The Stigmatisation of Obesity by University Students Who Will be the Future Counsellors, Educators, and Psychologists^{*}

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To investigate the attitudes of prospective counsellors, psychologists, and educators, Obesity Prejudice Scale was used. Participants are ninety university students, thirty from each mentioned department. Founded mean score 82,422 ($SD = 1,091$) is very close to 85 which indicates prejudicial attitudes. Even for the group of participants who informed they have no prejudicial bias toward people with obesity, total mean scores was not below 68 which means unstigmatising attitudes. Participants who attribute personal responsibility for obesity condition are more biased toward people with obesity than participants who does not. Mean scores above three (on five point likert) at item level accepted as indicators of the participants' biased attitudes. According to mentioned findings, people with obesity conceptualised as “unhealthy” people, who “doesn't like to move”, “has restricted ability to move”, “moves slowly”, “quickly get tired”, “vulnerable to illnesses”, “smelling sweat”, “unattractive”, “unhappy”, “unesthetic”, “lazy people”, who doesn't have “self confidence” or “will power”, “unfavorable for sentimental relationships”, “seem older than they really are”. Stigmatising attitudes towards people with obesity held by authority figures at school settings dangerously depletes the potential for early detection and prevention for obesity and eating disorders. Therefore findings implies a need to plan educational intervention programs for prospective counsellors, educators and psychologists to shape more positive, more indiscriminative attitudes.

Keywords: obesity stigma, attitudes, stereotypes, people with obesity, stigmatisation

Introduction

The word “Stigma” is such a concept which can be explained with “negative labeling”, “stereotyping” and many other concepts which implies negativity. It is a study area which has become topic of interest for many researchers (Jorm, Christensen, & Griffiths, 2005; Link & Phelan, 2001; Corrigan, 2005). The word “Stigma” accomodates ignorance, prejudice, negative attitudes and discrimination too (Thornicroft, Rose, Kassam, & Sartorius, 2007). Stigma includes stereotypes which relates the target person with a set of negative characteristics and these stereotypes are resistant to change (Jacoby, Snape, & Baker, 2005). People can be stigmatised because of many different reasons and one of these reasons is obesity. People who has Body Mass Index greater than 30 ($BMI \geq 30$) are accepted as having obesity (Ogden, 2007; WHO, 2013). Obesity is accepted as a global epidemic; a pandemic (Ogden, 2014; WHO, 1997). Therefore, there are lots of studies

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about stigmatisation of individuals with obesity which reflects existence of weight bias (Harriger, Calogero, Witherington, & Smith, 2010; Link, Yang, Phelan, & Collins, 2004; O'Brien et al., 2008; Sayce, 1998). According to Carr and Friedman (2005), the discrimination that people with obesity encounter is one of the worst a person can encounter in social context.

Stigmatisation hosts many disadvantages for people with obesity and leads to negative consequences in multiple areas of lives of people with obesity including health (Major & O'Brien, 2005). Stigmatisation and related negative consequences may arise in many different settings and in many different forms. Sikorski et al. (2013), emphasized the negative attitudes of health workers toward people with obesity and they explained how harmful this could be through preventing help seeking behavior. Even perceived discrimination affects people's lives and treatment results (Sikorski et al., 2011). Stigmatising attitudes, intolerant and negative attitudes toward people who are fighting with obesity have a link with low self-esteem (Puhl & Brownell, 2006), social isolation, depression and future eating disorders (Tang-Peronard & Heitmann, 2008) for stigmatised one. Thereby stigmatisation deteriorates physical and psychological well being of the targeted person.

When students with obesity or overweight encounter with negative, stigmatising attitudes, their psychological well being and participation to school activities being affected unfavourable (Bauer, Yang, & Austin, 2004). When the target of the negative attitudes and discrimination is young students, it is obvious that all mentioned negative effects of stigmatisation will be maximized.

The potential of school setting for early detection and prevention efforts for obesity or eating disorders is huge. School setting also has potential for prevention of development of negative attitudes toward the "other" including weight based discrimination. Under the light of related literature, it is obvious that negative attitudes held by authority figures who work with students at school settings has crucial importance. Thereby the aim of this study was investigation of stigmatised attitudes toward people with obesity at a group of prospective counsellors, psychologists, and educators. Therefore, in this study weight based prejudicial attitudes of a group of future counsellors, psychologists, and educators have been investigated.

Method

Participants

Participants are ninety university students from fourth grades of various departments of various universities. Fourth grades have chosen since they are close to perform their job. The students are from Psychology Departments, Psychological Counselling and Guidance Departments and from other departments of Education Faculties which raise teachers for intermediate level schools. Thirty university students from each of the mentioned departments were reached according to convenience principle till equal groups are handled. There is 39 women and 51 men. The percentages of women and men in groups are approximately matched (see Table 1). Age range is between 18 to 27 ($M = 20.366$, $SD = 1.725$). Participants' Body Mass Index (BMI) which was calculated through division of weight by the square of height is between 15.62 kg/m² to 32.49 kg/m² ($M = 22.435$, $SD = 2.954$). 75.55% of the participants' BMI is in "normal" range ($18 \geq \text{normal BMI} \leq 24.9$). In terms of BMI there is no statistically meaningful difference among groups. Participants are from various parts of Turkey (13 from Marmara Region, 18 from Aegean Region, 27 from Mediterranean Region and 32 from Eastern Anatolia region).

Table 1

Crosstabulation for Sex among Groups

Groups		Psychologists		Counsellors		Teachers		Total	
		<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
Sex	Women	13	43.3	14	46.7	12	40	39	43.3
	Men	17	56.7	16	53.3	18	60	51	56.7

Tools

The Obesity Prejudice Scale and Demographic Information Form were performed.

Obesity Prejudice Scale

For assesment of discriminative, prejudicial attitudes of participants, the Obesity Prejudice Scale which was developed by Ercan, Akçil Ok, Kızıltan, and Altun (2015) was used. It is a 27 item, 5 point likert type scale. Possible scores which participants can get from this scale are between 27 to 135. Higher scores mean higher prejudice. According to Ercan et al. (2015) Obesity Prejudice Scale scores which are ≤ 68.00 indicate unprejudiced attitudes. Scores between 68.01-84.99 reveal inclination to prejudicial attitudes and scores ≥ 85 means having prejudicial attitudes.

Demographic Information Form

By this form which was prepared by investigator participants' demographics like sex, age, department, and home city were recorded. Participants' attributions about personal responsibility of individuals with obesity and participants self perceptions about their own weight were also asked. Also participants self informed weight and height were handled and BMI was calculated through this data.

Procedure

Ethical rules followed, each participant was volunteer. After informed consent and anonimity guaranty were provided by the investigator, scales were administered to the participants who volunteered to enrol.

Statistical Analysis

Data analysis was performed by Statistical Package for Social sciences (SPSS-16). Statistical signifiante level was choosen as 0.05.

Since the main aim of this study is handling data about prejudice level of prospective professionals who will work at school settings, descriptive statistics of total Obesity Prejudice Scale scores were performed to handle total stigmatisation level of participants and to get item level biased conceptualisations of participants. Also descriptive statistics carried out to see sample demographics.

Also, in order to investigate attitude differences among groups, one way variance analysis (ANOVA) were performed. Participants' total Obesity Prejudice Scale scores were used as dependent variables and groups as independent variables. Groups were formed according to departments of participants. Beside this, groups were formed through personal responsibility attribution for obesity condition, self reported prejudicial attitudes, sex, self perception about their own weight, and home city.

Results**Descriptive Statistics of Total Obesity Prejudice Scale Scores**

According to descriptive statistical analysis, the range of participants Obesity Prejudice Scale scores is

between 58 to 122 ($M = 82.422$, $SD = 1.091$). Mean score 82,422 reveal inclination to prejudicial attitudes.

According to Ercan et al. (2015), Obesity Prejudice Scale scores which are ≤ 68.00 points out unprejudiced attitudes. Scores between 68.01-84.99 reveal inclination to prejudicial attitudes and scores ≥ 85 means prejudicial attitudes.

According to means for each item which are above three on the five point likert scale at least most of the participants attitudes for certain items are biased like this: Participants generally have a tendency to think that people with obesity “don’t like to move” and “have restricted ability to move”. They think people with obesity are “unhealthy” people, who “move slowly”, “quickly get tired”, “vulnerable to illnesses”, “smell sweat”, “unattractive”, “unhappy”, “unesthetic”, “lazy” people. They think people with obesity “don’t have self confidence” or “will power”, “unfavourable for sentimental relationships” and “seem older than they really are” (see Table 2).

Table 2

Descriptive Statistics for Obesity Prejudice Scale Items by Ascending Means

Items	People with obesity...	Mean for item	Std. Deviation
ObPrejudice 12	Restricted Ability to move	3.8667	1.13375
ObPrejudice 15	Unhealthy	3.7778	1.11957
ObPrejudice 23	Slow	3.7667	1.17129
ObPrejudice 21	Get tired easily	3.7333	1.26135
ObPrejudice 6	Vulnerable to illnesses	3.7000	1.08566
ObPrejudice 11	Unattractive	3.5667	1.01727
ObPrejudice 16	Do not like to move	3.4000	1.32224
ObPrejudice 7	Unhappy	3.2444	0.96350
ObPrejudice 3	Unesthetic	3.2222	1.13946
ObPrejudice 24	Lazy	3.2111	1.24967
ObPrejudice 17	Do not have self confidence	3.2000	0.99662
ObPrejudice 13	Smell sweat	3.1667	1.11426
ObPrejudice 5	Do not have will power	3.0889	1.22378
ObPrejudice 26	Unfavourable for sentimental relationships	3.0778	1.09368
ObPrejudice 19	Seem older then they are	3.0667	1.12978
ObPrejudice 18	Have low quality of life	2.9889	1.13667
ObPrejudice 20	Strong at social relations	2.8000	1.01892
ObPrejudice 8	Do not like to eat in public	2.7778	1.23414
ObPrejudice 22	Good listeners	2.7667	0.96045
ObPrejudice 25	Cook well	2.7333	1.10971
ObPrejudice 10	Hospitable	2.6778	0.94605
ObPrejudice 2	Have beautiful face	2.6667	1.01671
ObPrejudice 4	Good humored	2.5889	1.02655
ObPrejudice 9	Coward	2.4667	0.99662
ObPrejudice 27	Outgoing	2.4556	0.97337
ObPrejudice 14	Sympathetic	2.4222	1.00535
ObPrejudice 1	Selfish	1.9889	0.96564

Note. Obesity Prejudice Scale items were rated on a five point likert.

Analysis of Variance (ANOVA)

(1) One way ANOVA between groups based on personal responsibility attribution to people with obesity for their condition and total Obesity Prejudice Scale scores

Participants grouped according to informed attributions about personal responsibility of individuals with obesity for their condition. The number of participants who informed that they believe people with obesity are responsible for their condition is 57 and 33 participants informed they do not think people with obesity have personal responsibility for their condition. Variance analysis between these two groups revealed a statistically significant difference ($F(1, 88) = 94.553, p < 0.05, \mu^2 = 0.518$). According to this result, participants who attribute personal responsibility ($M = 88.368, SD = 8.557$) are more biased toward people with obesity than participants who does not ($M = 72.151, SD = 5.629$).

(2) One way ANOVA between groups based on participants' departments and total Obesity Prejudice Scale scores

Analysis revealed no statistically significant differences among departments in terms of total Obesity Prejudice Scale scores ($F(2, 87) = 0.266, p > 0.05$).

(3) One way ANOVA between groups based on self reported prejudicial attitudes and total Obesity Prejudice Scale scores

Participants were asked to inform either they have prejudicial attitudes towards people with obesity or not. The percentage of participants informed they have no prejudicial attitude toward people with obesity is 88.88% ($M = 81.687, SD = 10.253$) and 11.11% informed they have prejudicial attitude ($M = 88.300, SD = 14.598$). Depending on existence and non-existence of self reported prejudicial attitudes two groups were formed. One Way ANOVA between these two groups and total Obesity Prejudice Scale scores revealed no statistically significant differences among mentioned groups ($F(1, 88) = 3.346, p > 0.05$).

(4) One way ANOVA between total Obesity Prejudice Scale scores and Sex

Analysis which performed to see differences among males and females in terms of Obesity Prejudice Scale scores depending on sex showed no statistically significant differences ($F(1, 88) = 2.44, p > 0.05$).

(5) One way ANOVA between groups based on self perception about own weight and total Obesity Prejudice Scale scores

Participants were asked to inform how they perceive their own weight by choosing from given words as "thin", "medium/normal" and "overweight". Variance analysis among these groups which determined according to self perceived weight revealed no statistically significant differences among groups in terms of total Obesity Prejudice Scale scores ($F(2, 87) = 2.014, p > 0.05$). Since informed weight is "medium/normal" for 71 of the participants over 90, group sizes are uneven.

(6) One way ANOVA between participants departments and BMI scores

Participants weight and height were asked and Body Mass Index (BMI) was calculated through this data. Analysis revealed no statistically meaninfull differences among department groups in terms of BMI ($F(1, 87) = 0.53, p > 0.05$) which indicates groups are matching in terms of BMI.

Discussion and Conclusion

The main aim of this study was investigation of stigmatising attitudes toward obesity among prospective professionals who will work at school settings. Founded general mean score 82,422 reveal a tendency to prejudicial attitudes. This score is close but higher than the mean ($M = 76.394$) which was founded by Ercan et al. (2015). When it is thought that having scores which are equal to or greater than 85 indicates prejudicial attitudes, it became obvious that this founded "moderate" tendency to prejudicial attitudes is very strong.

Results of this study point out a general tendency of participants to have biased attitudes toward people with obesity to conceptualize them as individuals who “does not like to move” and “have restricted ability to move”. Participants tend to think people with obesity as “unhealthy” people, who “move slowly”, “quickly get tired”, “vulnerable to illnesses”, “smelling sweat”, “unattractive”, “unhappy”, “unesthetic”, and “lazy”. They tend to think people with obesity “do not have self confidence” or “will power”, “do not preferred for sentimental relationships” and “seem older than they really are”. Findings are parallel with other studies which pointed out negative attitudes toward people with obesity (Chambliss, Finley, & Blair, 2004; Harris, Sandoval, & Cortese, 1998; Sikorski et al., 2011, 2013).

Analysis revealed that even participants who informed they have no prejudicial bias toward people with obesity does not have mean scores below 68 ($M = 81.687$, $SD = 10.253$) which means having non-prejudicial attitudes. It means people have no insight about their biased attitudes toward people with obesity as mentioned in Miller et al.'s study (2013).

The participants who attribute personal responsibility for obesity condition ($M = 88.368$, $SD = 8.557$) are founded more biased toward people with obesity than participants who does not ($M = 72.151$, $SD = 5.629$). It is parallel with the literature which relates stigmatising attitudes and rejection with personal responsibility attribution (Crandall et al., 2001; Weiner, Perry, & Magnusson, 1988).

School setting has potential to increase the risk factors which creates vulnerability for any kind of psychological disturbance like eating disorders and obesity. School setting is also important in terms of early detection and prevention efforts for obesity and for eating disorders, and for any kind of psychological disturbance. Even perceived discrimination effects people's lives (Sikorski et al., 2011). Therefore, it is obvious that discriminative prejudicial attitudes by authority figures will effect all these areas negatively, will make things worst. These facts increase the importance of negative attitudes held by authority figures at school settings.

Beside possible effects to self esteem and psychological well being of students with obesity, attitudes of counsellors, psychologists, and teachers who work with students have potential to shape students' attitudes towards obesity, therefore findings of present study seems alarming.

As pointed out (Puhl, Chelsea, & Heuer, 2010), the stigmatisation of obesity creates barriers for promotion of effective intervention efforts beside having undesired consequences in terms of health. Because of all possible negative consequences, findings of this study implies a serious need to shape indiscriminative attitudes to promote acceptance about weight diversity. The findings of present study implies a need for comprehensive educational interventions which can challenge existing stereotypes for university students who will be the future counsellors, educators and psychologists.

Results also points out a need for future research about the factors effecting weight stigma in order to be able to plan future educational intervention programs that adressing to these aspects. Because of sample size there might be limitations in terms of generalisability, therefore results of present study can be accepted as a pilot study for guidelines to design future studies with bigger sample sizes to study prevalence of weight stigma among prospective professionals of school settings.

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