Living With the Obesity Stigma: Perceptions of Being Obese From Three Cultures
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ABSTRACT
One defining antecedent of marginalized consumer groups is their status as being stigmatized. Although much research has investigated the perceptions of onlookers of a stigmatized person or group, little research has been conducted regarding the stigmatized person themselves and what impact the stigma has on his or her behavior. Using qualitative methods, this paper investigates the way in which an understanding of the obesity stigma develops within the individual, the impact that the obesity stigma has on consumers’ perceptions of themselves and finally, their ability to internalize and act upon social marketing interventions.

INTRODUCTION
The increasing interest in marginalized consumer research has led to a recent increase in exploratory work in the area. One defining antecedent of a marginal consumer is his or her status as being stigmatized or separated from society in some way (Burden 1998). Many studies have elucidated the range of effects expressed by onlookers of stigmatized consumers; however, little research has focussed on the effect a stigma can have on afflicted consumers themselves. This paper uses the visible stigma of obesity as the context for understanding how consumer perceptions and actions may change as the stigma attachment is internalized in the obese individual’s life. As such, the questions are asked: how does the sense of stigmatization develop in an obese person, and secondly, how do obese people cope with this feeling of stigmatization? Qualitative research methods were employed to understand how informants’ lives have been affected by their stigmatized status as being obese, and subsequently offer avenues of investigation for social marketers in order to more effectively target marginalized groups with their campaigns.

After exploring the extant literature surrounding stigmas and prejudices a brief discussion of the methodology is presented. This is followed by a summary of findings, a discussion of main themes from the research and some implications for social marketers, public policy makers and academicians.

WHAT IS A STIGMA?
A stigma, in its simplest form, is any distinguishing mark or characteristic that distinguishes a consumer as being different (Allport 1954). Although stigmas do not necessarily need to be negatively valanced, stigmas are often reported as being negative marks or characterisations. For example, Link and Phelan (2001) note that stigmatization is the combination of distinguishing a person or group based on known differences; associating these differences with negative attributions; separating these individuals or groups based on these negative differences and assigning a loss of status to this stigmatized individual or group. This definition, based on the earlier research of Goffman (1963), outlines both the distinguishing quality of stigmas but also the dynamic, processual nature of stigmas.

In the case of obesity, known differences between an obese person and a non-obese person can result in the obese person being stigmatized and therefore, thought of as being lesser by the non-obese person. For example, obese persons are excluded from certain social groups (Crocker and Luhtanen 1990), thought of as having lowered self control (Brown, et al. 2003) and academically less superior than non-obese persons (Tiggeman and Anesbury 2000).

One of the precursors to modern stigma research stems from Gordon W. Allport’s work in the 1950’s and Henri Tajfel and John Turner’s work on Social Identity Theory (SIT), beginning in the mid 1970’s. SIT is grounded in the premise that consumers, as social beings, categorize themselves into separate groups and protect their ‘in-group’ from the distinct ‘out-groups’ (Tajfel 1979, Turner 1991). In-groups are characterized as being groups that one currently belongs to or wishes to belong to, while an out-group is any group that one does not belong or does not wish to belong to. Stigmas form the basis for forming in-groups and out-groups. For example, a male consumer may walk into a women’s clothing store with his partner. Generally speaking, the male consumer in outside of his normal domain and surrounded by persons he represents as being part of his out-group. In an attempt to feel some form of belonging and comfort in his surroundings he may instinctively approach another male in the store who appears equally uncomfortable. Even though the two persons may never associated with one another in a ‘normal’ setting, when surrounded by a distinct out-group a male in-group is formed. The two consumers may never have met however, if the stigma of discomfort was not perceived by both members. That is, the discomfort of the two men drew them together to form an in-group. If one of the consumers expressed extreme ease and comfort with the situation the other male may not have been able to associate himself with the comfortable consumer and no contact would have been made.

A prejudice, in its mildest form, can be thought of as the relative preference of one’s in-group over the out-group, expressed in evaluation, liking, or allocation of resources (Struch and Schwartz 1989). The strength and explicitness of an individual’s prejudicial tendencies was dichotomized by Allport (1954) from the bigoted individual to the compunctious individual. The actual strength of prejudice seems to vary from individual to individual from a mild annoyance to a true hatred of a stigmatized group. Although a compunctious individual may feel a sense of guilt once his or her prejudicial behavior has been brought to light, the fact remains that subconscious favoritism towards one’s in-group and the relative discrimination of an out-group is endemic of natural human behavior.

The two-factor Justification-Suppression Model (JSM) of prejudice by Crandall and Eshleman (2003) operationalizes prejudicial expression as a function of both suppressive factors (the internally or externally motivated attempt to control or reduce the expression or awareness of prejudice) and justifying factors (the internal or external process that can serve to express genuine prejudice without the threat of sanctions). The JSM model determines that an individual’s prejudicial behavior and thoughts are expressed in such a way based on their ability to control or justify innate prejudicial desires (genuine prejudice).

Although genuine, an innate prejudice may exist within an individual but it may or may not be expressed overtly based on his or her ability to justify or suppress the prejudice respectively. Allport’s (1954) notion of the bigot would have relatively high justification factors in play compared with his or her suppression factors; whilst a compunctious individual would have the reverse. That is, the prejudice exists innately within the compunctious individual, but is repressed rather than expressed.

Renfrew’s (1997) study into the causes of aggression showed that certain ‘noxious stimuli’ can elicit escape, avoid or punishment strategies. In a similar way, stigmas can elicit prejudicial or aggres-
sive tendencies toward a stigmatized individual or group. A stigma can be seen as an activator or initiator for prejudicial expression; that is, the stigma is used as the distinguishing mark that leads to favoritism towards unstigmatized persons or groups and aggression, avoidance or animosity towards stigmatized persons.

Explicit stigmas include sex, age, ethnicity or weight and are easily identified by onlookers. A person may have an innate or genuine prejudice towards persons of Asian descent but this would only be expressed either when in the physical presence of an Asian person or the subject of Asian ancestry is highly salient in the minds of the racist, such as when persons of Asian descent are discussed amongst others. As the name suggests, latent stigmas are more concealed than the above examples, which may result in prejudicial behavior not being expressed until the stigma is unveiled. For example, an environmentalist may have a strong attachment with a commercial whaler until realising their ideologies clash (latent stigma), at which point it is likely that varying levels of prejudicial expression would surface depending on the strength of the participant’s use of available justification and suppression factors. Obesity falls into the first of the two stigma categories. Obesity is often easily identifiable, allowing those with prejudicial beliefs about the obese to make quick assumptions (Ferraro and Holland 2002). Some overt consequences of prejudicial behavior often include, but is not restricted to, physical detachment; social segregation, fear, reduced family cohesion, secrecy and lowered social status (Phelan, et al. 1997).

Hebl and Mannix (2003) extend the stigma literature to show that it is not only the stigmatized individual that is subject to prejudicial expression, but also persons that associate with the stigmatized individual. In their study, Hebl and Mannix (2003) found that an unstigmatized person standing with their obese partner was seen as less favorable than an unstigmatized person standing with their nonobese partner.

WHY OBESITY?

The clinical definition of obesity is an excess of fatty tissue to the point that the person is in significant medical risk (Aronne and Segal 2002). However, it is not the presence of fatty tissue that is of concern in the present study, but rather the perceptions that are associated with the excess fat that an individual carries. One may be slightly overweight and feel far more stigmatized than one who is extremely overweight.

Obesity not only defines a person as being different, but is still considered by many to be a point of negative differentiation (Crandall 1994, Ferraro and Holland 2002). Weiner, Perry, and Magnusson (1988) empirically showed that the stigma associated with obesity is one of the most damaging of the 10 they studied. Obese persons were seen as being highly responsible and to blame for their current size, one of the least liked groups in society and worthy of little pity or financial assistance. Respondents identified obesity as one of the least likely stigmas to deserve social welfare. Other than drug abusers and child abusers, obese persons are ranked with obesity as one of the most damaging of the 10 they studied. Magnusson (1988) empirically showed that the stigma associated with obesity falls into the first of the two stigma categories. Obesity is often easily identifiable, allowing those with prejudicial beliefs about the obese to make quick assumptions (Ferraro and Holland 2002). Some overt consequences of prejudicial behavior often include, but is not restricted to, physical detachment; social segregation, fear, reduced family cohesion, secrecy and lowered social status (Phelan, et al. 1997).

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Aside from the extreme effects obese consumers may experience by being stigmatized are the increasing rates of obesity across much of the Asia Pacific region. The New Zealand Ministry of Health rated research designed to curb the rise of obesity rates as being its most important goal in the near future (Minister of Health 2003, New Zealand Ministry of Health 2001). The Australian Department of Health and Ageing has ranked Australia as being one of the fattest developed nations in the world and has instigated a number of initiatives to control the onset of obesity in Australian society (Australian Department of Health and Ageing 2004). Further research into all aspects associated with obesity has been called for from a number of academic sources, including the Journal of Consumer Research (Mick 2003).

The greater understanding there is surrounding obese consumers’ perceptions towards themselves and the obesity stigma, the greater likelihood that more effective social marketing campaigns can be developed that meet their needs as well as promote healthy weight goals. Qualitative research methods were employed so as to provide richness of data regarding the obesity stigma. The following section discusses the methodology drawn on and the respondents that participated in the investigation.

METHODOLOGY

Qualitative methods were employed in order to gain a greater understanding of the perceptions, motivations and feelings behind the informants’ actions. As with much interpretivist work the research was undertaken with the aim to inform and develop theory, rather than to generalize or predict actions and behavior to populations (Walsham 1995). Two main qualitative methods were undertaken. Firstly, focus groups were used to help individuals open up and discuss the topic of obesity amongst peers who were in a similar situation. It was reasoned that a group forum would allow greater flow of conversation and interaction with the sensitive topic of obesity stigma (Onkvisit and Shaw 1987). Following the focus groups depth interviews were conducted to gain further insight based on individual cases. Depth interviews provided a more private setting where an informant was able to express themselves without the fear of social judgement (Thornton and Moore 1993). With obesity becoming increasingly prevalent in the South Pacific region the countries of Fiji and New Zealand were used as a source of data for the current research.

Four focus groups were conducted in three distinct populations. Two focus groups were conducted in an indigenous Fijian community based outside of Suva, Fiji. One group was made up entirely of male informants, and the other comprised solely of female informants. One focus group was conducted with Indo-Fijian women living outside of Suva, Fiji. The final group was taken from high school students studying in the south Auckland suburb of Mangere, which is recognized as having a high proportion of Pacific Island and Maori students. All respondents felt they were overweight or obese. Actual weights and body fat measures were not completed so as to not further emphasize the obesity stigma in the minds of the respondents.

Although each group may be distinct from one another in many ways all groups were well represented by high levels of obesity, generally low levels of education and income in their communities and very little understanding regarding the consequences of obesity and its related illnesses. For the Fijian and Indo-Fijian groups a local interviewer was used to conduct the focus group and translate the transcripts into English for analysis. Local interviewers were chosen so that informants can communicate in their native language, providing greater expression and more effective communication. Each interviewer was provided with a standard set of questions, but also encouraged to ask questions along a line they felt may be useful. Interviewers were hired from a local medical college and were both experienced in qualitative interviewing techniques as well as obesity related issues.

During each focus group a second researcher was present to take fieldnotes of general observations made during the focus groups. Even though the second researcher may not understand the language being spoken, the observations made provided valuable insight into the setting in which the focus was conducted as well as the overall tone and atmosphere of the focus group; qualities that the moderator may not have had time to note. Table 1 outlines the make up of each focus group.
TABLE 1
DESCRIPTION OF FOCUS GROUP INFORMANTS

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of Informants</th>
<th>Language Spoken</th>
<th>Length</th>
<th>Researchers present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fijian males</td>
<td>7– ranging in ages from 25 to 50 years old.</td>
<td>Fijian</td>
<td>90 minutes</td>
<td>1 Fijian speaking moderator, 2 non Fijian speaking observers. All male.</td>
</tr>
<tr>
<td>Fijian females</td>
<td>9– ranging in ages from 30 to 52 years old.</td>
<td>Fijian</td>
<td>65 minutes</td>
<td>2 Fijian speaking moderators, 1 non Fijian speaking observer. All female.</td>
</tr>
<tr>
<td>Indo-Fijian females</td>
<td>7– ranging in ages from 18 to 55 years old.</td>
<td>Fijian Hindi</td>
<td>80 minutes</td>
<td>1 Hindi speaking moderator (female), 2 non Hindi speaking observers (male).</td>
</tr>
<tr>
<td>Mangere High School students</td>
<td>8– ranging in ages from 15 to 18 years old.</td>
<td>English (all informants fluent in English as a first language)</td>
<td>55 minutes</td>
<td>1 English speaking interviewer (male), 1 English speaking observer (Female).</td>
</tr>
</tbody>
</table>

One on one depth interviews were then conducted with selected focus group participants. Snowballing data sampling was used to acquire further informants. Depth interviews were conducted in order to obtain greater clarification about issues the researcher felt were important to discuss but not appropriate for a group forum. That is, issues that may be deemed shameful to the social group, such as binge eating, depressive feelings or suicide, could be more readily discussed with an interviewer in a private setting. Eight depth interviews were completed in total. Table 2 provides a brief description of informants who participated in depth interviews.

Each transcript was analysed by two researchers, one using the native language and one using the English translation. Open ended and Axial coding methods were used in order to obtain a number of coherent emergent themes within each transcript and then across all transcripts (Spiggle 1994).

Final inter-coder reliability was ascertained by comparing themes and major quotes from transcripts pertaining to each theme. Conflicts were discussed between the coders and resolutions made. When no resolution was possible a third coder, independent from the research collection process, was called to examine the discrepancies and offer a final opinion. Final agreed upon themes were then independently scrutinized by two judges in order to determine their value in aiding the understanding of stigmatized consumer groups.

FINDINGS

Three major themes emerged as being both salient and valuable in informing extant theory. These themes have been labelled Hopelessness, Blindness, and Variable Salience. Each theme will be discussed in greater detail with relevant implications for theory.

Hopelessness

Although the notion that the obese can suffer from depressive disorders is not novel, the consistent theme of hopelessness indicated a strong sense of a deeper, more enduring feeling of despair. Interestingly it was not exacted at other aspects of the individual’s life. Divya recounts her previous experiences with dieting and her weight as being a never ending cycle.

“It’s not... It’s not as if my life, my size is not a problem. I know it is... I know the pain I suffer from the diabetes and the puffing [breathlessness]... but it [weight loss] can’t be done... I have done it before and I... I just can’t do it... it’s too hard and too difficult... if it was easy and I could do it, it would still be too hard I think... I just have no more power or fight left...” Divya, 55 year old Indo-Fijian female

Lei narrates how his father and mother continue to talk to him about his size and what it means to them.

“I don’t understand it sometimes... I know I can do it but my Mum keeps saying “it’s too late... it’s too late for me to, to be healthy—but you, you have [a] chance...” I guess they’ve given up and accepted it...” Lei, 18 year old Asian male.

The sense of hopelessness in the older informants and the desire for the younger ones not to lose hope or stop trying is also evident in the way the parents purchase and cook foods for themselves and for their children.

“it’s not right I know... but the children need to run and the children need to play and they need to have good food... we give them a little bread and some butter and some milk and they play... while we buy for ourselves the bad [fatty] foods and the drink... I don’t want my son to be me this way... I want him to be big and strong... but not big... like me...” Joeli, 38 year old Fijian male.

There is also a sense of fear espoused by the older informants. However, rather than dispossess the feared self as suggested by self
regulation theory (Carver and Scheier 1981) Joeli has chosen to accept his status but attempts to protect his dependents from the consequences of his actions.

**Blindness**

The theme name was chosen as it highlights the lack of understanding, especially amongst the younger informants, about the risks of obesity and the reality of being stigmatized until they were confronted with a situation in which prejudice was expressed.

“I really didn’t understand it aye…you know, they are all the same…well…they are all us…but it was like they didn’t want to have anything to do with me and wanted to look at me as the fat guy that people like to laugh at you know…I was like only 12 then and I didn’t think about it until then…it’s like I just [expletive deleted] woke up for the first time…I had to look at myself for a while…you know…think about it and wonder what happened to me…” Rangi, 16 year old Maori male.

Lei continues with his narrative of his parent’s history with obesity

“My dad tells me that he gets looked at you know…by the family and the other people at work…I didn’t even think of it that way…he’s just my dad…it’s like some people look at him…at his weight…and then others look at him (emphasis present) at himself…not what he looks like, but who he is…I only thought of it afterwards when some people look at me differently…like at the dairy [local shop] there’s always bad food there and people watch me as I buy it…it’s not like I noticed before…but now I do…” Lei 18 year old Asian male

Not only is there a sense of distress, as with those informants who expressed hopelessness, but also a ‘loss of innocence’ regarding their perceived self. There is a turning point where suddenly the stigma becomes apparent to the obese informant, and it is from this awareness that his or her perceptions and actions change. Lei’s father seems to have been subject to ongoing situations that significantly impact his life, which in his mind, continue to reinforce the stigma attachment. These situations or negative interventions are now being seen by Lei himself, which also heightens his awareness about his size and the stigma associated with it.

**TABLE 2**

DESCRIPTION OF DEPTH INTERVIEW INFORMANTS

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to other groups</th>
<th>Language Spoken</th>
<th>Length</th>
<th>Age</th>
<th>Researchers present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitiveni</td>
<td>Male, part of Fijian community</td>
<td>Fijian</td>
<td>70 minutes</td>
<td>26</td>
<td>1 Fijian speaking interviewer (male)</td>
</tr>
<tr>
<td>Joeli</td>
<td>Male, part of Fijian community</td>
<td>Fijian</td>
<td>65 minutes</td>
<td>38</td>
<td>1 Fijian speaking interviewer (male)</td>
</tr>
<tr>
<td>Adi</td>
<td>Female, part of Fijian community</td>
<td>Fijian</td>
<td>45 minutes</td>
<td>45</td>
<td>1 Fijian speaking interviewer (female)</td>
</tr>
<tr>
<td>Rangi</td>
<td>Male, high school student in Mangere</td>
<td>English</td>
<td>45 minutes</td>
<td>16</td>
<td>1 English speaking interviewer (male)</td>
</tr>
<tr>
<td>Lei</td>
<td>Male, high school student in Mangere</td>
<td>English</td>
<td>65 minutes</td>
<td>18</td>
<td>1 English speaking interviewer (male)</td>
</tr>
<tr>
<td>Hine</td>
<td>Female, high school student in Mangere</td>
<td>English</td>
<td>45 minutes</td>
<td>17</td>
<td>1 English speaking interviewer (male)</td>
</tr>
<tr>
<td>Asha</td>
<td>Female, part of Indo-Fijian community, Daughter of Divya</td>
<td>Indo-Fijian</td>
<td>60 minutes</td>
<td>18</td>
<td>1 Hindi speaking interviewer (female)</td>
</tr>
<tr>
<td>Divya</td>
<td>Female, part of Indo-Fijian community, Mother of Asha</td>
<td>Indo-Fijian</td>
<td>80 minutes</td>
<td>55</td>
<td>1 Hindi speaking interviewer (female)</td>
</tr>
</tbody>
</table>

1Note that names have been replaced with synonyms to retain the anonymity of informants.
Variable Salience

The final theme discussed here is that of variable salience regarding the obesity stigma. It was seen from the data that at various times the felt importance of informant’s obese stigma was more or less pronounced. That is, situations arose where informants would think more about their physical size in a negative sense. As with Rangi’s account these interventions could lead to a time of personal reflection and introspection. That is, after an intervention is a time of reflection about the prior occurrence and a time of self examination. Sitiveni recounts occasions such as this in his time at school.

"yeah…there were times when I knew I was bigger…I mean…we’d play rugby against people…small people and everyone would laugh at me as I would be bigger than two people and they said we just need four Sitiveni’s and we’d win…I mean…It was good that I am thought of as strong…but not then…but at other times…like with my family…I don’t think of my size…I like fit in with the group and I’m just normal…but then I remember where I have just been and I think again about myself…it’s different for us you know…" Sitiveni, 26 year old Fijian male.

Reed (2004) discusses how varying levels of heightened awareness about a personal characteristic may lead to altered perceptions and behavior; however, with the nature of a prejudicial stigma being a negatively valanced characteristic the effects are far more pronounced.

"I hate it when I feel ugly…when it’s my bigness that makes me ugly…it’s when the younger girls I know are laughing…but with my husband I know I am not ugly…it’s a way of think[ing] I know…it’s my way of thinking more and more about what my belly is doing…and more and more about my looks…it’s not right…" Adi, 45 year old Fijian female.

This quote by Adi reinforces the sentiment that there are occasions or interventions when the negative connotations associated with her obese size can lead to feelings of negative self worth and subsequent levels of dissatisfaction about her size. However, the relatively short lifespan of such feelings is also evident. That is, as quickly as negative feelings may appear in her life they also disappear when she is with her husband. The cumulative effect on her overall body satisfaction may be of no consequence; however, with ongoing interventions that continue to make her feel negatively about her self it is anticipated that a more enduring feeling of being stigmatized and ‘ugly’ could occur.

DISCUSSION

The findings indicate a definite change from a state of blindness about the obesity stigma and its effects on obese individuals to a state of hopelessness about ever changing state. Understandably there are a multitude of intermediary stages, for example acceptance, apathy, motivation or narcissism. However, it is at the extreme poles of the scale that the most explicit findings can be discussed. The relationship between salience and self image is key to understanding exactly how the iterative process operates. As shown in Figure 1, it is theorized that an intervention at some point has led to an increased sense of salience about the obesity stigma. This starts a period of personal self reflection and personal dissatisfaction, as Rangi discussed, which then comes back to a sense of varied salience. Depending on the valance and the frequency of the interventions the process continues to reinforce the stigma attachment in the mind of the victim to the point, over many years possibly, whereby the individual feels a sense of hopelessness about his or her situation.

The process of moving from a state of blindness to that of hopelessness does appear to be an iterative one, developed over time over a number of intervening situations. For example, Lei’s account of his father being stared at by colleagues or family members can lead to increased salience about his size, and depending on the messages being internalized the outcome could be a positive or negative self image. Figure 2 shows how the process of stigma reinforcement can continue in a vicious cycle manner from a point of blindness to a state of hopelessness.

Figure 2 represents a deterioration in self efficacy regarding an individual’s perceived ability to lose weight (Wilson, Wallston and King 1990). This is in contrast to a notion of external locus of
control whereby the blame may be directed elsewhere (Weiner, Perry and Magnusson 1988). Here we see that these informants know that they had control, however, have since lost the ability to enact any significant change in themselves.

Hopelessness is theorized here as being a state of zero self efficacy that is a result of longitudinal deterioration. The methods needed to alter an individual who exhibits signs of no personal self worth or no perceived ability to change would need to be both rigorous and ongoing. Early positive interventions are critical.

CONCLUSION

The role of the intervention as a method for social change has been discussed in length by many leading social marketing academicians (Andreasen 1995, Donovan and Henley 2003, Kotler and Roberto 1989). However, understanding how the everyday interventions, such as family meetings and social interactions may lead to a feeling of negative self worth has not been investigated. From this study there exists a gap in the extant literature regarding the importance of stigma salience as a driving force for understanding how consumers can go from total unawareness about the need to lose weight to a state of hopelessness regarding their ability to lose weight.

The premise therefore exists that one off ad hoc campaigns are unlikely to provide any significant impact on the consumer’s sense of personal efficacy. That is, when ongoing negative interventions surround the consumer there needs to be adequate positive interventions to ensure that the consumer does not continue to spiral into a deeper feeling of hopelessness. This is not to say that obese consumers are praised for their size, rather that they are encouraged and motivated by their in-group to maximize their feelings of personal self efficacy. Ideally any intervention would be targeted early on when the consumer has been fraught with only a few negative interventions and he or she still feels the ability to make significant changes to his or her weight. The evidence presented here directs greater attention towards the need for more social marketing interventions to be targeted at younger populations before hopelessness takes hold and self efficacy deteriorates. Further research is needed to identify specific motivating antecedents that may increase self efficacy, motivation to lose weight and locus of control so that more effective social marketing campaigns can be developed and implemented.

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