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# Obesity, Stigma, and Civilized Oppression

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The study was conducted to explore what it is like for individuals and family members to live with obesity as a chronic illness. An interpretive phenomenological design was used to obtain and analyze interviews of 13 obese individuals and 5 of their family members. A convenience sample was used to recruit the subjects who participated in the audiotaped interviews. The interviews used open-ended questions. Audiotapes were transcribed and analyzed for identifying the major themes within each transcript, and patterns of meaning across narratives. The major themes and patterns were described through written essays and group discussions about the transcripts. The participants revealed frequent experiences of stigmatization and discrimination on the basis of their obesity. Those who are obese are reminded through their everyday encounters with family members, peers, healthcare providers, and strangers, that their being deviates from social norms, and that they are inferior to those who are not obese. Obese subjects experience a pattern of denigration and condemnation that is so pervasive as to constitute what Harvey has called civilized oppression. A discussion of the social construction of obesity and the elements of civilized oppression, as they are experienced by those who are obese, offers new insights into interpersonal relationships that can provide a foundation for more effective care of the obese population. **Key words:** *discrimination, illness construct, obesity, oppression, stigmatization*

## PURPOSE OF THE STUDY

With the dramatic decline in mortality from infectious diseases in the 20th century, other health problems have gained in significance. Toward the end of the century, overweight and obesity* came to be regarded as the most preventable causes of morbidity and mortality, primarily because of their links to hypertension, coronary artery disease and stroke, and diabetes.[1,2] Yet, obesity carries psychological and social consequences no less serious than the physical consequences, and Stunkard and Sorensen have called attitudes toward obese individuals "the last socially acceptable form of prejudice."[3(p1037)]

*The Surgeon General's Call To Action To Prevent and Decrease Overweight and Obesity* states that one of the priorities should be to "change the perception of overweight and obesity at all ages. The primary concern should be one of health and not appearance."[1(p33)] However, for millions of Americans, attitudes about obesity are socially deep-seated and go far beyond issues of health. While it is common to hear people informally discuss their latest dieting strategy and the degree of success they have had in losing unwanted weight, it is unusual to hear obese people discuss what it is like for them to be overweight, and still more rare to hear them describe their weight control failures. For this reason, as a first step toward

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*Although they are distinguished for diagnostic purposes, the terms obesity and overweight will be used interchangeably throughout this article to refer to excess weight. All subjects reported a BMI greater than 35.

improving clinical care, the authors conducted a small hermeneutic phenomenological study to learn what it is like for obese individuals and their families to live with obesity as a chronic condition. The study aims at understanding what is meaningful and significant about being obese, not at solving the problem of obesity.[4(p2)]

## METHODOLOGY

Interpretive phenomenology was selected as the methodology to study how individuals and families live with chronic obesity, because this methodology is directed toward "gaining a deeper understanding of the nature or meaning of our everyday experiences."[4(p9)] Phenomenological research provides a way of bringing to light how individuals and families are aware or conscious of obesity in their life world. Although theory development is not an essential outcome of phenomenological research, the methodology may lend itself to theorizing by revealing the phenomena's previously hidden meanings, essential structures, and relationships. Phenomenology may also prompt theorizing by calling us to reflectively bridge these new insights with other touchstones we use in making sense of being human and living in the world.[4(pp8–21)]

### Sample and data collection

A convenience sample of 7 subjects who were personally known to the investigators was recruited for the study; 6 additional subjects were recruited through advertisements posted in a public place in a large mid-western medical center. In addition, 5 family members identified by the obese subjects were recruited for the study. The study received institutional review board approval, and all subjects gave informed consent to participate after the purpose and procedures of the study were explained to them.

All of the obese participants in the study were women; men were found to be reluctant to discuss their obesity for the study. Each woman was well educated; only 2 women had not attended college; the other subjects had achieved an associate degree or higher, and 2 of them had doctoral degrees. The sample included one African American woman and one Hispanic woman; all other subjects were Caucasian. The women ranged in age from 24 to 57 years. Each woman was employed, and all were working in a healthcare setting. These characteristics may have given the subjects a greater awareness of the potential complications of obesity and expected benefits of weight loss than the general population. Four of the family members interviewed were men: 3 husbands, and one father of the subjects. The other family member was the mother of one of the subjects. While the subjects were not representative of the obese population in terms of sex, education, or employment, they were candid and articulate in discussing their experiences and concerns about obesity and were able to demonstrate practical understanding about a growing health problem.

After giving their informed consent, the subjects participated in tape-recorded interviews, which used open-ended questions, and lasted between 1 and 2 hours. A nondirective approach to interviewing was used so as to elicit what was important to the participants about obesity. However, to help the participants tell their stories, the researchers developed several general questions to initiate their conversations, and to prompt the participants' discussion of their personal experiences when they seemed to have exhausted a particular line of thought. Typical interview items were as follows: (1) Tell me about when you first realized you were overweight. (2) What kinds of things have you tried in the past to lose weight, and how did they work? (3) What do you think has caused you to be overweight? (4) How has being overweight affected you? (5) What do you wish other people knew or understood about your weight problem? (6) Tell me about one of your experiences with a doctor or nurse related to your weight. (7) What do you see in the future for yourself? (8) How do you think your life would be different if tomorrow you awoke and were normal weight? The sample

questions were reframed for the family members, to assist them in talking about their relative's obesity.

The audiotapes were transcribed verbatim, with the names of all people (including the participants), places, agencies, and institutions replaced by pseudonyms. After rechecking the transcripts' accuracy against the tape recordings, punctuation was corrected to improve readability without changing meaning. Original tape recordings and copies of the transcripts are kept in a secure location and are to be maintained by the principal investigator for 7 years beyond completion of the study to provide an audit trail.

**Data analysis**

Copies of the transcripts were given to each member of the research team to analyze. Analysis of the data was based on the broad, fluid, nonlinear procedures identified by Spiegelberg. These procedures were as follows: (1) phenomenological description, involving intuiting, analyzing, and describing the phenomena; (2) apprehending the general essences or intuiting common patterns; (3) apprehending essential relationships; (4) observing modes of appearing; (5) suspending belief in the existence of the phenomena; (6) watching the constitution of phenomena in consciousness; and (7) interpreting the meaning of the phenomena.[5(pp259–298)]

Phenomenological description began with each member of the research team becoming immersed in the phenomenon of living with obesity by reading each transcript multiple times. The researchers noted elements of the narratives—concerns, aspirations, actions, phrases, and feelings—that stood out for them as they read and thought about the stories the participants told, as well as the sections of the texts that fueled those impressions. From these initial findings, they identified the essences, or common themes, that recurred within the narrative, and began grouping or classifying the themes within the transcript, and identifying the relationships between the elements. For each transcript, the team members wrote individual essays conveying their impressions of the narrative and their identified themes, to be shared with the group. Every 2 weeks, research team members met to discuss the major themes, and their relationships, revealed within individual transcripts.

After all transcripts had been individually analyzed, the researchers analyzed the transcripts with the aim of identifying common patterns (apprehending general essences) across the collection of narratives. This phase of analysis permitted the team members to compare and contrast similar experiences among the participants and to identify ways in which their experiences were alike and when they diverged. By exploring concrete examples of the essences, the group refined the themes and began to discern the ways in which being obese shows up in the lives of the participants by their encounters with others and in everyday situations.

The group discussions facilitated phenomenological reduction, or suspending beliefs about the phenomena. In analyzing the data, it is imperative for the researchers to bracket, or set aside, their prior beliefs, understandings, and assumptions about the phenomena and concentrate on the lived experiences presented by the participants "as fully and purely as possible."[5(p691)] Because obesity has been recognized as a major health problem and is often the subject of public, social commentary, the team members were often challenged to confront their own prior understandings and biases about obesity. Common preconceptions, such as "obese people need to lose weight," "losing weight improves health," and "people can lose weight if they want to," arose in early group meetings. The researchers found it useful to discuss their between-meeting exposures to mass media coverage of obesity, such as news reports on the obesity epidemic, as well as personal contacts influencing their awareness of obesity, as when friends discussed the Atkins diet. By openly contemplating these influences, the team members were able to come to an understanding of the social construction of

obesity (described below) and how it shapes their own opinions.

These discussions also helped the researchers to then detach from their preconceptions and shift their focus to what the participants had to say about obesity, without dwelling on whether the participants' experiences were true, exaggerated, or appropriate. As the researchers identified important themes or common elements of living with obesity, they developed descriptions of the structures and relationships of the themes, how the themes show up in the lives of the participants, and how their encounters with others shade the participants' understandings of their own lives. For example, early writings and discussions revolved around themes of control and its converse, lack of control, power and powerlessness, and meanness or rude behavior toward the participants. Attempts were made to explicate what was meant by control or lack of control through describing the mood or feelings of the participant and exploring what control meant in terms of control over whom or what, control by whom, how control was wielded or forfeited, and what the expected or real consequences of exercising control were. Drawing on specific examples to illustrate the control or lack of control themes revealed multiple aspects of the theme. These were attempts by the participants to control themselves, their eating and exercise behaviors, and their weight; and attempts by others to control the participants and their behaviors. Similarly, the team used passages from the transcripts to explore episodes in which the participants described other people doing or saying things to them that were mean or hurtful. The researchers focused on the relationship of the other person to the participant, what was hurtful in the situation, the participant's response, the consequences, including feelings and emotions, and what the participant found significant in the encounter.

By examining such themes as control or lack of control, power and powerlessness, and meanness, the researchers discerned common patterns of situations in which the obese person was taunted by others, usually people who were not overweight. Typically, the participant was in a position of less perceived power than the person doing the taunting, and the effect was to shame, humiliate, diminish, coerce, or silence the person who was overweight. As a result, the participants revealed that they often become aware or conscious of obesity when it shows up in their everyday world through experiences in which they are discriminated against, ridiculed, or put down by others.

Finally, in attempting to better understand what happened to the overweight participants in these encounters, team members considered other contexts in which people exercise unequal power, or members of one group seem to be able to abuse others with impunity. Only after the major themes and patterns had been set forth, did the researchers conduct an extensive review of the literature. The researchers compared what they learned from additional sources about power, control, and abuse with what they understood of the themes and patterns found in the transcripts. In reviewing the literature, attention was paid to ways in which the transcripts did, or did not, overlap the published sources.

## FINDINGS

In analyzing the interviews about living with obesity, the researchers were not surprised to find that the obese women were subjected to stigmatization and discrimination. However, in returning to the literature to understand the participants' stories of stigmatization, powerlessness, and humiliation, the authors were startled to find that the insidious and pervasive pattern of casting present in the narratives epitomize what Harvey has called *civilized oppression*.[6] In the discussion that follows, the authors will describe the social construction of illness and obesity and how that social construction shapes the lived experience of those who are obese. The characteristics of civilized oppression will be presented

and related to the experiences of those who were interviewed about what it is like for them to be obese. Finally, implications for nurses and other clinicians, who are often unwitting sources of civilized oppression against those who are obese, will be considered.

## SOCIAL CONSTRUCTION OF ILLNESS AND OBESITY

Individuals and groups within a society define the meaning of diseases and disorders. The social construction of a disease is the ordinary or conventional point of view about the disorder, and is the amalgamation of perspectives put forth by diverse and sometimes competing groups with vested interests in the condition. These divergent groups establish how a disease is perceived and what it means to the society as a whole.

Western societies share a common social construction of obesity. Historically, being overweight has been associated with gluttony and sloth, which represent overindulgent behaviors. This connection between obesity and 2 of the 7 deadly sins equates obesity with sinfulness and connotes a lack of moral rectitude by the obese person. Bovey contends that the Protestant and Puritan work ethic, which valued the virtues of self-denial and discipline, consequently denounced opposing behaviors as sinful and immoral. The author also maintains that early Christians equated food with sensuality that nurtured the flesh.[7] Therefore, spiritual growth could be found in sacrificing food and the flesh. Fasting is still practiced by many religions as a path to purification of the body and spirit. In contrast, obesity represents the outward manifestation of self-indulgence and spiritual imperfection, exemplifying the biblical admonition "the spirit is willing but the flesh is weak" (Matthew 26:41).

Building on this religious foundation, other groups have contributed to our prevailing conception of obesity. In the United States, the National Institutes of Health (NIH), the United States Public Health Service (USPHS), and the Centers for Disease Control and Prevention (CDC), along with major organizations such as the American Heart Association and the American Diabetes Association, and healthcare providers are major contributors to the social construction of obesity. These agents have a significant influence on what society thinks about obesity, and they stress the relationship between obesity and the risk of death and disability.[1,2] These forces contribute to our understanding of obesity as unnatural, abnormal, and unhealthy. They reinforce the social understanding of obesity as a disease, but one that can be prevented or corrected by personal effort. In this construction of obesity, those who are overweight bear the blame for having the condition. This construction of obesity is similar to the condemnation faced by people contracting sexually transmitted diseases or lung cancer. However, it is in contrast to the social construction of other illnesses, such as pneumonia, arthritis, appendicitis, breast cancer, cystic fibrosis, or leukemia, in which having the condition is considered largely beyond the control of the affected individual.

Other parties also frame the meaning of obesity. Drawing on the conceptualization of obesity as unhealthy, undesirable, and personally malleable, diet book publishers, diet food producers, and pharmaceutical and insurance companies stress the need to fight and abolish obesity. Fashion designers and clothing manufacturers, as well as advertising agencies, promote an ideal, often emaciated, body image. More recently, the airlines industry announced a vested interest in the meaning of obesity, announcing obese passengers would be charged for 2 seats.[8]

Perhaps most paradoxical is the contribution that obese individuals themselves make to the common understanding of obesity. From a social construction perspective, obesity is a problem about *losing* weight. From local healthcare providers to national advocacy agencies, the challenge to the obese person is to lose weight to improve health. Diet books, programs, and supplements are aimed at helping the obese person lose weight. That most

obese individuals can—and do—lose weight contributes to the perception of obesity as a problem of individual voluntary control. The frequency with which overweight people are able to lose substantial amounts of weight reinforces the impression that individuals are able to control their weight by caloric restriction and exercise. Unfortunately, successful and repeated weight loss through personal effort obscures the conceptualization of obesity as a problem, not of losing weight but of *sustaining* weight loss. The evidence that only a small percentage of obese individuals can successfully lose weight and maintain the weight loss over several years has been carefully documented,[9–11] but is absent from the broader social construction of this condition.

The prevailing, culturally shared meaning of obesity as a consequence of self-gratification is the foundation for the widespread prejudice against those who are overweight. It is this commonly held conceptualization of obesity that gives rise to the civilized oppression faced by overweight people as part of their everyday lived experience.

## CIVILIZED OPPRESSION

Oppression generally refers to burdening another person physically, mentally, or spiritually by abuse of power or authority. Harvey discussed that within Western societies, subtle forms of civilized oppression exist, as exemplified by racism, classism, and sexism. Harvey claims that "oppression involves a systematic and inappropriate control of people by those with more power,"[6(p37)] and asserts that oppression "has at its heart systematic and morally inappropriate control embedded in relationships that are morally unacceptable."[6(p53)] Not all forms of oppression are overt, or violent, or physically brutal. Although they are not always as readily apparent as other forms of abuse, the lifelong effects of civilized oppression are nonetheless degrading and destructive to the recipient, in part, because they are not recognized as morally wrong.

Characteristics of civilized oppression come into play in the day-to-day relationships and experiences of overweight individuals. According to Harvey, key elements of these oppressive relationships are that they (1) are nonpeer, power-laden relationships, (2) involve interactions that diminish and control the recipient who has little recourse, (3) pose cumulative acts of omission and commission that distort the relationship(s), (4) cause harm or disadvantage to the subject, (5) may be without malicious intent, and (6) are insidious and obscured in routine or daily encounters.[6] Harvey's characterization of civilized oppression provides a valuable framework for understanding the lived experiences of people who are obese.

### Nonpeer, power-laden relationships

For civilized oppression to take place, a nonpeer, power-laden relationship must exist. The individuals in the relationship are mismatched on the basis of personal power derived from such attributes as wealth, education, attractiveness, and athleticism. The relationship may also be unequal based on organizational power or assigned power within an organization. One individual in the relationship may also hold more power on the basis of social prestige; this individual, such as a judge, cleric, or elected official, is afforded special rights, respect, or consideration on the basis of a social position.[6(p49)] The person who is overweight or obese is likely to be in the subordinate power position as a result of his or her obesity. His or her personal power is diminished by virtue of being less attractive[12–14] and less athletic. In addition, those who are obese often have less education and a lower income than do nonobese people.[12,15]

In oppressive relationships, interactions and attitudes tend to devalue, humiliate, or denigrate the target individual.[6] In describing her experiences of being obese, Barbie told of being devalued in a particularly memorable

encounter with her physician:

> I went to talk with her about a big ugly scar and protruding hernia that I had after my gallbladder surgery. She asked me why I was worried about it since I wouldn't be wearing a bikini anytime soon. I thought that her comment was offensive and inappropriate, and I wanted to slap her across the room, but I couldn't argue with her.[16(p27)]

The nature of the unequal power in relationships makes it possible for the oppressor to feel it is safe to "put down" the other person. Obesity seems to be one of those factors that subordinates an individual in a relationship. Carol, an obese respiratory therapist, told the interviewer of patients feeling safe in calling attention to her weight. She stated,

> Sometimes you get so aggravated because you think, "These people are making fun of me." I've had patients say to me, "Well, they must pay pretty good, because obviously you haven't *made* a lot of meals."[17(p6)]

The patient assumed that Carol's obesity is the consequence of her overindulgence by dining out. Ordinarily, healthcare personnel are shielded from personal gibes because they have the advantage of high levels of education, and they have power over the care the patient can expect to receive. However, as this episode demonstrates, the patient-clinician role has been distorted by the clinician's obesity, and Carol's professional prestige was not high enough to ward off the patient's ridicule.

The embedded cultural attitude that obesity is a failure of willpower may be counter to scientific evidence,[18–22] but it continues to be the prevailing social construction of obesity. Because obese people are considered morally "inferior," it is socially acceptable to make slighting comments without regard to their feelings of embarrassment or humiliation.

### Diminishing and controlling the obese person

In Harvey's understanding of civilized oppression, relationships are laden with interactions that diminish, degrade, belittle, and control the oppressed person.[6] This was evident in the previous encounters described by Barbie and Carol. When Barbie was ridiculed by her physician about her scar, she was placed in a position in which there was no logical or appropriate response. She was silenced and left powerless in the patient-physician encounter. Similarly, Carol was the object of ridicule by her patient, but had no immediate recourse to exert her power or control in the situation. Two hours later, having been the recipient of a stinging put down by the patient, Carol would be involved in resuscitating the patient, thinking, "Do you understand you just insulted me and here I am using the Ambu-bag to put life-giving oxygen into your lungs and I really don't want to."[17(pp6–7)] Carol has no acceptable way of countering the callous remarks of her patient. The oppressive comments not only demean the individuals but also silence their protest. From these types of incidents, obese individuals find they must "live in constrained silence."[6(p59)]

For the person who is obese, but who has lost weight, the moral advantage his or her weight loss should provide is often denied to him or her. Even when patients do succeed in meeting the recommendation to improve their risk of other chronic illnesses by losing 5% to 10% of their total body weight,[1,2] they often *remain* overweight or obese. This dilemma was revealed in the interview with Deborah. She recalled that after she had "lost about eighty pounds," and "knew she looked very nice," she was still subjected to slighting comments:

> There would be people who would say, "You know, you are so pretty, if all you'd lose is twenty pounds." I'd lost eighty pounds at one time . . . and I thought, "If only you knew." I was starving myself and I needed to lose another twenty pounds.[23(p3)]

For Deborah, substantial weight loss did not elevate her public worth. She was still obese, and, thus, in an inferior position of personal power. She remained the recipient of degrading comments that served as effective put downs. The efforts she had put into losing weight, and her substantial

achievement, were irrelevant within the larger social context.

In subtle ways, individuals who are obese are often publicly reminded that they do not "fit in." Facilities in public places are designed for slender people and do not accommodate size diversity. When overweight people attend public events, this can be both uncomfortable and humiliating, as Barbie recalled when describing an event in which she attended a professional football game. She said,

> We were given tickets through work to a game, and we were sitting in the lower level. My ass was too big for the seats, so it was very difficult for me to fit into the seats. During the game, it was very uncomfortable, so that was . . . very embarrassing.[16(p19)]

Since taxes are often used to build sporting venues and civic arenas, the lack of attention to the needs of overweight citizens in seating arrangements is not just a lack of consideration, it wrests control away from many of those who pay for these public assets.

With an increasing number of people becoming obese, the lack of accessible public facilities will continue to surface as a problem. The lack of comfortable, "obese friendly" accommodations will increasingly exclude this segment of the population from full participation in normal social events and activities.

### Cumulative acts of omission and commission

Civilized oppression involves cumulative acts of coercion and control that distort interpersonal relationships. Harvey contends that relationships

> . . . can be molded by a series of trivial acts, which cumulatively distort the relationship in an anything but trivial fashion. Nothing visibly dramatic may be involved, and one has to appreciate the pattern of the acts before the nature of the problem is clear. Bystanders and even victims themselves often realize the problem very late in the day in such circumstances . . . Realization is even harder to come by when many of the contributory acts are acts of omission—something . . . not uncommon in oppressive relationships.[6(p34)]

Furthermore, the subject may be trapped in a web of distorted relationships affecting multiple areas of the person's life. Thus, the person who is the recipient of these hurtful acts of omission and commission experiences them as the fabric of his or her everyday life.

For people who are obese, oppression results from being exposed to frequent expressions of prejudice in multiple contexts of daily life, often beginning in childhood. Crystal became aware of her weight problem in the second grade,

> when one of the kids in my class called me fat. We were playing four square . . . and one girl pushed me aside and said, "Get out of here, fatso, you can't play." . . . That's when it hit me.[24(p4)]

Similarly, Barbie, now in her mid-thirties, remembers the first time she realized she was overweight, "I was probably between 7 and 8 years old. I was outside playing, and someone said, 'fat-ass, get off of me.' "[16(p1)] Carol has memories of her mother telling her, "You're fat and you're ugly, and your dad's not going to love you."[17(p8)] Probably, as a result of her memories of the ridicule she endured, Crystal is especially sensitive to the relationship between her teenage son and overweight daughter. She stated,

> It's kind of hard for me to watch that, because she's been like me since day one . . . [My son] is just like his dad, he's a toothpick. So that's a source of contention with them. He calls her fat all the time, and it just upsets me to no end.[24(p10)]

Unfortunately, taunting does not end in childhood. Barbie's husband Ted is embarrassed to remember how he chided her about her weight. His disclosure indicates how he perceives a lifelong distortion in their relationship:

> I told her—I made the mistake of telling her this—it was a joke. When we were young, she was eighteen and I was twenty six, I made the comment that "If you get fat, I'll divorce you." It was a mistake. She lives with that every day. I think that worried her more than anything, that if she got heavy that I would leave her.[25(p2)]

Public slights are common experiences for those who are overweight. Carol stated,

"Clerks don't wait on you, they ignore you,"[17(p2)] and she gave specific examples, including an incident at a large department store where she had gone to buy paint:

> I stood there for forty-five minutes to an hour waiting on the clerk to come back and wait on me and mix the colors I had already chosen. And when he did come back, he didn't even speak to me. He just done it and put it in the cart . . . I had talked to him and he said, "I'll be right back." And I even flagged down a couple of other clerks and they just [said] "Well, we'll let him know." And he just came back in his good old time, which was close to an hour later.[17(pp2–3)]

As when the store clerk refused to speak to Carol when he returned with her paint, and did not return in a reasonable time, obese individuals are diminished by acts of omission as well as acts of commission.

Perhaps in no area of life is the obese person diminished by acts of omission more than in dating practices. Overweight boys and men may be turned down for dates because of their weight, and obese girls and women are slighted by just not being asked. Carol recalls that as an adolescent she felt "very awkward, very backward, and very self conscious"[17(p9)]—typical feelings among teenagers. However, by the time she was a sophomore, she was not dating and it was not because she did not have boys who were friends:

> I was not dating, I was not being asked to dances and boys were not calling me at home, although I had a lot of guy friends. They were not calling me in a romantic way. They were calling me and saying, "You know such and such, did she say anything about me?" Stuff like that. I was everybody's best friend, but nobody's girlfriend.[17(p9)]

Barbie echoed Carol's experiences. As a teenager, she was overweight, but very active in sports, and performed well in athletics. She stated:

> I was a tomboy growing up. I didn't have a lot of girlfriends, I had boyfriends. I did a lot of things with them. I didn't have dolls. Then all of a sudden the guys looked different to me. You know, it's hard when they're not looking back. Then you start to understand and realize why.[16(p2)]

Dating is an integral form of social interaction and the basis for important interpersonal relationships. Appearance is a key ingredient in initiating social contacts, and on the basis of judgements about attractiveness, many of those who are obese miss out on the opportunities for social engagement. Research has shown that overweight individuals are more likely to be viewed as unattractive than those who are not obese.[13,14] It should come as no surprise, therefore, that overweight adolescents and young adults have been found to be more likely to have low self-esteem, have smaller social networks, and lower rates of marriage,[15,26] than do people who are not overweight.

### No malicious intent

Civilized oppression occurs even when the perpetrator does not mean to inflict harm; well-intentioned acts can contribute to oppression, because they reinforce an unequal relationship and are typically hurtful to the recipient. Shannon, an obese woman with type 2 diabetes, described the taunting she faces from her husband Bobby, who does not have a weight problem and enjoys eating out.

> . . . [W]e'll go somewhere and eat out, and sometimes he orders dessert or something and he'll say, "You want a bite of that?" And he'll pull his plate away and say, "No, you aren't suppose to have that!" Sometimes that only makes you want it more, and sometimes I just wanted a tiny bite to taste, and sometimes he'll let me have it and then he'll say, "No more!"[27(p12)]

Ironically, Bobby's tempting of Shannon with foods she should not eat is not malicious. As he explained,

> The thing of it is, I don't like to go out and eat by myself, so I gotta take my wife with me, too, but sometimes I wanna put a black blind between us—what I eat and what she eats—so she can't see what I'm eating. But I want her to be there.[27(p13)]

It is not Bobby's intent to persecute his wife with foods that contribute to obesity for her—but not for him—and it is tragic that these hurtful encounters arise out of his love for her and his desire for her companionship.

The healthcare community exhorts the obese to "lighten up" through public campaigns,[28,29] and both family members and strangers may harshly criticize and taunt the obese person. Healthcare providers also frequently criticize their overweight patients, for as Shannon stated, "I've gained about fifteen pounds since I went back to work and I have an upcoming doctor appointment and she's not going to be thrilled to hear that, but I'm trying to work on that. It's just a struggle."[27(p14)]

### Harm or disadvantage accrues

Another element of civilized oppression is that harm or disadvantage accrues.[6(p19)] These harms range in degree of severity and visibility and include shame and humiliation, economic disadvantages and sanctions, and constraint, isolation, and alienation. For obese individuals, oppression can also undermine their health and healthcare.

Shame or humiliation is one of the chief harms inflicted on the obese population. Often, the shame begins in childhood and continues throughout a lifetime. Even after losing weight, the obese person is likely to experience the shame of regaining the weight that was lost through intense effort. The person comes to view the weight recovery as a personal failure, and the exigency to lose the weight is unrelenting. Having tried a number of weight control programs, Traci described herself as unhappy with her current weight and explained,

> None of my clothes fit. I'm heavier than I've ever been . . . I'm heavier by about ten pounds than I have ever been . . . There's not a day that I'm not thinking about losing weight, or I've gotta lose weight, or this doesn't fit anymore, I've got to get down. And it's always gotta, gotta, gotta, gotta.[30(p12)]

Barbie reported that in her latest dieting efforts she had lost a lot of weight, but acknowledged she was concerned because, "at the moment I've put on 25 of the 95 pounds that I've lost in a year. I'm on that cycle again, that I need to stop now."[16(p15)] Her husband Ted, however, had a different perspective:

> She is not forgiving of herself at all. She lost a dramatic amount of weight this last time, and she has picked up fifteen pounds. She's angry at herself for that, I can tell. And she's back working at getting it back off—a lot harder.[25(p4)]

One of Deborah's weight loss attempts left her with enduring shame and humiliation. As she began regaining weight, she began practicing bulemic behaviors, sometimes forcing herself "to throw-up, up to three times in one night."[23(p6)] She started taking diet pills, and although the pills helped her lose weight and gave her the "stamina" to take care of her other children when her son required surgery for a brain tumor, they had disastrous results when she brought him home:

> Boy, I was thin, I'll tell you . . . And when I came home, I had probably not eaten for three days, and I think that he was not eating well either. I was supposed to be giving him a growth hormone injection, and I was thinking, I won't give it to him tonight, 'cause I feel too messed up. I won't give it to him tonight, I'll give it to him tomorrow night . . . Well this went on for several days . . . and then he had a seizure. He had a seizure, and I tried to mix the glucagon, I could barely mix the glucagon. And I revived him from the seizure with the glucagon, and I ran and got him something to eat . . . I couldn't take him to the emergency room, because then they would take him away from me. So I said, "God if you just help me get him through this and get him stable, I will never take another diet pill again, ever." And I didn't, I stopped right that night.[23(p7)]

Economic harm and disadvantage accrues to obese individuals in a myriad of ways. A longitudinal study of young people aged 16 to 24 at the outset of the study showed that both men and women who had been overweight at the beginning of the study completed fewer years of study, were less likely to be married, and had lower household incomes than did those who were not overweight. These findings were more pronounced among women than among men. Furthermore, these trends were greater than those for many other chronic physical disabilities, including asthma, musculoskeletal

anomalies, and neurological and sensory disorder.[15] Employment opportunities and advancement are often denied to people who are overweight.[12,15,31,32] Interestingly, none of our subjects thought that they had been discriminated against, either in hiring or promotion, perhaps because they were all well educated and had skills in high demand. However, Carol reported,

> There seems to be a general consensus until coworkers . . . get to know me, that I am dumb, lazy, dishonest, lying, because after talking to some of them after they've gotten to know me, [they've] actually told me that they never figured that "somebody with your actual body weight could actually know what they were doing." Because if you were that smart you wouldn't be that heavy or that fat . . . I've definitely had to [fight for respect], making it known, especially to the nursing staff, that I do know what I am doing . . . It has been almost two years, and it's taken every bit of that time. So you have to get past the first impressions, the prejudice.[17(p3)]

Civilized oppression is also harmful because it "undermines a person's confidence about life,"[6(p76)] and engenders isolation and alienation. Recipients of oppression develop "self-doubt about one's personal integrity," and may come to "despise their day-to-day lives, perhaps even themselves."[6(pp76–77)] Carol was particularly clear about how the social isolation and self-alienation develops for overweight children:

> In kindergarten, I was really popular. That was before myself and the rest of the children realized that being heavy . . . was a bad thing. During grade school, not much of a problem . . . But by the time I was ten, I was being trained by my mother and my three very slender brothers, that this is not acceptable to be this way. So I started feeling different, not only toward my family, but towards myself. And looking back on it now, I saw that it started affecting my peers. So that by the time I was in the seventh grade, I was very introverted, very shy, and stayed very much to myself. Didn't have a lot of friends . . . It didn't seem to be a big deal until the fifth grade. So by the time I was in the seventh grade, I was very awkward, very backward, and very self-conscious.[17(p9)]

Self-alienation was apparent in several of the interviews, including among subjects who did not develop their weight problem until adulthood. Kelley, a 34-year-old mother of 3 children, who developed her weight problem following her first pregnancy, stated, "Oh, I am just so tired of myself. [I] don't need to be this heavy; [I] need to get it off. And the harder I am on myself, the more I go and eat."[33(p6)] Barbie revealed,

> There's been [times] when I'm happier being overweight and I've been more unhappy when I'm losing weight. I almost have to get to a state of mad, or determined, so I feel like I can do it; so that I can do it, to overcome cravings or whatever it is that forces me to eat what I . . . shouldn't.[16(p10)]

To lose weight, she says, "Anger or passion is usually what gets me motivated . . . The anger coming at myself for allowing myself to get that way to begin with."[16(p4)] Likewise, Kisha, a 30-year-old Black woman, finds self-directed anger over her weight a prime motivating factor in her efforts to control her weight. "I just get real angry sometimes," she said, ". . . and it just gets so frustrating. It just gets frustrating . . . I just get *mad* . . . I just get mad, because why can't I lose this weight? Why is it so hard?"[34(pp10–11)]

Deanna exclaimed about being heavy, "I hate it!"[35(p16)] She hates her current way of being so much, she has consulted a surgeon about a bariatric procedure, and says:

> This really sounds terrible, I would just about . . . do anything to be able to lose this weight . . . That's why I went to talk about that. I mean . . . to go in and have your stomach partly removed and reattached, I mean there's some desperate feelings going on there.[35(p16)]

Deanna and thousands of other patients are willing to "divorce" part of their bodies if it will help them not be obese. Obese individuals will risk the common complications of gastroplasty to lose weight because the prospect of vomiting, severe diarrhea, electrolyte imbalance, infection, and reoperation[36(pp986–987)] is preferable to living as a fat person in contemporary society. Dieting, surgery, and losing weight become

additional forms of self-reproach and punishment obese people impose on themselves for "getting that way in the first place." In their efforts to conform to the expectation to be slender, they become complicitous in their oppression.

Often, obese individuals have been so oppressed that they are cut off from their understanding of their own bodies, their own worth, their own feelings. Each of our subjects voiced self-blame for their obesity. For example, Deanna stated, "I have done what I have done . . . The blame has to come on my shoulders . . . When it comes down to it, it's me."[35(p21)] Traci, a nurse who has been struggling with her weight since college, is equally straightforward, saying,

> I think my real reason I haven't lost weight over the last few years is just lack of exercise. Diets have come and gone, I've tried everything. I've done the meat diet, the Slim-Fast diet, and I would lose four or five pounds, and then it would come back. And I just don't stick with anything consistently.[30(p4)]

Without a second thought, obese people passively agree with the major construction of obesity as their own fault, because that is how they have been inculcated socially. They rarely publicly challenge the social construction that weight is the result of personal weakness and that their obesity is the product of self-gratification and moral failure. They continue to hold to the notion that if only they were more disciplined and self-controlling they could overcome their weight problem. Only rhetorically do they question why achieving that level of self-discipline and control proves so elusive, as when Kisha described getting angry and frustrated at herself, and questioning, "Why can't I lose this weight? Why is it so hard?"[34(pp10–11)] For the vast majority of people who are obese, this question has no meaningful answer; to say it is because they eat more calories than they expend misses the heart of the problem: *why* do they eat more and *why* are they so resistant to exercise? However, there are scientific answers for why their struggle is so hard and why they so easily recover the weight they do lose.[18–21] Yet, none of our subjects were aware of the known metabolic effects of weight loss. The withholding of this information (an act of omission) from the people who most desperately need it contributes to the civilized oppression of those who are obese.

A paradoxical harm that accrues through civilized oppression is the recipient's absorption of the social construction and negative attitude toward others who are obese. People who are overweight often develop the same prejudices against obese individuals as the general public. Barbie demonstrated amazing insight when she revealed:

> I can't say that I don't avoid fat people, as well, which is pathetic. But as much as I don't like to be judged by it, I understand that our society does, and I have been brought up in that society as well. And I've been taught that fat isn't healthy, good . . . So I have to say that I pretty much have the same opinions that a lot of people have about fat people, even if I'm that way.[16(p7)]

Having been stigmatized and ostracized because of their weight, those who are obese are likely to contribute to the oppression of others for the same reasons because that is how they have been socialized. They are confronted with their own tendencies to stereotype others as unattractive, less worthy, and inferior on the basis of weight.

Finally, overweight and obese patients are also subjected to harm from a healthcare environment that subjects them to civilized oppression. The lack of sensitivity to their weight problem was often cited among our research subjects. Martine, a 30-year-old lab technician, stated that when she sought help for her weight problem, her physician told her: "If you were my wife I wouldn't let you eat that much."[37(p1)] When Deanna consulted a surgeon about knee surgery, she was frustrated by his cavalier attitude about her weight:

> And he says, "Before we operate, you need to lose twenty pounds. You just need to lose twenty pounds. That oughta be easy."... How dare you think that will be easy for me? . . . That's not to say

I didn't need to lose that twenty pounds, but it was just the fact that he said, "That'll be easy."[35(pp1–2)]

Research has shown that healthcare providers, like others in society, describe overweight individuals as repulsive, disgusting, weak, and lacking self-discipline.[38] Prejudice against people who are overweight is as prevalent among healthcare providers as among the general public.[31,39] It is noteworthy that research has found that obese women, who are at higher risk of breast and endometrial cancer, undergo screening for breast and cervical cancer less frequently than do nonobese women.[40–42] Obese patients may choose to forego early or preventive healthcare so as to avoid oppressive encounters with clinicians.

The women described other health risks to which their weight control efforts exposed them. In high school, Barbie discovered that taking speed helped her keep her weight down.[16(p3)] Kisha, Kelly, and Deborah used prescription appetite suppressants,[34(p5),33(p2),23(p7)] risking addiction. Deborah's use of these drugs made her "practically psychotic" from lack of sleep,[23(p7)] and put her son at risk as well, because of her inability to properly care for him. Deanna is willing to risk the acute and chronic complications of gastroplasty to be slender.[35(p16)]

## IMPLICATIONS FOR NURSES

Nursing's tradition is steeped in the ideal of providing care to all people in a manner that respects their human dignity and individual worth. Recognizing the ways in which oppressive, denigrating, and demoralizing encounters find subtle expression in daily life for obese patients is essential if nurses are to extend that tradition to the care of obese patients. Intangible components of victimization and civilized oppression, such as degrading humor, publicly demeaning another person, abusing interactive power, silencing protest, and moral abandonment, are insidious because they are subliminal. This is especially relevant to healthcare providers caring for obese patients, because, in civilized oppression,

> . . . it is harder to spot power at work, when it does not involve outright physical force or use of the law, and it is far harder to spot one's own involvement in such oppression, most especially when the involvement is habitual, expected, and perhaps completely unconscious.[6(p96)]

Nurses in all settings have an obligation to recognize their personal attitudes about obesity and obese patients. Each clinician needs to develop self-awareness of the overt and covert messages conveyed to obese patients about their weight, their weight loss efforts, and especially their weight control failures. Enlisted in the war on obesity, nurses seek to inspire and motivate diabetic, hypertensive, and cardiac patients to lose weight, and are frustrated when patients are "noncompliant." Rather than react to that frustration in ways that diminish the patient's moral standing, nurses need to focus on the frustration the patient is likely to be experiencing. Few overweight patients have not made previous attempts to lose weight, and nurses need to engage their patients in exploring what they have tried in the past, how successful they were, and how long they sustained their success. Nurses also need to examine what their obesity and their efforts to control their weight have cost these patients in terms of their self-esteem, their relationships with others, and their outlook for a satisfying life. This interaction, in and of itself, may not assure the desired behavioral changes from their patients, but can assist nurses in gaining sensitivity toward the unending struggle and suffering these patients face.

In counseling patients of the need to lose weight, nurses need to avoid creating unreasonable expectations, and need to appreciate the success patients do achieve. Optimal weight loss is 5% to 10% of starting weight. However, for many patients, even this modest goal may not be achievable, and what is needed is an appreciation for the intense effort that every lost pound represents.

To combat the prevailing social construction of obesity as a moral failure, nurses must actively seek a greater understanding of the physiological processes that protect obese patients' excess weight. At a time when nurses are in the forefront of teaching patients about the pathophysiology of diabetes, heart disease, cancer, human immunodeficiency virus infection, and genetic disorders, it is unacceptable for them to not also be teaching patients about how adipose tissue develops and how physiology is altered by caloric restriction and weight loss. Nursing educators need to confront and challenge their students' attitudes about obesity and people who are overweight, and model for them attitudes of caring and compassion for obese patients. Encouraging patients to lose weight is not enough; good nursing practice requires nurses to be in the vanguard opposing the stigmatization and oppression of those who are obese.

**REFERENCES**


1. US Department of Health and Human Services. *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity*. Rockville, Md: US Dept of Health & Human Services; 2001.
2. National Heart Lung and Blood Institute Obesity Education Initiative Expert Panel on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. The Evidence Report*. Bethesda, Md: National Institutes of Health; 1998. NIH Publication No. 98-4083. Available at: http://www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm. Accessed October 23, 2001.
3. Stunkard AJ, Sorensen TIA. Obesity and socioeconomic status—a complex relation. *N Engl J Med*. 1993;329:1036–1037.
4. Van Manen M. *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. Ontario, Calif: The Althouse Press; 1990.
5. Spiegelberg H. The essentials of the phenomenonological method. In: Spielgelberg H, ed. *The Phenomenonological Movement: A Historical Introduction*. Vol 2. Hague, The Netherlands: Martinus Nijhoff; 1965:653–701.
6. Harvey J. *Civilized Oppression*. Lanham, Md: Bowman & Littlefield; 1999.
7. Bovey S. *The Forbidden Body*. London: Pandora Press; 1994.
8. Beaudette M. Southwest will charge large fliers extra fare. *The Washington Times*. June 19, 2002:A01.
9. Stunkard AJ. The management of obesity. *N Y State J Med*. 1958;58:79–87.
10. Wadden TA. Treatment of obesity by moderate and severe caloric restriction: results of clinical research trials. *Ann Intern Med*. 1993;229:688–693.
11. Rosenbaum M, Leibel RL. Pathophysiology of childhood obesity. *Adv Pediatr*. 1988;35:73–137.
12. Puhl R, Brownell KD. Bias, discrimination, and obesity. *Obes Res*. 2001;9:788–805.
13. Tovee M, Areinhardt S, Aemery J, Corneissen P. Characteristics of male attractiveness for women. *Lancet*. 1999;353:1500–1503.
14. Furnham A, Dias M, McClelland A. The role of body weight, wait-to-hip ratio, and breast size in judgments of female attractiveness. *Sex Roles*. 1998;39:311–326. Available at: http://www.findarticles.com/cf_0/m2294/n3-4_v39/21227871/p1/article.jhtml. Accessed July 27, 2003.
15. Gortmaker SL, Must A, Perrin JM, Sobol AM, Dietz WH. Social and economic consequences of overweight in adolescence and young adulthood. *N Engl J Med*. 1993;329:1008–1012.
16. Rogge MM. M Greenwald interview with Barbie. In: *Living With Obesity: The Patient's Point of View*. Indianapolis: Indiana University School of Nursing; 2003.
17. Rogge MM. A Golden interview with Carol. In: *Living With Obesity: The Patient's Point of View*. Indianapolis: Indiana University School of Nursing; 2003.
18. Leibel RL, Hirsch J. Diminished energy requirements in reduced-obese patients. *Metabolism*. 1984;33:164–170.
19. Ravussin E, Lillioja S, Knowler WC, et al. Reduced rate of energy expenditure as a risk factor for body-weight gain. *N Engl J Med*. 1988;318:467–472.
20. Weigle DS, Sande KJ, Iverius PH, Monsen ER, Brunzell JD. Weight loss leads to a marked decrease in nonresting energy expenditure in ambulatory human subjects. *Metabolism*. 1988;37:930–936.
21. Leibel RL, Rosenbaum M, Hirsch J. Changes in energy expenditure resulting from altered body weight. *N Engl J Med*. 1995;332:621–628.
22. Okasha M, McCarron P, Smith, GD, Gunnell D. Trends in body mass index from 1948 to 1968: results from the Glasgow alumni cohort. *Int J Obes*. 2003;27:638–640.
23. Rogge MM. MM Rogge interview with Deborah. In: *Living with Obesity: The Patient's Point of View*.

Indianapolis: Indiana University School of Nursing; 2003.
24. Rogge MM. MM Rogge interview with Crystal. In: *Living with Obesity: The Patient's Point of View*. Indianapolis: Indiana University School of Nursing; 2003.
25. Rogge MM. M Greenwald interview with Ted. In: *Living with Obesity: The Patient's Point of View*. Indianapolis: Indiana University School of Nursing; 2003.
26. Strauss RS. Childhood obesity and self-esteem. *Pediatrics*. 2000;105:e15.
27. Rogge MM. D Leverett interview with Shannon and Bobby. In: *Living with Obesity: The Patient's Point of View*. Indianapolis: Indiana University School of Nursing; 2003.
28. The Care Group. Lighten up Indiana. Obesity: an epidemic that's not contagious. 2001. Available at: http://www.lightenupindiana.com. Accessed February 10, 2002.
29. Iowa Games. Lighten Up Iowa. Get ready to lighten up Iowa! Available at: http://www.lightenupiowa.org. Accessed January 22, 2003.
30. Rogge MM. MM Rogge interview with Traci. In: *Living with Obesity: The Patient's Point of View*. Indianapolis: Indiana University School of Nursing; 2003.
31. Falkner NH, French, SA, Jeffery RW, Neumark-Sztainer D, Sherwood NE, Morton N. Mistreatment due to weight: prevalence and sources of perceived mistreatment in women and men. *Obes Res*. 1999;7:572–576.
32. Wadden TA, Stunkard AJ. Social and psychological consequences of obesity. *Ann Intern Med*. 1985;103:1062–1067.
33. Rogge MM. T Bock interview with Kelly and Katy. In: *Living with Obesity: The Patient's Point of View*. Indianapolis: Indiana University School of Nursing; 2003.
34. Rogge MM. MM Rogge interview with Kisha. In: *Living with Obesity: The Patient's Point of View*. Indianapolis: Indiana University School of Nursing; 2003.
35. Rogge MM. MM Rogge interview with Deanna. In: *Living with Obesity: The Patient's Point of View*. Indianapolis: Indiana University School of Nursing; 2003.
36. Kral JC. Surgical treatment of obesity. In: Bray GA, Bouchard C, James WPT, eds. *Handbook of Obesity*. New York: Marcel Dekker; 1998:977–992.
37. Rogge MM. MM Rogge interview with Martene. In: *Living with Obesity: The Patient's Point of View*. Indianapolis: Indiana University School of Nursing; 2003.
38. Petrich BEA. Medical and nursing students' perceptions of obesity. *J Addict Nurs*. 2000;2:3–16.
39. Young LM. The effects of obesity on the clinical judgements of mental health professionals. *J Health Soc Behav*. 1985;26:233–246.
40. Adams CH, Smith NJ, Wilbur DC, Grady, KE. The relationship of obesity to the frequency of pelvic examinations: do physician and patient attitudes make a difference? *Women Health*. 1993;20:45–57.
41. Olson CL, Schumaker HD, Yawn BP. Overweight women delay medical care. *Arch Fam Med*. 1994;10:888–892.
42. Wee CC, McCarthy EP, Davis RB, Phillips RS. Screening for cervical and breast cancer: is obesity an unrecognized barrier to care? *Ann Intern Med*. 2000;132:697–704.