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Meaning of the Terms "Overweight" and "Obese" Among Low-Income Women

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Abstract

Objective—To determine how low-income United States women understand the meanings of the terms “overweight” and “obese”.

Methods—Low-income women [n = 145; 72% white, 12% black, 8% Hispanic; 59% obese, 21% overweight] each participated in an individual semi-structured interview during which they were asked to explain what the terms overweight and obese mean to them. Responses were transcribed and the constant comparative method was used to identify themes.

Results—Three themes emerged: (1) The terms are offensive and describe people who are unmotivated, depressed and do not care about themselves; (2) Obese is an extreme weight (e.g. 500 pounds and being immobile); (3) Being overweight is a matter of opinion; if a woman is “comfortable in her own skin” and “feels healthy” she is not overweight.

Conclusions and Implications—Health education focused on obesity should consider that vulnerable populations might consider the terms "overweight" and "obese" offensive and stigmatizing.

Keywords

Obesity; overweight; communication

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INTRODUCTION

As of 2010, 69% of United States adults are overweight or obese and rates are higher among low-income women.[1] Prior work has found negative attributions and stigma associated with being overweight, with studies reporting that obese individuals are often viewed as, "lazy, unmotivated, lacking in self-discipline, less competent, noncompliant, and sloppy." [2] Understanding the meaning that these terms have, particularly among low-income women, is important for several reasons. First, many overweight or obese individuals do not self-identify as such,[3, 4] feeling that the terms "overweight" and "obese" do not apply to them, and therefore public health messaging referring to these weight categories may not reach its intended audience. Second, these descriptors may elicit such strong negative feelings in certain groups that the use of these terms in obesity prevention or health promotion messaging is potentially detrimental to how the intended message will be interpreted. Thus, obesity prevention programming may be more effective if the messaging uses language more acceptable to the population. Finally, a better understanding of how individuals understand these terms may provide an agenda for future health education initiatives. The present study therefore used qualitative methods to better understand how low-income women interpret the terms "overweight" and "obese."

METHODS

Participants (n=145) were part of a longitudinal study examining psychosocial and behavioral contributors to low-income children's obesity risk. Participants in the original longitudinal study were invited through their child's Head Start program, located in Southeastern Michigan, to participate in a study about children's eating behaviors. Participants were followed longitudinally, and about two years later invited to participate in this follow up study, which was explained as aiming to "understand how mothers and caregivers feed their children."

Exclusion criteria for the parent study were: parent with ≥ 4 year college degree; parent or child not English-speaking; child in foster care, with food allergies, significant medical problems or perinatal complications, or gestational age < 35 weeks. Each female primary caregiver participated in a semi-structured audiotaped individual interview with a trained interviewer focused on women's beliefs about feeding their children. A semi-structured individual interview rather than a focus group approach was used because prior work[5] has found that the topics of child feeding and weight status often evoke strong feelings that may not emerge in a group setting. The study was approved by the Institutional Review Board following full review. Written informed consent was provided and women were compensated for their time.

Interviews were completed by 7 different research assistants. All research assistants had bachelors' degrees and were full time research staff. Each research assistant participated in several hours of training in appropriate interview administration by a doctoral level research psychologist experienced in the administration and interpretation of similar interviews for research purposes. Training included instruction on approaches to establishing rapport, decisions regarding whether and how to give verbal and non-verbal feedback to the

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participant during the interview, allowing for pauses to provide the participant time to elaborate on her response, and when and how to probe for additional detail. Audiotapes of previously completed interviews were reviewed with the research assistants to provide both positive and suboptimal examples of interview administration for discussion. Following training, each research assistant conducted one interview; the audiotape of this interview was reviewed by the research psychologist who provided written and verbal feedback to the research assistant. Specifically, corrective feedback was provided if interview questions were not asked verbatim or if prompts, pauses, or feedback to the participant during the interview were not used effectively or appropriately. In addition, feedback was provided to the research assistant regarding approaches to establishing rapport, managing unelaborated responses, negotiating the interview when the participant repeatedly digressed far off topic, and sensitively responding when the participant shared a particularly emotional or personal detail. This process continued until each research assistant demonstrated acceptable and reliable interview administration skills, as assessed by the doctoral level research psychologist. Audiofiles of each research assistant's interview administration were periodically reviewed by the research psychologist to ensure ongoing reliability of administration. Research assistants also performed peer review of audiofiles and new examples of the challenges to appropriate interview administration, as described above, were discussed in regular staff meetings.

Interviews were conducted privately at a location of the participant's choice, which included her home or a room at a local community center. Interviewers followed a standardized interview guide developed by the authors; the guide could be referenced as needed, but research assistants were expected to be fluent in the interview. The interview guide was developed by two authors (both clinician-researchers in developmental psychology, developmental and behavioral pediatrics, and obesity) over a period of 8 years and over this time the interview was administered to 133 women of diverse race/ethnicity and socioeconomic status (none of these women are included in the present analysis).[5, 6] The interview guide was modified based on this initial work, prior to implementation with this cohort. The interview began with the research assistant explaining that "we would like to spend some time hearing from you about feeding your child(ren)." This paper describes responses to the two open-ended questions occurring near the middle of the interview, following a series of questions about mealtimes at home, child eating behaviors, and child feeding practices: "What does the word overweight mean to you?" and "What does the word obese mean to you?"

Participants reported their race/ethnicity, highest education level attained, and age, and were weighed and measured. Body mass index (BMI) was calculated and categorized as obese (BMI ≥ 30), overweight (25 ≤ BMI < 30) or normal weight (BMI < 25). A majority of the women were non-Hispanic white (n = 105 (72%)), 18 (12%) were black, 11 (8%) were Hispanic, and the remainder (8%) were other races or multiracial. Regarding education, 18% had less than a high school diploma, 33% had a high school diploma or equivalent only, and 49% had taken some college courses. Most of the women (58.6%) were obese, 20.7% overweight, and 20.7% normal weight. Prevalence of overweight and obesity did not differ across racial/ethnic groups by Chi square analysis. Mean age was 31.6 (SD 7.8) years (range 21.1 to 62.8 years). Twenty-seven percent were married, 28% in a committed relationship,

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26% never married, 17% separated/divorced, and 2% widowed. Of the 102 women in the sample who provided income data, 73% reported some household income from paid employment. The mean age of the participants' children enrolled in the study was 5.9 (SD 0.6) years (range 4.3 – 6.9).

Interviews were digitally audiorecorded and transcribed verbatim with identifiers removed. All transcripts were reviewed for accuracy by a second transcriptionist. The portion of the interview that included the answers to the questions regarding weight status was saved in a separate file, and only this portion of the interview was reviewed by the readers. The transcript data were systematically analyzed using the constant comparative method.[7] Two independent readers who did not participate in data collection read the same 45 interviews. Readers remained blind to the weight status as well as the race/ethnicity of participants to avoid any possibility of biasing the identification or interpretation of themes. The readers annotated the interviews, generating themes and identifying supporting quotes. They collectively identified 21 themes. The two readers then met with a third reader and reviewed the identified themes. Collaborative discussion allowed evaluation of possible biases among readers as perceptions and interpretations of interviews were checked and alternative approaches to interpreting and grouping the data were considered. Many of the identified themes required further specification, or were felt to be more appropriately integrated into a single unified theme. Four of the initially identified 21 themes were ultimately not included. Review of the remainder of the interviews confirmed the initial impression that these four themes represented deviant cases. Analysis of these deviant cases contributed to refinement of the themes. Following the initial identification of themes, readers continued to review the remainder of the interviews to determine if the initially identified themes were valid, adequately detailed, and appropriately grouped into subthemes.

Themes ultimately identified were peer reviewed with one research psychologist, one clinical psychologist, and a doctoral level nutritionist. These individuals reviewed the identified themes and provided feedback on plausibility of the themes and their interpretation.

RESULTS

Three primary themes were identified. Specific quotes were selected on the premise that they illustrated a range of viewpoints while also representing a concise summary of the theme.

Theme 1: The terms overweight and obese are offensive and are used to describe people who are ugly, lazy, unmotivated, depressed and do not care about themselves

Most women indicated that the terms "overweight" and "obese" had a negative connotation. That is, these terms did not simply describe someone with a BMI ≥ 25, but rather implied something more about a person. Some women explicitly stated that they did not like the terms, and that overweight and obese are "bad" words.

It's not a good word; it's not a good word to hear. - Obese, black

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Obese to me, that just sounds fat, sounds like a bad, a negative word. - Overweight, white

They need a nicer word for it. - Obese, white

Other women indicated that the negative connotation of the term was rooted in how it reflects an undesirable physical appearance.

Fat. Heavy. Disgusting. - Overweight, white

Obese is very, very fat, kind of grotesque, um . . . someone that has completely let themselves go. - Obese, white

Other women's definitions suggested that they associate additional, non-physical attributes with the terms overweight or obese. These women felt that the terms overweight and obese convey the attributes of being lazy, unmotivated, depressed, and not caring about one's self or one's life.

Overweight is somebody that you can tell that is fat, lazy, and is not active at all. - Normal weight, white

I think it's like, kind of big, lazy . . . they want to eat a lot. - Obese, biracial

Not caring about yourself anymore and really not taking initiative. - Obese, black

I think the majority of the [obese] people are probably miserable with themselves. - Obese, white

Theme 2: Obese is believed to be a weight status that is much more extreme than the definition based on body mass index

Many women understood the term "obese" to mean a weight status that is much more overweight than the actual definition.

If you're wider than you are tall, then you're obese. - Overweight, white

You're just way off the charts I guess, in my opinion. - Obese, black

Other women applied a more specific cut-off, stating that obese is a specific number of pounds overweight.

Somebody that's like a couple hundred pounds more than they should be. - Obese, white

Somebody that's like 60, 70, 90, 125 pounds overweight. That's obese. Somebody that's morbidly fat. - Normal weight, white

Other women cited weighing more than a certain number of pounds. The numbers women gave as examples were generally quite extreme.

If you is like four-two and you weigh 300 pounds, that's obesity. - Obese, black

Really large people. Like 3 . . . 400 pounds huge. - Obese, biracial

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That uh, those 500 ton people that I see on TV I think is obese. - Obese, black

Overbese [sic] is that guy you see that's 500 pounds or 400 pounds or that lady that can't bend down because she's so heavy. - Obese, white

Many women indicated that being obese is defined by an inability to move or to complete basic tasks of daily living.

Obese is like, to me the people that can't get out of bed. Cause they're so big. If you're able to up and walk you're just overweight. When it gets to the point that you can't, um, you can't get up or you can't do something, that's obese. - Obese, white

I'm obese which is actually supposed to be according to the whole BMI thing but in my opinion obese is like the really, really heavy people - the people that are in the supermarket with their little scooter things. - Obese, Hispanic

Theme 3: Being overweight is a matter of opinion, not fact

Many women indicated that they felt the "medical" definitions of overweight and obese are flawed and do not apply to them. They conveyed a sense of disdain for scientists and doctors who created these definitions and stated that even though the charts may say they are overweight, they do not feel that they are.

If I got down to 150 I would consider myself healthy where they would still consider me overweight, which I think is crap. So I mean scientifically I think overweight is overrated. - Obese, white

You know my BMI can be 30 and I'll be okay. You know [doctors] think that that's still obese but I'm like,'I don't think so'. - Obese, Hispanic

Not being healthy and bigger than what you're really supposed to be. But I do really have like, uh I'm kind of iffy on that and [the doctor] told me I'm overweight but I only weigh 168 and I felt offended. She told me I'm a little bit overweight but I don't really think that I am. - Overweight, black

Women indicated that if someone is carrying extra pounds, but still feels good, is active, and does not have any evident health problems, the person is not overweight.

But you know, um, there's a healthy overweight I feel and an extreme overweight. So, like me I'm slightly overweight but I feel it's healthy. I don't feel it's hurting my health over the extra pounds that I have. - Obese, white

I'm probably still overweight when I like get down to where I want to be, um, but for me it's where I want to be and where I feel the healthiest. - Obese, white

I know I'm a little overweight but my health is still good so I don't feel like I am. - Obese, white

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Finally, women indicated that if a person is comfortable with him/herself, he/she cannot be overweight. They implied that being overweight instead was defined by having poor self-esteem or body dissatisfaction.

Overweight is over the weight that I would like to be . . . it's just in my mind, overweight is something over what I want to be. - Overweight, white

I guess it depends on the person to me. [It means] not comfortable with yourself. - Overweight, black

If you're not comfortable in your body the way that it is, then you're probably overweight.- Obese, white

Where you're just not feeling comfortable, um within yourself and your own self-esteem. - Normal weight, white

DISCUSSION

The findings of this study support and extend the results described in several prior qualitative reports, all of which were performed in non-US samples. Specifically, both obese Australian women and English adolescent girls perceived obesity as representing a very extreme weight status that even prevented walking.[4, 8] They "othered" the obese person, viewing themselves as very distant from this 'grotesque other'.[4, 8] Identifying the correlates and predictors of viewing obese individuals as 'grotesque others' is the first step toward understanding the etiology of these views, as well as their ramifications for obesity interventions. For instance, the "othering" of the obese individual may be particularly prominent among females, given prior work indicating that obesity-related stigma is particularly prevalent and damaging for women.[9] Also of note, when obese individuals "other" the obese person, this may represent an externalization of their locus of control. At least one study has shown that obesity-preventative behaviors are less common among individuals with this perception,[10] and the intense stigmatization of obesity may lead to an external locus of control. Reducing stigma may allow obese individuals to internalize their locus of control, and interventions may therefore be more effective.

In addition to "othering" the obese individual, many women in this study rejected the medical definition' of obesity. This is consistent with the findings of at least one other qualitative study among obese Australian women[4] and highlights the disconnect between health care providers and obese individuals. This rejection of the 'medical definition' by obese individuals may reflect their rejection of a health care system that often conveys unfavorable judgment towards obese patients. Disparaging views of obese individuals among physicians and health care providers are pervasive. In general, health care providers report viewing obese individuals as noncompliant and lacking motivation and self-control.[2] In one study, these perceptions were linearly related to the patient's BMI -- the heavier the patient, the less the physician reported wanting to help the patient.[11] Among overweight and obese women, 69% reported experiencing weight-related stigma from a physician, and 37% from a dietitian.[12] The willingness of the lay public to accept "medical" definitions of obesity may be impeded by the strong negative views of obese individuals within the health

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care setting. It is also important to note that the "medical definition" of obesity is not perfectly sensitive and specific for adiposity,[13] and the strength of evidence to indicate that obesity causes disease has been called into question.[14] Increasing public acceptance of formal definitions of overweight and obesity may require a combination of further scientific evidence for their relevance to health, a reduction of stigma in the health care setting, and identification of treatment strategies for obesity that health care providers can effectively deliver.

For many individuals in this study, being considered obese was not a matter of weight, medically defined or otherwise. The finding that the low-income women in this study felt that feeling "good about one's self" was incompatible with being obese is consistent with prior work. Three qualitative studies have observed that lower socioeconomic groups tended to equate health with a sense of well-being, self-worth, and "feeling well." In contrast, middle and upper socioeconomic groups tended to view health as defined by exercising often, eating well, and "combatting" obesity.[4, 15, 16] It is also possible that this frame represents a coping strategy that obese people use in response to weight bias. Coping with weight-related stigma by using "self-love" and "self-acceptance" was reported by 86% of individuals in one study.[12] Once again, reducing the stigma surrounding obesity may be an important first step towards individuals accepting the 'medical' definition of obesity, and acceptance that a problem exists is the first step towards behavior change.

This study has several limitations. The question about "overweight" was always asked before the question about "obesity" and these questions were preceded by a series of other questions that could have shaped responses. The study participants were recruited from a longitudinal cohort of low-income mothers of children originally responding to an invitation in the child's preschool to participate in a study seeking to better understand children's eating behaviors, and results therefore may reflect the beliefs of individuals most likely to respond to an invitation to participate in this type of study. The results of this qualitative work may only be applicable to other low-income women who are mothers in the Midwestern United States. Finally, future work should consider examining these patterns within individual racial/ethnic groups.

IMPLICATIONS FOR RESEARCH AND PRACTICE

There are several implications of this study. First, interventionists might consider focusing efforts on educating the public regarding the definitions of overweight and obesity, while acknowledging both the limitations of the definition[13] as well as the current controversy regarding the robustness of links between obesity and disease.[14] Secondly, interventionists may focus efforts on reducing the stigma around overweight and obesity. While there is pervasive talk of "blame" for obesity among the lay public, the idea of "blame" is generally avoided during intervention delivery.[17] The role of personal responsibility for weight control versus regulation of the environment is a topic of intense political and personal debate. Interventions that involve public health messaging about behavior change, whether delivered to individuals or communities, by definition focus on personal responsibility. They also therefore imply "blame". In order to engage in an intervention, an individual must embrace some level of personal responsibility. However, in the current climate of intense

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stigmatization and blame, the obese individual is faced with a challenge. Specifically, he or she must embrace personal responsibility in order to embark on behavior change, but also dissociate that sense of personal responsibility from the blame that it connotes. Dissociating oneself may be the only way to cope with the idea that personal responsibility implies that one is 'lazy' and 'has no self-control'. At least one study has shown that treatment-seeking obese individuals manage "blame" by externalizing the locus of control for weight management.[17] Interventions may benefit from addressing this conundrum directly, particularly given that stigmatization is not a desirable motivator for behavior change and interventions may be most effective when there is an internal locus of control. Educating the public that the causes of overweight and obesity are complex, multifactorial, and not simply about "not caring about oneself" or lacking motivation is an important focus. In the short term, interventionists might consider finding a different term to convey the health risks associated with a certain body mass index. The use of the terms "obese" and "overweight" seem to elicit such strong feelings as to distract from the intended health message. Finally, substantial research is needed to understand (and address) the link between an elevated body mass index and health[18] and to identify ways in which to encourage healthful behaviors without increasing the stigma associated with obesity.

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