Family Metabolic Health Service changing its name from the Family Obesity Service, highlights the difficulty the term creates. The same difficulties apply to public information campaigns where the messaging needs to be focused on positive behavioural change, with a focus on health rather than weight.

2.4 The committee therefore is of the view that the term should not be used for intervention and prevention programs. These programs should emphasise healthy weight; good nutrition; increased physical activity and appropriate public and community infrastructure. This is discussed in the rest of this chapter.

2.5 However, in medical and high level policy settings, there is no current alternative to the term. The efforts to tackle obesity are multipronged, and require coordinated efforts from across all levels of government and public agencies. Obesity is the single catch-all term that covers all elements that need to go into prevention and intervention efforts, and as such, brings all of those programs under one policy. The committee therefore accepts that until an alternative is available, the term needs to remain attached to government efforts and bodies charged with implementing change.

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1 School of Social Sciences, University of Adelaide, *Submission 52*, p. 5.

Focus on health, not weight

2.6 Food Fairness Illawarra recommended that programs to address the problem should ensure that they do not attribute the blame for a person's weight solely to the individual:

> Education or campaign approaches need to demonstrate that they will not have an unfavourable impact, such as stigmatisation, blaming and misconceptions about the importance of physical activity and good diet as protective factors for disease prevention irrespective of weight.[2]

2.7 The National Centre for Epidemiology and Population Health (NCEPH), Research School of Population Health at the Australian National University, also pointed to evidence which suggests that the focus on body size, rather than health, is detrimental to people's mental health:

> Campaigns tend to target obesity using a bio-medical focus on individual bodies and weight contributing to the stigmatization of fat people and potentially contributing further to unhealthy food consumption practices (Kinmonth 2016) and mental health issues. If the focus was shifted to directly addressing chronic diseases such as Type 2 diabetes, hypertension, cardio-vascular disease and cancers associated with obesity this might reduce the obsession with body size.[3]

2.8 As did the Royal Australian and New Zealand College of Psychiatrists in its submission:

> Research has established an association between increased body weight and mental health disorders, with increased odds for mood disorders or anxiety disorders (Scott et al., 2008; Simon et al., 2006). People with obesity are also at increased risk of exposure to bullying, social stigma and weight bias in employment, education and health care. This can have a significant impact on mental health, and exacerbate psychological issues around diet and healthy eating. In addition, stigma can often form a barrier to seeking help. It is important that these factors are considered when designing services to meet the growing need for obesity-related interventions.[4]

2.9 The focus on health rather than weight was raised by a number of witnesses, including Ms Sarah Harry from Health at Every Size Australia:

> It is taking the things that we know stigmatise like BMI and weight, measuring those things in research and putting the focus on health and wellbeing. I do keep coming back to This Girl Can because it worked so well…It worked because it was stigma free, weight loss free and number

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2 Food Fairness Illawarra, *Submission 27*, Attachment 1, p. 12.

3 National Centre for Epidemiology and Population Health, Research School of Population Health, Australian National University, *Submission 29*, p. 3.

4 Royal Australian and New Zealand College of Psychiatrists, *Submission 30,* p. 2.

> free, and the focus was entirely on getting out, having fun and being healthy.[5]

2.10 The committee was also told of health services that no longer use the term obesity, for fear of stigmatizing those who are most in need of treatment. The Nepean Family Metabolic Health Service (formerly known as the 'Nepean Family Obesity Service') changed its name to remove any barriers for people accessing the service, particularly pregnant women:

> We had several clients tell us that they had problems sitting underneath the Nepean Family Obesity Service tag and they didn't like taking referrals for various investigations saying 'obesity service'; they felt judged. It's already hard enough for them to attend our clinic. In the first clinic appointment they're usually very anxious and they don't want to be there. It's our job to make them feel very comfortable, and we want to remove every single barrier that there is. One area that we found particularly difficult was the obstetrics services. Even midwives and other healthcare professionals had problems referring pregnant mothers to our service because they themselves felt uncomfortable with the concept of obesity and, indeed, their own weight.[6]

Psychological impact of stigma around weight

2.11 The psychological impact of obesity on those affected can be profound. The committee received evidence from the Nepean Family Obesity Service, whose region has one of the highest levels of childhood overweight and obesity in Australia, explaining how children in particular are affected by obesity:

> The typical paediatric patient engaging with our tertiary service tends to live a stressful life. One or both parents of this child are obese, often living on minimal incomes, and have high stress and/or medical co-morbidities. Children suffer psychological illness due to bullying and weight stigma and feel excluded from school and peer interactions. These children can also have multiple medical conditions including diabetes, sleep disorders and joint and mobility limitations.[7]

2.12 The International Health Economics Association's Economics of Obesity Special Interest Group echoed findings citing the psychological effects of obesity on children:

> Children with obesity suffer from weight stigma and bullying. After accounting for confounding and selection bias, compared to healthy weight children, obesity among 6 to 13 year olds in Australia causes substantially

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5 Ms Sarah Harry, Board Member, Health at Every Size Australia, *Committee Hansard*, Melbourne, 7 August 2018, p. 42.

6 Dr Kathryn Williams, Clinical Lead and Manager, Nepean Family Metabolic Health Service, *Committee Hansard*, Sydney, 6 August 2018, p. 46.

7 Nepean Family Obesity Service, *Submission 18*, p. 3.

> more **emotional problems** (both genders) and **peer problems** (especially for boys). Similar findings have been reported in the United States.[8]

2.13 The committee also heard that one of the reasons previous measures to tackle childhood obesity have failed is because they have focused on weight, rather than health, and this results in stigmatization which has many unintended consequences:

> There is strong evidence that weight focused anti-obesity interventions have significant unintended harmful consequences through stigmatization of people of higher weight. This causes psychological harm including anxiety, depression, body dissatisfaction and disordered eating; that promotes adolescent dieting which predisposes and leads to eating disorders and weight gain. Weight focus and stigmatization result in reduced participation in health related physical activities.[9]

2.14 This view was shared by Professor Susan Sawyer from the Centre for Adolescent Health at The Royal Children's Hospital Melbourne:

> This is where it's also important to recognise the intersection between obesity and eating disorders… I'm just highlighting that we need to be very careful, particularly with children and adolescents. We know, absolutely, from the studies that at the age of three and five they are already highly aware of the stigma of being overweight. That then leads to the risk of very abnormal behaviours and the entry into anorexia nervosa and bulimia nervosa.[10]

2.15 The real life effects of this stigma on a child's life choices were illustrated by the Clinical Dietician from the Nepean Family Metabolic Health Service, Ms Sally Badorrek, who explained:

> They find every opportunity to get out of sport at school. They will choose to do art at high school instead of sport because often there are art classes that can be used as sport. That's an issue. Or they'll say that they're unwell, and they're often unwell, and they'll go and sit in the sick bay to miss out on sport. Often they feel a lot of stigma. They're not going to be chosen to be on a team sport, and that makes them feel even worse about themselves. So they grow to hate sport.[11]

2.16 The committee heard that stigmatisation has far-reaching health consequences beyond any conditions related to weight. Health at Every Size Australia provided the take up of pap smears as an example:

> We see time and time again that people in bigger bodies aren't presenting to primary care until it's way too late. They're putting off pap smears. They're

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8 International Health Economics Association, Economics of Obesity Special Interest Group, *Submission 26*, p. 6.

9 The Victorian Centre of Excellence in Eating Disorders, *Submission 21*, p. 3.

10 Professor Susan Sawyer, Director, Centre for Adolescent Health, The Royal Children's Hospital Melbourne, *Committee Hansard*, Melbourne, 7 August 2018, p. 20.

11 Ms Sally Badorrek, Clinical Dietician, Nepean Family Metabolic Health Service, *Committee Hansard*, Sydney, 6 August 2018, pp. 45-46.

> putting off treatment and they're coming in with illnesses way too late, because they're afraid of the stigma that's associated with weight when they come to primary care. [12]

Stigma in the medical profession

2.17 This sensitivity of treating obesity and weight-related conditions among health professionals was also evident for doctors. Dr Alexander, Staff Specialist and Head of Weight Management Services at The Children's Hospital Westmead, told the committee that there is a reluctance by general practitioners (GPs) to raise the issue, particularly in the case of children:

> Because it's such a sensitive thing, particularly general practitioners don't want to raise it because they think it's going to upset the family. Whereas the research suggests that, in fact, parents want you to raise any health issues, including weight management, but many GPs won't raise it because of their own barriers of feeling uncomfortable about raising it.[13]

2.18 This is an issue which is widely recognised in the medical profession and health sector. Professor Boyle, Deputy Director and Obstetrician from the Monash Centre for Health Research and Implementation, told the committee of the training for health professionals to overcome the stigma attached to the issue:

> There are a number of difficulties that health providers experience. One is time—training people to undertake these sorts of brief interventions in a short time, and understanding that it can be delivered by a health promotion officer; it doesn't actually have to be the doctor or the midwife. I think that a lot of health providers worry about talking to women about their weight. There is the stigma. How do they go about it? We need to train people at undergraduate and postgraduate levels about how to do that.[14]

2.19 Mr Ahmad Aly, a bariatric surgeon, told of the stigma and prejudice around surgical treatment to treat obesity, which includes from hospital administrators:

> Obesity has this stigma and prejudice. Further than that, surgery has a stigma as well, because people say: 'No, you should be able to do it yourself. You shouldn't need surgery; that's too drastic.' So that has a stigma as well...So, yes, prejudice is part of it. That probably is what happens at a local hospital level. If a surgeon went to their administrators and said, 'We'd like to start a bariatric surgical service,' one of the main reasons that that may not go ahead is that concept of stigma and perception.[15]

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12 Ms Sarah Harry, Board Member, Health at Every Size Australia, *Committee Hansard*, Melbourne, 7 August 2018, p. 42.

13 Dr Shirley Alexander, The Children's Hospital Westmead, *Committee Hansard*, Sydney, 6 August 2018, p. 4.

14 Associate Professor Jacqueline Boyle, Deputy Director and Obstetrician, Monash Centre for Health Research and Implementation, *Committee Hansard*, Melbourne, 7 August 2018, p. 19.

15 Mr Ahmad Aly, President, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 26.

Committee view

2.20 A fundamental and highly damaging feature of the obesity problem is the stigma associated with weight, and weight-related health conditions. The stigma is endemic, in that it impacts all aspects of how society thinks about overweight and obesity, how is describes it, how it attributes blame for the condition, and how it is treated.

2.21 The committee unsurprisingly received extensive evidence on the impact of stigma, and importantly and pertinently, how to avoid stigmatising the issue further, even to the point of the naming this inquiry differently. The overwhelming message in the evidence is that this goes far beyond a simple language issue.

2.22 How program and treatments are named impacts on how people will access them, which in turn impacts on their effectiveness. The psychological impacts from childhood onward have significant tangible effects, and exacerbate the health impacts of overweight and obesity. The attitude and understanding of the condition, and treatment options by health professionals, including doctors, and health administrators, again impacts hugely on clinical and medical outcomes.

2.23 The committee heard useful suggestions on how to best address stigma at all junctures. Care should be taken in naming programs and treatments, and funding for programs should be conditional on them being appropriately named. Health professionals at all levels should receive adequate training on how to ensure that recipients of care and treatment are best identified and encouraged to access services.

2.24 As discussed at the start of this chapter, the committee supports a move away from using the term 'obesity' in all prevention and intervention programs and public information campaigns, and move the focus from weight on to health. However the committee accepts that in medical and overarching policy settings, there is no current agreed alternative to the term, and as such it will continue to be used.

Recommendation 1

2.25 The committee recommends that Commonwealth funding for overweight and obesity prevention efforts and treatment programs should be contingent on the appropriate use of language to avoid stigma and blame in all aspects of public health campaigns, program design and delivery.

Recommendation 2

2.26 The committee recommends that the Commonwealth Department of Health work with organisations responsible for training medical and allied health professionals to incorporate modules specifically aimed at increasing the understanding and awareness of stigma and blame in medical, psychological and public health interventions of overweight and obesity.