Communicating about Obesity

A FrameWorks Strategic Report

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Introduction

In the London boroughs of Southwark and Lambeth, discussions about health and what it means to be healthy inevitably turn to the topic of obesity. People readily discuss body mass index (BMI) measures and healthy eating, argue that poverty makes people more likely to be obese and express support for the sugar tax introduced in April 2018.[1] Because these everyday conversations reference concepts from health science, social science and public policy, it is easy for advocates to assume that people grasp obesity as a public health issue. Yet the following analysis will show that there is still important work to be done to build a more accurate understanding of obesity in Southwark and Lambeth. People do see many pieces of the obesity puzzle – including some of the relevant ecological factors – but they tend to arrange them into a picture of individuals failing to overcome challenging circumstances.

To cultivate a deeper understanding of obesity and its systemic sources, it is necessary to first understand, at a deep level, how people currently think about the issue. This report outlines findings from research conducted in Southwark and Lambeth by the FrameWorks Institute, a nonprofit think tank that investigates the communications aspects of scientific and social issues, to identify the ways people in these boroughs think about obesity. This research, sponsored by Guy's and St Thomas' Charity, complements and extends research that FrameWorks is conducting, with support from The Health Foundation, to reframe the social determinants of health in the United Kingdom. A description of the methods used in this research and participant demographic information can be found in the Appendix.

This report outlines the findings of this initial stage of communications research, yielding a provisional strategy for framing obesity as a systemic issue, building public understanding of obesity and boosting support for evidence-based policies and programmes to address it. The report unfolds in three parts:

1. The *Expert Perspective* section distils the major concepts that characterise expert thinking on obesity – the 'big ideas' that the field wants to get across to the public.

2. The *Public Perspective* section summarises FrameWorks' findings on cultural models[2] – shared assumptions and common patterns of thinking – that shape how people in Southwark and Lambeth think about obesity.[3] These cultural models shape public opinion in these boroughs and provide insight into whether and why certain frames will build, or undermine, support for reforms intended to address the problem. This section distils how the public defines and thinks about how to solve the problem, and unpacks the communications implications of these models.

3. The *Initial Recommendations* section offers a set of preliminary recommendations for those seeking to communicate more effectively about obesity in Southwark and Lambeth.

If subsequent stages of this project are pursued, FrameWorks will build on this analysis to develop and test framing hypotheses tailored to specific perceptual challenges and designed to dislodge misperceptions about obesity. In the meantime, this report offers insight into the underlying drivers of public opinion about obesity, and equips communicators with sound ways to navigate the public discourse on this issue.

Expert Perspective on Obesity in Southwark and Lambeth

Clear communications goals are essential to any effective plan for engaging and informing the public about social or scientific issues. In addition to traditional communications metrics like reach, advocates must articulate the desired *conceptual* outcomes of the field's communications efforts. A Strategic Frame Analysis® therefore begins with distilling an 'expert perspective': identifying key concepts and fundamental ideas that experts take for granted as established facts. To arrive at the Expert Perspective Analysis on obesity in Southwark and Lambeth, FrameWorks' researchers reviewed Guy's and St Thomas' recent report on childhood obesity; expert interviews conducted for the parallel project, sponsored by The Health Foundation, on the social determinants of health in the United Kingdom; and a review of relevant literature on obesity and its drivers.

To condense the field's underlying assumptions, FrameWorks organised points of agreement as answers to questions that establish the fundamental contours of the topic.

What Is Obesity?

Experts define obesity as an excessive accumulation of fat due to a chronic imbalance between how much energy the body ingests and how much energy it spends.[4] Experts point out that what qualifies as an 'excessive accumulation of fat' can vary considerably from one individual to another; as such, body mass index (BMI) scores cannot alone determine whether someone is obese. The same amount of excess fat can lead to significantly different health outcomes for different individuals.

According to experts, obesity significantly increases an individual's risks for poor health outcomes, such as type 2 diabetes, heart disease and some cancers, as well as for reduced life expectancy. Fat accumulated around the waist is more likely to lead to negative health outcomes than a similar amount of fat more evenly distributed throughout the body.

How Common Is Obesity in Southwark and Lambeth and in the United Kingdom?

Studies show that 27 per cent of the current UK population is considered obese[5] and project that, by 2050, 60 per cent of men and 50 per cent of women could be clinically obese. Compared to the nation and to Greater London, the boroughs of Southwark and Lambeth are among the more critically affected by obesity. A recent study shows that Southwark and Lambeth display some of

the highest obesity rates among children in the United Kingdom, and that the difference in childhood obesity rates between the boroughs' least and most deprived wards is more than double[6].

What Are the Risk Factors for Obesity?

Experts explain that at the population level, obesity is shaped by systemic factors, including marketplace regulations and taxation, because these factors create the conditions in which institutions and individuals function. They argue that the primary driver of obesity is inequalities in money, resources and power, which influence policymaking and the characteristics of the social, physical, commercial and work environments that promote or prevent obesity. For instance, experts point to wealth inequality, not poverty itself, as a key factor, noting that regardless of absolute wealth in a country, the higher income inequality is after tax-based redistribution, the more prevalent obesity is.[7] Experts specify a number of ways in which social and economic inequalities increase the risk and prevalence of obesity:

- Characteristics of the built environments where people live and work critically shape behaviours that influence weight, especially levels of physical activity and the number and nature of calories consumed. In the United Kingdom, inequalities in resources and power have left certain communities – especially densely populated and distressed urban environments – with the following obesity-promoting characteristics:
  - Cheap, high-calorie, high-fat, high-sugar foods are the most readily available, which makes people more likely to adopt unhealthy dietary habits.
  - There is no easy, affordable access to an efficient public transportation network, and the neighbourhood lacks safe pavements, green spaces or cycle paths, which makes people much less likely to walk or cycle.
- Social conditions that involve or directly result from inequalities in resources and power – like poverty, lack of access to quality education, poor working conditions and exposure to discrimination – increase people's exposure to chronic or severe stressors, which increase their risk of developing obesity. Experts point to several ways in which psychological stress can increase the risk of obesity:
  - It can directly cause changes to the body; for instance, stress leads to more fat settling around the abdomen, which increases the risk of obesity-related diseases.
  - People may adopt behaviours to help them cope with it (for example, stress-eating).

- Some social conditions may act as barriers to making health a priority. For example, pressing financial problems or long work hours could generate chronic psychological pressure and take up so much space in people's lives that it becomes almost impossible for them to prioritise health and healthy eating.

Experts explain that genetics or individual choice are not significant risk factors for obesity. While a few cases of obesity can be primarily explained by genetics, the dramatic increase in obesity rates in the United Kingdom over the past 30 years (up 92 per cent since 1990) cannot. As for individual diet and exercise behaviours, experts consider these to be not the origin of risk for obesity but the endpoint of a long chain of causes and consequences in people's lives.

Some experts also express concern that high obesity rates in a geographical area – as in Southwark and Lambeth – can themselves become a risk factor for obesity through what is called a 'normalisation' of the condition. Research shows that if larger body sizes are prevalent in people's environment, people tend to underestimate whether they or others are overweight or obese.[8] Experts argue that this process of normalisation can make people less likely to seek treatment for obesity and less likely to support social and environmental changes, which can contribute to rising obesity rates.

How Can Obesity Rates Be Reduced in Southwark and Lambeth and in the United Kingdom?

Experts agree that obesity in the United Kingdom can be prevented, but only through a systemic approach. They recommend adopting policies that reduce inequalities in money, power and resources. For instance, social policy aiming to increase equity would redistribute resources through both revenue (increased taxation of the wealthy) and expenditures (greater subsidies and benefits to prevent poverty and more significant investments in public services that affect long-term health outcomes, such as high-quality education.) Policies that influence the physical, social and commercial environments would also protect against obesity by making the healthy choice the default choice for the whole population. For instance, policies could reduce the availability and prominence of energy-dense food everywhere – not just in fast food restaurants.

According to experts, a series of cumulative and coordinated small actions can also be valuable at the local level. Experts recommend that local initiatives actively engage communities in the design and decision-making process, as this helps communities to build resilience and fosters a sense of collective control over what happens to them at the local and the national levels (for example, neighbourhood budget initiatives). Even if co-constructed projects are initially partial or imperfect, experts argue that in the short term even marginal gains – like reducing unhealthy snacking or increasing incidental physical activity – are steps in the right direction.

Public Understandings of Obesity in Southwark and Lambeth

Before designing communications on a complex issue like obesity, it is helpful to anticipate how and why communications might go awry. When people's existing ways of thinking are at odds with research and evidence, advocates need strategies that can shift perspectives and allow people to incorporate new ways of thinking. A systematic assessment of where and how public thinking differs from expert consensus helps communicators to establish communications priorities and design a strategy to meet those priorities.

The research presented here is distinct from public opinion research based on polls or focus groups, which documents people's surface-level responses to questions. Instead, this research deconstructs the assumptions and thought processes that inform what people say and how they form judgements and opinions, looking beneath the level of opinion to underlying ways of reasoning. The unit of analysis is *cultural models* – the shared assumptions and patterns of reasoning that inform the public's thinking on a topic.[9] In this section, we present the cultural models that shape public thinking about obesity in Southwark and Lambeth.

This focus on common understandings doesn't dismiss or dispute the fact that people and groups also have different ways of understanding this issue. Rather, identifying the patterns that are shared across an otherwise diverse group of people allows for a more strategic deployment of communications resources later, because it focuses reframing efforts on the assumptions that inhibit productive consideration of a topic across the entire public.

Cultural models are ways of thinking that are *available* to the public, although different models may be activated at different times. It is important to emphasise at the outset that people are able to think about obesity in multiple ways. They toggle between these models, thinking with different ones at different moments, depending on context and conversational cues. Some models are dominant, and more consistently and predictably shape public thinking, while others are recessive, and play a less prominent role. Some models are productive, facilitating a fuller understanding of obesity and support for the policies and programmes that experts recommend, while others are unproductive, impeding understanding and getting in the way of people's support for solutions.

In addition to these cultural models, there are *cognitive holes* around certain issues: areas where the public lacks models or ways of thinking about an issue. These cognitive holes represent areas where understanding must be filled in. By seeing the models available to the public and the cognitive holes, communicators can frame messages to activate productive models, background unproductive ones and fill in understanding where needed.

Here, we first describe the cultural models the public uses to think about what obesity is and how it works. In the next two sections, we explore two strains in public thinking: an *individualistic* strain, which is dominant, and an *ecological* strain, which is more recessive but still available. Specific

cultural models comprise these strains, which have particular implications. Finally, we explore public thinking about solutions – about what can be done to improve obesity in the boroughs of Southwark and Lambeth and in the United Kingdom – and discuss how this thinking stems from the cultural models available to people.

Cultural Models of Obesity

Obesity Is the Epitome of Poor Health: The *Absence of Illness* Cultural Model

Members of the public in Southwark and Lambeth implicitly defined health as the absence of illness. Health was assumed to be the default state of the body and the mind before the inevitable accumulation of pathologies and dysfunctions over time.[10] When people think with this model, obesity is understood as the epitome of poor health, because it is seen as both an illness in its own right *and* a cause of other serious illnesses.

This explains why obesity is one of the chronic, noncommunicable illnesses that are top-of-mind for people when thinking about health in general, as illustrated in these quotes from interviews with people in Southwark and Lambeth:

> **Researcher**: What are some ailments and diseases that spring to mind when you think of someone that's got poor health?
> **Participant**: Heart disease, obesity, cancer, MS, dementia, mental health.
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> **Participant**: The first thing that comes into my head when you said 'someone with a health problem' – I don't know why, but obesity is the first thing I think of.

Yet, people think of obesity as not only one example in a general category of chronic illnesses, but as having a distinguishing characteristic – namely, that it causes other, more serious illnesses. For example, people explained that obesity leads to other noncommunicable diseases, like heart disease and diabetes. Moreover, they talked about obesity as a condition that makes the accumulation of other illnesses virtually unavoidable. Many participants described obesity as the trigger for a worst-case health scenario, condemning individuals to crushed organs and joints, loss of mobility and basic bodily function – and, ultimately, death.

> **Participant**: Obesity does lead to health issues, diabetes, heart diseases. That link is there. It's undeniable.
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> **Participant**: It's bad for your health to be obese. […] It puts a big strain on your organs because they'll need to pump more blood around, but they're not any bigger than they were before. So, it puts a lot of stress on your heart, I think, and it could be really bad for your joints, as well, because they're carrying extra weight. And I suppose if you're obese you're probably not in very good physical health

in terms of fitness. So, your lungs and heart aren't working as well and they ought to be or as hard as they should.

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Participant: Sometimes people get what we call fat. Around their organs and their limbs. That can start to have a deleterious effect on their health. Such as they can't move as well as they should. Their organs in the body don't function as well. That can lead to early death.

The *Obesity as Visible Abnormality* Cultural Model

People also focused on the perceived visibility of obesity, and viewed it as a transgression of the norms of acceptable physical appearance and function. They described obesity as not *looking* 'normal'. In this way of thinking, obesity is understood as *visibly* excessive weight.

Participant: [Obesity] is being very overweight, but not just fat. Being very over-fat. I suppose it affects much more visually. Obviously, they would be a lot larger than your average slimmer person.

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Participant: You would know if someone's very 'obese', or has a lot of fat in their body, because you can tell. It's very obvious.

Estimating Prevalence Nationally and Locally

Members of the public in Southwark and Lambeth believed that obesity rates were high, and still rising, in the United Kingdom. They were aware that obesity had often been described as an 'epidemic', which led them to assume that obesity was an impending threat[11] to themselves and the nation. People in Southwark and Lambeth did not, however, think these boroughs might be more severely affected by obesity than other London boroughs or other areas of the country. In other words, people saw obesity as a serious issue *nationally*, but they did not see that there might be *local* differences in the severity of the crisis within their boroughs.

Participant: More people are becoming obese. Lots of people think it's things like processed foods and processed sugars. No one really knows why as a nation we're getting more and more obese. Lots of scientists have tried to say what it is, but at the minute I don't believe anyone really knows.

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Participant: People talk about this obesity epidemic that we're supposedly in the throes of. Not sure if I'd quite call it an 'epidemic', but I guess it's something of a concern. You know, […] I notice the fact that my daughter is drawn to eating rubbish. And it's hard to get her to exercise. And I suppose it slightly worries me that that's maybe what's waiting in years to come. I may be a bit more concerned about that than I realised.

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Researcher: Do you think there's any particular problem with health in Southwark?
Participant: Maybe we're drinking. I'm not sure about anything else.

Obesity Requires Treatment and Control: The *Health Is Medical* Cultural Model

For the public, the concept of health is deeply and implicitly understood to be about the field of medicine. People therefore assume that the health of the population is controlled by health care – specifically, the quality and efficiency of the National Health Service (NHS), and the quality and pace of medical and technological advances.

People apply this model to obesity, reasoning that medicine in general, and the NHS in particular, have a key role to play in dealing with the issue. The model includes three related assumptions about how medicine can control obesity:

1. **Medicine offers a scientific definition of obesity.** People are aware that a scientific definition of obesity is more desirable than a subjective description. When thinking about obesity with the *Health Is Medical* model, people invariably discuss the body mass index as best they can, though they often find themselves unable to clearly identify what exact BMI score is associated with an obesity status. This leads them to fall back on subjective descriptions of obesity as *visibly* excessive weight, which they present as a close enough approximation of the aforementioned science.

2. **Medicine offers innovative ways of treating obesity.** Medical methods used to control and reduce weight are, for the most part, assumed to be good for health, even when they are unnatural or invasive (for example, diet pills or surgical procedures).

3. **Medicine can tell us how to maintain a healthy weight (that is, avoid obesity) through daily behaviours.** Doctors and health professionals are treated as scientific authorities on issues of diet and exercise. For instance, participants argued that it was possible, if not easy, to avoid becoming obese by abiding by scientific guidelines.

These closely associated assumptions are illustrated in these quotes from interviews:

Participant: I guess it's a clinical definition to do with your BMI. I don't know what that definition is. If you're between two levels, that's counted as within the normal range. So, that's the clinical definition of it. But I guess when people talk about obesity, when they're not doctors or clinicians, they're more talking about just a person's physical appearance. […] I suppose what you're doing ultimately is you're comparing them to yourself, really.

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Participant: People might then even want to go for a gastric band bypass just so they can lose the weight. […] There are two different versions. There is one where they cut your stomach to make it smaller so that you can consume less food, and there is another one where they put something in

there. […] So either way, it just basically reduces your daily intake of food to literally mouthfuls, to lose stones.

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Participant: Yeah. I don't really know at what point you go from being a bit fat to being obese. I suppose that's indicated by BMI, body mass index. But I guess you've got to be calculating that all the time just to make sure that you don't tip over.

Obesity Is a Burden: The *Health Is Independence* Cultural Model

Members of the public in Southwark and Lambeth consistently identified health as the ability to *get things done* and be useful to society – and to do so without help. When thinking with this model, health is identified as the capacity to work, carry out daily tasks and move about unhindered. Ill health is thought of as the inability to do those same things.[12] The *Health Is Independence* model has a clear moral dimension: Having poor health means not only being forced to depend on other people to function in society but also being a drain on society's resources.

Members of the public in Southwark and Lambeth often relied on this cultural model when reasoning about obesity specifically. As people thought that obesity is the epitome of poor health, they consistently associated it with the inability to perform even the most basic actions, like moving about unassisted. From here, people concluded that obesity makes personal independence impossible. As a result, people viewed obese people as a serious burden on those around them – and, by extension, on society.

Participant: It has a big impact on children if their parents are obese, because it's hard for them to go out. Because they can't take their children out or they're not willing to go out. They can't manage physically.

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Researcher: Who's affected when someone suffers from obesity?
Participant: The people themselves and friends and family members, because there'll be certain things that the family members that aren't obese can do, that the people that are obese would be more restricted, and watching them might be painful for the person that's obese. They might feel, 'oh I wish I could do that', but they can't because they have a weight problem.

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Researcher: How might social services be affected by people who experience obesity?
Participant: Well, because generally they are the ones that have to pick up the pieces, aren't they, if somebody's […] unable to manage and they don't have relatives to care for them and children to care for them and become a burden on the state.

Energy Imbalance Is a Vicious Cycle: The *Health Is Mechanical* Cultural Model

People sometimes thought and talked about health as working like a machine that runs well or less well depending on the amount and quality of the fuel – the calories, oxygen or other substances consumed by the individual. Reasoning with this model, the public could see that being overweight or obese is primarily caused by an imbalance between what an individual consumes and how much energy they produce – in other words, by an imbalance between the quantity of food and drinks consumed by an individual and the amount of energy they ultimately spend, notably through exercise.

> **Researcher**: Are some people more likely to be obese than others?
> **Participant**: I guess people who eat too much and don't exercise to get rid of the weight. People who don't use up their calories. So, instead of losing them it stays with them and turns into fat.

While this cultural model gets the public close to experts' basic definition of obesity, reasoning in terms of inputs and outputs also led people to make some unproductive assumptions. While they reasoned that physical fitness is not a complex thing to achieve, as it mostly requires energy outputs to be larger than calorie inputs, they also assumed that once someone suffers from obesity they are likely to never recover. Because exercise plays an essential role in weight reduction for people, and obesity is associated with a loss of basic physical function (see the *Absence of Illness* and the *Health Is Independence* cultural models above), members of the public thought that obese people are stuck in an inextricable situation: They have become unable to spend more energy than they consume, and are therefore unable to lose enough weight to ever escape their status.

> **Participant**: I think it's like a vicious spiral. […] Because you want to lose weight and you can't because you can't exercise properly or even walk properly, sometimes. Because you're just too large. You can't physically, your knees hurt, when you get up and do things, your mobility is affected. And it's difficult to even walk for any length of time without being breathless or feeling ill.

Implications for Communicators:

- **The *Absence of Illness* cultural model makes the role of health creation in reducing obesity difficult to think.** Because this model defines health as *absence* of illness rather than a positive state, it makes it difficult to understand health as something that can be actively created to reduce obesity rates. To increase understanding of health creation and its importance for health in general, and obesity in particular, communicators need strategies to background the *Absence of Illness* model and foster an active, positive understanding of health as something that can be built, rather than as the passive absence of disease.

- **Thinking about obesity as the epitome of ill health leads people to misunderstand the influence that weight has on health.** People's understanding of obesity led to attitudes towards weight that are more categorically negative than experts', because their evaluations of the risk associated with weight differ significantly. Whereas experts understand obesity as a factor that increases people's risk of experiencing health issues,

people in Southwark and Lambeth saw obesity as an illness in its own right, or an inevitable cause of other illnesses. In both cases, people's understanding of obesity as the epitome of ill health led to an overestimation of the influence of weight on health outcomes.

- **The *Obesity as Visible Abnormality* and *Health Is Independence* cultural models contribute to the stigmatisation of obesity.** When thinking with the *Obesity as Visible Abnormality* model, people defined obesity as a deviation from the norms of physical appearance and function. This way of thinking is at the root of stigmatising attitudes towards obesity in Southwark and Lambeth, and in the United Kingdom: It separates obese people from the majority who represent and adhere to those very norms. The *Health Is Independence* cultural model reinforces this process of stigmatisation. The model narrowly defines what it means to function in society and links obesity with images of immobility and inactivity. From here, the public focused on the time, energy and money expended to help obese people, and judged them unfavourably for imposing these costs on others.

- **The *Health Is Medical* cultural model narrows people's focus to treatment and individual-level prevention**. When reasoning with this model, the public focused predominantly on medicine's ability to *treat and control* obesity once it has occurred, and assigned a key role to efficient health services and quality medical research in determining obesity rates. While the model allows for limited thinking about prevention at the individual level – following good medical advice about diet and exercise, for example – it obscures the need for health creation and preventative approaches (for example, early detection and intervention) or public health approaches that fall outside the scope of health care (for example, poverty relief, affordable child care and walkable communities).

- **The *Health Is Mechanical* cultural model got people to reason about obesity as an energy imbalance, but also cued individualistic and fatalistic thinking.** While this cultural model gets the public close to experts' understanding of the direct causes of obesity, it places a disproportionate focus on the role of individual behaviours like eating or exercising, and obscures the indirect, systemic sources of obesity. This, in turn, leads people to think that obesity is individuals' own fault and to blame individuals.

Cultural Models of the Determinants of Obesity: The Individualistic Strain

As noted above, there are a variety of cultural models available to members of the public in Southwark and Lambeth to think about the drivers of obesity. These models can be divided into an *individualistic* strain, which assigns a central role to individual choice and willpower, and an *ecological* strain, which sees obesity as, at least in part, a product of social and environmental influences. The individualistic strain is dominant – more readily called to mind – and makes the task of communicating the expert perspective more difficult. The ecological strain is recessive, but more hospitable to expert understandings.

Each strain is made up of a set of models that share significant similarities. Yet each model provides a distinct way of thinking about obesity, foregrounding particular considerations, relying on specific assumptions and yielding distinctive, if overlapping, implications. Below, we discuss the specificities of each model within the individualistic strain, and highlight what they have in common – including their joint tendency to obscure systemic influences and stigmatise obesity.

Obesity as Individual Failure: The *Health Individualism* Cultural Model

At the core of this cultural model is the assumption that health outcomes are driven by individual choice, and that each individual is responsible for their own health. *Health Individualism* leads people to focus on the crucial role played by what they consider to be individual 'lifestyle' choices, like diet and exercise, (not) smoking and (not) drinking, as well as mental and emotional 'self-care' practices like yoga or meditation.

Members of the public in Southwark and Lambeth consistently relied on this cultural model to reason about obesity, which they assumed to be a failure of *Health Individualism*. Reasoning from this model, people understood obesity as the direct result of poor personal choices that lead to a failure to exert self-control, and, in turn, an indulgence in excess: excessive consumption of food and drink, and an excessively sedentary existence.

> **Researcher**: Why do people experience obesity?
> **Participant**: Generally, overeating, sometimes overdrinking in terms of alcohol or sugary drinks, because alcohol has a lot of sugar in it, soda, carbonated drinks, fizzy drinks.
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> **Participant**: Again it boils down to choices of people, [some people] just love that fit, healthy lifestyle, and others don't. Some people probably just live to eat.

Obesity as Moral Failing: The *Mentalism* Cultural Model

According to the *Mentalism* cultural model, the choices people make are primarily – if not exclusively – determined by individual drive and strength of will. This focus on willpower reinforces the sense that each individual is morally responsible for his or her own health. When reasoning with this model, members of the public saw obesity as a moral failing – one that reflects a character flaw of some kind, such as laziness or arrogance.

> **Participant**: If someone I knew was overweight [...], if it was just because they ate too much, I would have a negative opinion of them. Because they are the only ones in control of what they consume.
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> **Participant**: Sometimes [overweight] people will say, 'You know what, mind your own business, I'll do what I want, I don't care'. The more you tell them, 'This is the way to go', the more they could rail against you.

At other times, when reasoning from the *Mentalism* model, people connected the outer appearance of obese people with their inner character, explaining that personal appearance reveals people's will to – or not to – 'take care' of themselves. In this way of thinking, being overweight indicates the absence of personal strength and pride; it is a sign that the individual lacks inner strength, resolve and willpower.[13] Obesity is understood as the *visible* manifestation of inner character failings.

> **Participant**: There are people out there that are embarrassed about being overweight or obese.
> **Researcher**: Why are people embarrassed?
> **Participant**: Because generally they've done it to themselves. It's usually something that you've done to yourself. So, it's an external sign that you've not been healthy in your choices.

As people assumed that obesity is the result of individual failure to make healthy choices, they also argued it could easily be eradicated, with sufficient individual effort from every member of society.

> **Researcher**: What are obstacles to reducing obesity rates?
> **Participant**: Sometimes people have a good idea of what they should be doing but it's too much effort and they can't be bothered – it's not fun or it's too hard. Breaking old habits can be difficult.

The *Genetic Exception* Cultural Model

People often pointed to genetics and fate to explain exceptions to the perceived rule that obesity results from personal choices and character. People assumed that in some cases, obesity comes from the genetic hand a person was dealt and conditions that are seen to stem from genetics, like thyroid imbalances or mental disorders. The *Genetic Exception* model reinforces the power of the *Health Individualism* and *Mentalism* models by providing a way to explain outlier cases without directly violating people's assumption that obesity is the result of poor individual choices and lack of willpower.

> **Researcher**: Why do you think people experience obesity?
> **Participant**: On the one hand, it could do with what you are eating and, on the other hand, it could be to do with something genetic or an illness that you have.

Because the *Genetic Exception* model involves the assumption that only a fraction of the obesity problem is due to unusual, rare and randomly occurring conditions, it allowed Southwark and Lambeth residents to conclude that *most* obesity is the result of personal choices. From here, it was easy for the public to draw a line between the 'deserving' and 'undeserving' ill – and place obese people squarely in the 'undeserving' category. According to this line of thinking, people who suffer from self-inflicted illnesses are less deserving of care than those whose poor health is no fault of their own – and obese people are the least deserving of all.

This pattern of reasoning becomes especially important in the context of the public conversation about the 'NHS crisis'. Knowledge of the serious financial strain the NHS is currently under led people to assume that health services are no longer in a position to accommodate the needs of all patients. When health care is seen as a limited commodity, it becomes easy to reason that the

'deserving' ill must be prioritised over those who are assumed to suffer as a result of bad choices and lack of will, including most obese people.

> **Researcher**: Who else is affected when people have health issues?
> **Participant**: The doctors and the nurses, and the NHS who are over-burdened and need to have their time divided up amongst people who needn't have been there, had they been well. If there are fewer habitual smokers and fewer obese people, and fewer people giving themselves strokes and heart attacks, that would free up a lot of the NHS's time.
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> **Participant**: More people attend hospitals [nowadays]. And someone with obesity – and that is a lifestyle choice – [...] because they're not making changes to their lifestyle, they may be frowned upon by the medical fraternity. They will take up a lot of space and it would be used otherwise for more serious medical conditions, and emergencies.

Implications for Communicators:

- **Individualistic cultural models make it difficult for the public to think about social determinants of obesity.** Because these models focus attention on individual-level factors (choices, behaviour, personal character or genes), they obscure the critical role played by social determinants and systemic factors. Cultivating a full understanding of the social determinants of obesity will require backgrounding these individualistic models in people's thinking to make room for them to see the role of social and systems-level factors in determining obesity rates in Southwark and Lambeth, and in the United Kingdom in general.

- **The *Health Individualism* and *Mentalism* cultural models stigmatise obesity.** These cultural models understand ill health as the result of a failure to make good choices or to exert willpower. This can lead people to conclude that people with ill health are responsible for their own problems and unworthy of treatment and public spending. To avoid reinforcing stigma, communicators need strategies that place individual behaviour in context and deepen understanding of the relationship between environments and individual choices. This is perhaps the most important framing challenge identified in this work: As long as people focus on the individual level and see choice and will as the most important drivers of obesity, social factors will, at best, remain in the background.

- **Crisis messaging about the NHS is likely to activate the assumption that obese people are undeserving of public resources.** Communicators should tread carefully in discussing the 'NHS crisis'. Doing so reinforces the view of health care resources as limited and pushes people into seeing the NHS as a zero-sum game. From this perspective, people are motivated to distinguish between the deserving and undeserving ill and draw distinctions

between who should get these resources and who shouldn't – namely, most obese people in the country.

- **Public thinking about genes and fate makes obesity prevention hard to think**. Because people have a deterministic understanding of genetics, when genes are implicated as a cause of obesity, prevention seems impossible. It is, after all, hard to prevent something that results from the genetic hand we are dealt. Communicators need strategies for explaining how genes and environments interact, to make it possible for people to understand how prevention can work for obesity – even those cases that have a significant genetic component.

Cultural Models of the Determinants of Obesity: The Ecological Strain

While the individualistic strain is dominant in public thinking about the drivers of obesity, a recessive ecological strain also exists. This strain is made up of models that allow people to recognise some of the ways in which money, commercial and physical environments and community influence obesity rates in Southwark and Lambeth. Chicken shops and fast food advertising in the boroughs were, for instance, top-of-mind issues for people. While this strain is more productive than the individualistic strain, the models that comprise it focus attention only on certain dimensions of the environment; at best, they provide a partial understanding of *how* context leads to obesity. And even within this ecological strain, there is a residual degree of individualism, as individuals are ultimately considered responsible for the choices that cause obesity.

As with the individualistic models, the ecological models make up a family of models that have things in common but also distinctive implications. Despite their limitations, these models provide a promising starting point for communicators, and have the potential to be leveraged and expanded to enhance understanding of the social determinants of obesity.

The *Consumerism* Cultural Model

Members of the public in Southwark and Lambeth recognised that poverty increases one's chances of becoming obese, but they primarily understood the influence of money and wealth in terms of individual purchasing power. The core assumption of the *Consumerism* cultural model is that money facilitates personal choice and the adoption of healthy individual behaviours, because it is exchangeable for the best foods and access to the gym – the best insurance against obesity, in people's minds. In other words, how many pounds someone has in their pocket (as one participant put it) determines how much they can spend on healthy purchases, which in turn directly shapes how healthy they are, or how likely they are to experience obesity. Participants sometimes acknowledged that Southwark and Lambeth are poorer than other boroughs in London, and that this meant the boroughs' residents were more likely to have poor eating habits than people in wealthier areas of the city.

Participant: Some people don't have much money, and that is also another factor when it comes to obesity levels and health levels, because sometimes people are forced to go for the cheaper options when it comes to food and drinks, and they're usually not healthy. So, to a point, it can be more expensive to maintain a healthy lifestyle.

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Participant: If you don't have very much money but you need to feed yourself and your children, or your family, and fill them up, it can be a lot cheaper to buy food that's not very good for you than to buy healthier food that perhaps takes longer to prepare. If you work several jobs then you'd rather have a frozen pizza than bothering to make yourself a healthy meal full of chicken and chickpeas, that sort of thing.

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Participant: I would say Southwark is a lot poorer borough than Richmond, or some place like that. And of course you've got a poorer borough, then you've got austerity, then you've got low wages, and people are gonna spend the least amount on maybe the poorer quality of food. You know, in order to survive. Whereas if you had a richer more affluent borough, those people can then afford to eat better and watch their diet more than the poor borough.

It is important to note that, even though the *Consumerism* model was frequently used by the public, it is relatively weak – in the sense that people quickly defaulted back to *Health Individualism* or *Mentalism*. For example, after suggesting that the cost of food is an important factor in dietary habits, in the next breath participants returned to asserting the primacy of choice and will and explaining that what people eat remains within their control.

Participant: It would be nice to see in the future a shift in our eating habits in terms of cheap meat being more expensive and the better stuff being cheaper. How long that would take I don't know. I mean I just bought Whole Foods and […] I came out of there with six items and I went overdraft. […] But in the future if Amazon can bring the cost down, maybe it will be available to more people, which would be better. But I don't know how likely that will be. But you know, there is nothing stopping people from going to the local market to buy fruit and veg. Because I know the market down the road, you can get so much stuff for one pound. It is ridiculous. I went in there once and spent like twelve pounds and I had enough to feed a village.

The *Behavioural Constraints* Cultural Model

According to the *Behavioural Constraints* cultural model, the main – if not only – way in which social and environmental factors affect an individual's likelihood of experiencing obesity is by restricting or encouraging individual behaviours. For instance, people saw that a time-consuming job could affect someone's ability to eat well or exercise, or that people's immediate commercial environment in some parts of the boroughs (where 'chicken shops' and fast food outlets are ubiquitous) could make it hard for them to adopt healthy habits. Following the same logic, they

argued that stress produced by social and environmental factors makes it difficult for people to adopt healthy habits.

> **Researcher**: And why do you think obese people might eat too much?
> **Participant**: Too much fast food around. I suppose people are wealthier so they can afford to spend more on food than they used to be able to. And it all leads to people buying too much and having too much in the fridge and ultimately eating too much. Eating too much sugar, as well.
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> **Researcher**: And do you think there's any relationship between stress and obesity?
> **Participant**: Yeah, because some people like to self-medicate, or they might just start stuffing their face […] People like to comfort eat.

Like the *Consumerism* model, the *Behavioural Constraints* model is relatively weak. After suggesting that environments constrain behaviour, participants quickly defaulted back to the more dominant and deeply entrenched individualistic cultural models. They argued that environments may constrain individual choice to a certain extent, but that they never prevent choice altogether: If someone cannot choose *what* they eat, they can still decide *how much* of it they eat, for instance. Participants suggested that, while fast food restaurants and processed foods are ubiquitous in Southwark and Lambeth, individuals can resist that temptation with enough willpower. And after suggesting that stress comes from the environment, participants frequently reverted to more individualistic ways of understanding stress, arguing that obese individuals are the main cause of their own stress and are stuck in a vicious circle that only willpower can save them from.

> **Participant**: When I was at school most of the people in my class would go straight to the McDonald's or KFC right after school was finished. I mean, our teachers would try and tell us, they showed us all these documentaries about what goes in your food, but no one really listened to it.
> **Researcher**: Why do you think they didn't listen?
> **Participant**: I don't think they cared.
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> **Participant**: Some people who are obese get trapped in a cycle where they say 'okay, I am overweight. Now I am stressed because I am overweight.' But rather than them trying to lose the weight, 'I am going to eat more. I am going to comfort eat.' So now they have eaten more, then they got bigger. […] It is a nonstop thing. […] But again, it is habits and it's knowing how your body works as well. […] So I know for myself I can't eat what I want because I will put the weight on and I don't want to be obese. Just out of choice, I don't want to be fat.

The *Cultural Norms of Obesity* Cultural Model

When explaining differences in obesity rates between boroughs, regions or countries, participants sometimes appealed to cultural norms. According to this way of thinking, different 'cultures', communities or family units set different norms about what is 'normal' and 'healthy', which in turn

shape personal choice and individual behaviour for the members of that group in an almost inescapable way. For instance, participants explained higher obesity rates in the Black communities of Southwark by community eating habits and culturally specific beauty standards.

> **Participant**: Well, in Southwark, there's a very large Black community. They seem to love fried chicken and stuff and maybe eat a little less unhealthily. […] I would see a hell of a lot more heavier, overweight people in the Black community than I would in the white. […] Especially in Camberwell, Peckham and Brixton, where there's a very large Black community.
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> **Participant**: So I know for a fact that a lot of my friends growing up were from like Africa and the Caribbean, and being thin is not a thing. You want to have a curvy body, you want to have a big bum. Fries and, … you know, that's normal. To be really thin is not something that they aspire to.
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> **Participant**: If kids are brought up in a home where one or both parents live a fit and healthy lifestyle, I think there's a far greater chance that the kids will live similar lifestyles to their parents. Whereas if you've got parents who are grossly overweight – maybe cooking at home, but it's all the wrong foods, and then of course they're feeding their children these foods that have made them grossly overweight, then you're going to end up with another generation of grossly overweight people. It's like a cycle.

The *Threat of Modernity* Cultural Model

When discussing drivers of obesity in their boroughs and in the United Kingdom, people often argued that the pressures of the modern world have a negative effect on individual behaviours. When drawing on the *Threat of Modernity* cultural model, members of the public identified a vaguely defined 'modernity' as a cause of obesity in the country. For instance, people argued that capitalism and technology reduce individual drive by making life too 'easy' for people and pressuring them into unhealthy consumption, or that the modern workplace is time-consuming, stressful and sedentary. The *Threat of Modernity* cultural model typically cues nostalgic thinking about the need to return to 'the good old days', when life was better and healthier.

> **Participant**: I honestly think one of the reasons that we are obese is because we are fucking greedy. We have so many options offered to us on a daily basis. Just think of when we go to the supermarket how many different products there are. I mean it is beyond ridiculous. Why are there 25 different soups and 20 different meats? Because we are in a period of our lives where we are getting used to having everything we want now and everything being so fast by the touch of a button. Whereas before, even, say, 100 years ago there wasn't as much choice.
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Participant: I think people are generally unhealthier than they used to be. […] I mean, when I was young there wasn't any fast food at all. And people cooked. People cooked from scratch. […] Mothers knew how to cook, and they passed on that knowledge to the younger generation. And I'm not sure if that's the thing now so much as it used to be.

The *Government Is Responsible* Cultural Model

Although members of the public in Southwark and Lambeth often assigned ultimate responsibility for obesity to individuals, they also understood that government has a central role to play in health and health care. The basic assumption that government has some responsibility for health outcomes in general, and for obesity specifically, was hardly ever questioned in the interviews; participants treated it as uncontroversial common sense. When thinking with this model, people focused on the government's responsibility to fund the NHS and financially support schools' health education efforts. They also argued that government – national or local – can support healthy individual behaviours by directly funding free gyms and cheaper healthy food.

Researcher: Who do you think is responsible for health in the UK?
Participant: It's the government. Because the government decides how much funding goes towards the National Health Service. So, effectively the government is responsible for running it.

Compared to our general UK sample,[14] participants in Southwark and Lambeth often argued that the government was not currently fulfilling its role of caring for people's health in the United Kingdom. Many participants denounced austerity measures and cuts to public funding, which they saw as detrimental to local services that promote good health in the community.

Researcher: What are the obstacles stopping the government from doing more?
Participant: Jesus Christ. It depends on who's in government, but if it's the Tories, everything's gone. It's just cut every angle to the bone and, of course, that has an effect on all of us. I'd say when Jeremy [Corbyn] gets in there'll be big changes. I don't know if many grossly overweight people are going to change their life just because Labour's in, you know, but it boils down to: They've got this word 'austerity' going on at the minute. And as I say, with all these cuts, we'll lose services. And some of those services I'm sure would be used for the people, the kind of people we're talking about, and of course if they get closed, then the person slips back into their old lifestyle and it just continues.

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Participant: Government cuts impact how much we share, how much community organisations can have. And I don't believe that this government cares about people's health, just for the way they treat disabled people, and the benefit cuts and things like that. Disgusting. Absolutely disgusting.

The Cognitive Hole of Power Relations

While people had a sense that discrimination and stigma can be *consequences* of obesity, they generally didn't think of discrimination, racism and other types of power imbalance as *drivers* of obesity. When people discussed the ethnic diversity of Southwark and Lambeth more specifically,

they presented it as positive, and did not see that certain communities might suffer from power inequalities and discrimination in their boroughs. Prior FrameWorks research[15] has shown that the British public doesn't see discrimination as a cause of bad economic outcomes; in much the same way, people do not see it as a cause of poor health outcomes in general, or obesity specifically. The public lacks a way of making sense of systemic imbalances in power and systemic forms of discrimination; as a result, people have a hard time thinking about how power inequalities might affect obesity rates.

Implications for Communicators:

- **The *Consumerism* cultural model allows people to see that money plays a role in the issue of obesity, but obscures important ways that wealth influences obesity rates.** Reasoning with this cultural model, people could see that lack of funds leads to higher obesity rates. However, it remained difficult for them to see the roles that social capital and access to quality education or employment play in determining obesity rates. While the model provides a potential entry point for discussing how wealth inequalities influence people's likelihood of experiencing obesity, communicators need to explain the fuller range of mechanisms at play to deepen public understanding of the relationship between wealth and obesity.

- **The *Behavioural Constraints* cultural model provides a productive starting point**. While this model does not provide ways of understanding the more complex interactions through which external factors can 'stack the odds' against individuals, it is a potentially useful starting point for communicators. They must leverage and expand this model to get the public to see that, when it comes to obesity, individual choice and willpower cannot override external factors (for example, commercial environment, poverty and stressful working conditions). For instance, communicators can build on the link people already see between a community's physical environment and opportunities for physical activity to explain other ways that physical environments can influence obesity rates (for example, by supporting or undermining social connections, or facilitating or impeding employment opportunities or educational success).
- **The *Cultural Norms of Health* cultural model obscures structural inequalities and leads people to blame marginalised communities.** By backgrounding the structural sources of health disparities between communities and attributing poor health to cultural differences, the model leads people to blame communities that suffer from obesity the most in the boroughs of Southwark and Lambeth. And because the model connects with stereotypes of marginalised groups, it leads to the sense that the normalisation of obesity is a problem only for 'other' people, communities and cultures. Communicators need strategies that bring into view the ways in which social structures and power relations shape health and influence obesity rates.

- **The *Threat of Modernity* cultural model leads to fatalistic thinking**. The model leads people to conclude that the issue of obesity could only be solved by a return to the past. Because this

is an unrealistic solution, it yields a sense that current obesity rates are an inevitable feature of modern life. Communicators should steer clear of arguments about how previous generations ate or exercised or the way things used to be, which are likely to cue this model and result in fatalistic thinking about the possibility of reducing obesity rates.

- **The *Government Is Responsible* model is productive but needs reinforcement.** Because people recognise that the government has a responsibility to take care of people's health, communicators do not need to devote great energy to making this point. However, this sense of responsibility needs to be deepened as part of an effort to help people understand all the ways in which the government could support a reduction in obesity rates – beyond strengthening the NHS and providing better funding for health efforts. Communicators need effective ways of explaining the government's role in intervening upstream to tackle systemic drivers. Helping people see that government has a wider sphere of responsibility for health is crucial to build support for the kinds of policies needed to address the social determinants of obesity.

Thinking about Solutions

Solution #1: Education and Awareness

People thought that providing more information about health behaviours and raising more awareness of health risks is critical to reducing obesity rates in their boroughs and in the country. This emphasis on awareness and education suggests that society's main role is to provide people with the necessary information to make the right choices for their individual health, and that the rest ultimately lies in their own hands.[16] People put special focus on the role of schools in educating the younger generations about healthy eating, exercising and individual responsibility, so that good habits are cultivated early in life.

> **Participant**: [Our health services must] try and 'educate', give information to people, so that they know what is good for them and what is bad for them, so that they can take more action themselves to try and look after themselves.

Solution #2: Governmental Regulation of Commercial Practices

While members of the public in Southwark and Lambeth primarily saw the government's role as funding the NHS and other services, when asked what could be done to lower obesity rates, they sometimes suggested that government should play a stronger regulatory role. Participants thought that government should do more to restrict unhealthy commercial practices, and to make unhealthy food and drinks less affordable or less attractive. This solution grows directly out of the *Consumerism* model.

> **Researcher**: What could the government be doing?

Participant: There's Jamie Oliver's sugar tax thing. It was things like chocolates, Coca-Cola, all those types of things you'd have to pay more tax on. I think the idea is if people are paying more for these things they're less likely to have as much of it because it's more expensive.

However, people's understanding of which types of regulations might be effective, and how they could technically work to reduce obesity rates, remained fairly thin. After bringing up government control, participants often defaulted back to individualistic cultural models. Making explicit or implicit references to the 'nanny state', they explained that government's regulatory power should not take over individuals' responsibilities and encroach on individual freedom. And they often concluded that, even if this were a good idea in theory, trying to solve the issue of obesity through government control is not likely to be effective.

Researcher: What do you think needs to happen to improve levels of obesity here in this borough?
Participant: Get rid of some of these chicken shops. There's far too many. Just shut them down. Especially those that are near the schools, as well. If they weren't there, then that wouldn't be an option for the children. But this is blue sky thinking.

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Participant: I question the efficacy of banning things generally. I'd sooner try and educate people to make smart decisions for themselves rather than ban bad food or ban drugs or ban this, ban that, whatever. I like having freedom to do what you want to do.

Solution #3: Local Initiatives

Members of the public in Southwark and Lambeth were less ambivalent about the role and influence of local councils, which they agreed should do more to combat obesity. People were less likely to fall back on individualistic thinking when discussing the role of local councils than when discussing that of central government. People's thinking about local solutions was also more expansive, as it focused more distinctly on the role of physical environments in encouraging the adoption of healthy habits to reduce obesity rates.

Researcher: Is there anything different that needs to happen on a local level to improve health or specifically reduce obesity levels?
Participant: Well, I've mentioned maintaining things like parks and bike paths, making sure that there are facilities for clubs for kids and adults as well. That there are maybe subsidies for these kinds of things to happen.

The Cognitive Hole of Health Creation and Public Health

Members of the public in Southwark and Lambeth had a hard time thinking about solutions that take a holistic approach to obesity, across sectors and government departments. They did not see how governmental actions targeting systemic drivers could result in health creation, and how government should collaborate with communities and private actors to lower obesity rates. Public

health initiatives targeting the social determinants of health, like *Health in All Policies*, were simply not part of current public thinking.

Implications for Communicators:

- When communicators talk about the role of education in improving health outcomes, they need to clarify that they do not just mean 'health education'. When members of the public think and talk about education as a solution to lower obesity rates, they have in mind 'health education' only. When talking about the long-term health benefits of quality education for all children, communicators should explain what they mean by 'education' and be explicit about its relationship with life opportunities and health.

- Communicators must expand public understanding of the role that government can play to improve health outcomes, beyond funding and regulations. Members of the public already see that the government has a role to play in reducing obesity rates. Future communications need to focus on getting the public to see how government can reduce obesity rates by working across sectors and departments to effectively address the social determinants of health.

- Communicators can build on the public's positive perception of locally based solutions to address the role of community empowerment in creating health. Communicators can show how involving communities more actively in decision-making at the local and the national levels can help lower obesity rates. This strategy would also allow communicators to address the importance of local initiatives without cuing concerns about the nanny state.

Initial Recommendations

The analysis of cultural models presented in this report yields a set of recommendations about how to communicate about obesity in Southwark and Lambeth. While more research must be done to understand which specific reframing strategies can be most effective for future communicators, the following recommendations offer a provisional strategy that advocates can use now to improve their communications practice.

- **Tell systems-level stories**. Communicators should tell stories about obesity that position social structures and environments as protagonists and antagonists alongside individuals – rather than stories that use isolated examples of the trials and tribulations of individuals and families.

  - **Avoid using stories about one individual or one family as the main message, and always place individual cases in a larger context.** When individual stories stand alone, they lead people to think about individual-level causes rather than systemic and environmental causes, thereby sapping popular support for systemic changes recommended by experts [17]. In other words, individual stories about obesity will likely reinforce the public's belief that obesity is the visible sign of a lack of willpower and moral resolve, which will undermine support for solutions that address social and environmental determinants.

  - **Give people enough context to help them think systemically about the drivers of obesity.** For instance, a discussion of the influence of commercial environments on the availability of food in Southwark and Lambeth can shed light on the responsibilities of the food industry and policymakers in shaping the food and commercial environment. Focusing on the characteristics of the food itself and the shops selling them (for example, processed food being 'quick, cheap and easy', or the negative influence of 'chicken shops') will, on the other hand, cue cultural models like *Health Individualism* and *Mentalism*, and lead the public to more individualistic thinking about commercial environments.[18]

- **Avoid restating misperceptions or myths about obesity, and never talk about them early in a communication.** One of the most important predictors of whether an idea is believed to be true is the number of times people have heard it. For this reason, when the goal is to advance a public health perspective on obesity, it is usually unproductive to mention the common belief that individual behaviours drive obesity – even to debunk it as a myth. It is especially unhelpful to open a communication this way, as this makes the task of advancing a new or different way of thinking more difficult. While research has shown that acknowledging or explicitly countering opposing messages might work in a few specific cases,[19] such a strategy is much more likely to backfire. For this reason, without specific evidence to the contrary, talking extensively about individual behaviour should be avoided in public-facing communications about obesity in Southwark and Lambeth.

- **Avoid crisis messaging**. Rising rates of obesity in the United Kingdom are often framed as an 'epidemic' or a 'pandemic'[20] caused by a 'tsunami of risk factors',[21] and issues within the NHS are called an 'emergency'. Both situations are frequently referred to as 'health crises'. Crisis-themed language like this is common in social change communications, often reflecting advocates' sense of urgency for change and the assumption that ringing the alarm bell will lead people to respond with action. Social science – including studies by FrameWorks – has shown that, in fact, crisis messages often backfire, leading people to conclude that the problem is too big to solve and nothing can be done. This fatalism leads to *lower* support for solutions and rapid disengagement from the issue.[22] Communicators should thus avoid characterising rising rates of a given illness, or strain on the NHS, as crises.

- **Avoid the terms *normal* and *abnormal* when discussing individual behaviour, weight status or environments.** The concept of normality presupposes its opposite – that there is something that is abnormal. Because people already model obesity as a transgression of social norms, introducing the concept of normality will activate and reinforce the tendency to draw a line between people who are and are not obese, inviting to mind stigmatising beliefs about obesity. For these reasons, saying 'obesity is a normal reaction to an abnormal environment' or 'obesity is the new normal in Southwark' is likely to backfire, and to strengthen precisely the attitudes that communicators intend to unseat.

- **Be careful when talking about the normalisation of obesity in Southwark and Lambeth.** Currently, members of the public see the normalisation of obesity as something that happens to 'other' people, communities and cultures. For this reason, when discussing the risks associated with a normalisation of obesity in the boroughs, communicators should avoid linking normalisation to specific communities, because this is likely to cue stigmatising thinking. Communicators should de-emphasise normalisation when possible and, when discussing it, reference a broader community – the borough or the United Kingdom – rather than specific ethnic groups.

- **Explain what obesity *prevention* means, to avoid cuing individualistic or fatalistic thinking.** Without context, members of the public in Southwark and Lambeth are likely to assume that 'obesity is preventable' means 'people need to behave more responsibly, earlier'. Moreover, the prevention theme runs the risk of backfiring, if not framed carefully. Because the public assumes that most cases of obesity can be avoided by individuals themselves, it is easy for people to conclude that those affected failed to take action, and therefore don't deserve treatment or public spending. Without a clear definition of what prevention means, people are also likely to focus on awareness or 'education' campaigns promoting healthy behaviours, which can further entrench the stigmatisation of obesity. Once people perceive that information on healthy eating and exercise is readily available and easily adopted, it is easier to assume that those who do not follow it have failed to take appropriate responsibility for themselves. Finally, people's understanding of genetics leads them to assume that some cases of obesity are inevitable and simply cannot be prevented. Communicators need effective strategies to counter such fatalistic thinking and communicate about the need for generalised prevention.

- **Use step-by-step causal chains to explain how social determinants affect obesity in Southwark and Lambeth.** Explaining the causal links between different social and environmental factors, and how they affect obesity rates, is critical for expanding the public's understanding of their role. For example, communicators might explain – in a simple, step-by-step fashion[23] – how limited access to quality education can 'stack the odds against someone'. Communicators must make each causal link in the chain explicit – for example, how lack of access to quality education leads to limited employment options; how this in turn affects people's housing conditions and nutrition; how these conditions conspire to decrease individual agency; how they yield specific effects on physical and mental health; and how these effects, in turn, influence a person's likelihood of experiencing obesity in their lifetime. By using causal chains to explain social determinants, communicators can deepen understandings of their role. This can help defuse the power of individualistic cultural models and generate public support for initiatives aimed at health creation in the boroughs, and in the United Kingdom.

- **Provide examples of health creation and an integrated approach to reducing obesity rates to broaden people's view of solutions.** Examples must illuminate the role that health-creating policies and community empowerment can play in reducing obesity rates in the boroughs and the United Kingdom – for the whole population. Communicators should make a point of discussing policy initiatives that go beyond health education and awareness campaigns (which the public already supports and recognises as important) and explain how more integrated public health strategies could help create health and reduce obesity rates. Examples should be carefully created to avoid assessments of the worthiness or deservingness of specific individuals or communities. Examples of solutions should be used in conjunction with causal chains that explain how social determinants determine obesity rates, so that people can see how the solutions address the root causes of obesity.

Appendix: Research Methods and Demographics

Cultural Models Interviews

The cultural models findings presented in this report are based on a set of interviews with members of the public. To understand the British public's current thinking, FrameWorks conducted 15 in-person, in-depth interviews with members of the public in August and September 2017 in the London boroughs of Southwark and Lambeth. These interviews were supplemented with material from 21 interviews in London, Cardiff and Sheffield, conducted during the same period for a related project on the social determinants of health for The Health Foundation. This supplementary material was used to confirm the patterns and tendencies identified in our primary data, and to allow us to compare thinking about health in Southwark and Lambeth to thinking about health in the United Kingdom more broadly.

Cultural models interviews – one-on-one, semistructured interviews lasting approximately two hours – allow researchers to capture the broad sets of assumptions, or 'cultural models', which participants use to make sense of a concept or topic area. These interviews are designed to elicit ways of thinking and talking about issues – in this case, issues related to obesity. Interviews covered thinking about health and obesity in broad terms before turning to a discussion of the systemic drivers of obesity specifically. The interviews touched on prevalence, causes and effects, responsibility for the issue and solutions to it. The goal of these interviews was to examine the cultural models that participants use to make sense of obesity and health, so researchers gave them the freedom to follow topics in the directions they deemed relevant. Researchers approached each interview with a set of topics to cover, but largely left the order in which these topics were addressed to participants. All interviews were recorded and transcribed with participants' written consent.

The Southwark and Lambeth sample included seven women and eight men. Of the fifteen participants, nine self-identified as 'white' (for example, English, Welsh, Scottish, Northern Irish, British Irish), five as 'Black' (for example, African, Caribbean, Black British) and one as 'Asian' (for example, Indian, Pakistani, Bangladeshi, Chinese). Eight participants described their political views as 'Labour or left-leaning (on the left)' and seven as 'middle of the road (moderate)'. All participants resided in the boroughs of Southwark and Lambeth. The mean age of the sample was 42 years old, with an age range of 22 to 59. Average annual household income ranged from £23,000 to £36,000. Seven participants held a GCSE (or equivalent) or below, six had completed university studies and two had completed postgraduate studies. Four were married, and six were parents of at least one child.

The Health Foundation sample included nine women and twelve men. Of the twenty-one participants, sixteen self-identified as 'white' (for example, English, Welsh, Scottish, Northern Irish, British Irish), one as 'Black' (for example, African, Caribbean, Black British) and four as 'Asian' (for example, Indian, Pakistani, Bangladeshi, Chinese). Two participants described their political views

as ‘Labour or left-leaning (on the left)’, seven as ‘conservative (on the right)’ and twelve as ‘middle of the road (moderate)’. Seven participants reported living in a suburban or rural area, and fourteen in an urban area. The mean age of the sample was 39 years old, with an age range of 24 to 64. Education was used as a proxy for socioeconomic status; nine participants held a GCSE (or equivalent) or below, seven had completed university studies and five had completed postgraduate studies. Ten were married, and seven were parents of at least one child.

Findings are based on an analysis of these interviews. To analyse the interviews, researchers used analytical techniques from cognitive and linguistic anthropology to examine how participants understood issues related to obesity and health.[24] First, researchers identified common ways of talking across the sample to reveal assumptions, relationships, logical steps and connections that were commonly made, but taken for granted, throughout an individual’s talk and across the set of interviews. In short, the analysis involved patterns discerned both from what was said (how things were related, explained and understood) and what was not said (assumptions and implied relationships). In many cases, analysis revealed conflicting models that people brought to bear on the same issue. In such cases, one of the conflicting ways of understanding was typically found to be dominant over the other, in the sense that it more consistently and deeply shaped participants’ thinking.

Analysis centred on ways of understanding that were shared across participants. Cultural models research is designed to identify common ways of thinking that can be identified across a sample. It is not designed to identify differences in the understandings of various demographic, ideological or regional groups (which would be an inappropriate use of this method and its sampling frame).

About the FrameWorks Institute

The FrameWorks Institute is a think tank that advances the nonprofit sector's communications capacity by framing the public discourse about social problems. Its work is based on Strategic Frame Analysis®, a multi-method, multidisciplinary approach to empirical research. FrameWorks designs, conducts, publishes, explains and applies communications research to prepare nonprofit organisations to expand their constituency base, build public will and further public understanding of specific social issues – the environment, government, race, children's issues and health care, among others. Its work is unique in its breadth, ranging from qualitative, quantitative and experimental research to applied communications toolkits, eWorkshops, advertising campaigns, FrameChecks® and in-depth study engagements. In 2015, it was named one of nine organisations worldwide to receive the MacArthur Foundation's Award for Creative & Effective Institutions. Learn more at www.frameworksinstitute.org.

Please follow standard APA rules for citation, with the FrameWorks Institute as publisher.

L'Hôte, E., Fond, M., & Volmert, A. (2018). Communicating about Obesity: A FrameWorks Strategic Report. Washington, DC: FrameWorks Institute.

[1] See, for instance, Pym H. (2018, 12 March). Sugar tax is already producing results. BBC News. Retrieved from http://www.bbc.co.uk/news/health-43372295 (Consulted on March 22, 2018).

[2] Quinn, N. & Holland, D. (1987). Culture and cognition. In D. Holland & N. Quinn (Eds.). *Cultural Models in Language and Thought* (pp. 3–40). Cambridge: Cambridge University Press.

[3] A description of the methods used in this research, and participant demographic information, can be found in the Appendix.

[4] This expert summary was mainly derived from the following two sources, which researchers supplemented with a review of materials from relevant literature:

1. Expert interviews conducted as part of communications research on health in the United Kingdom; see L'Hôte, E., M. Fond & Volmert, A. (2018). *Seeing upstream: Mapping the gaps between expert and public understandings of health in the United Kingdom*. Washington, DC: FrameWorks Institute.

2. The recent report authored by Guy's and St Thomas' Charity (2018). *Bite Size: Breaking Down the Challenge of Inner-City Childhood Obesity*. London: Guy's and St Thomas' Charity.

[5] See Organisation for Economic Co-operation and Development (OECD). (2017). *Health at a Glance 2017: OECD Indicators*. Paris: OECD Publishing.

[6] Guy's and St Thomas' Charity (2018). *Bite Size: Breaking Down the Challenge of Inner-City Childhood Obesity*.

[7] Swinburn, B. A., Sacks, G., Hall, K. D., McPherson, K., Finegood, D. T., Moodie, M. L. & Gortmaker, S. L. (2011). The Global Obesity Pandemic: Shaped by Global Drivers and Local Environments. *The Lancet* 378(9793), 804–814. https://doi.org/10.1016/S0140-6736(11)60813-1.

[8] See notably Robinson, E. (2017). Overweight but Unseen: A Review of the Underestimation of Weight Status and a Visual Normalization Theory. *Obesity Reviews* 18(10), 1200–1209.

[9] These patterns are sometimes referred to as 'cultural models', or simply 'models', throughout the report.

[10] See Crawford, R. (1984). A cultural account of 'health': Control, release, and the social body. In *Issues in the Political Economy of Healthcare* (pp. 133–143). London: Tavistock Publications.

[11] For a historical perspective on this 'fear of fat' in western culture, see Sawbridge, D. T. & Fitzgerald, R. (2009). 'Lazy, Slothful and Indolent': Medical and Social Perceptions of Obesity in Europe to the Eighteenth Century. *Vesalius* 15, 59–70.

[12] For a discussion of health and productivity, see Herzlich, C. & Pierret, J. (1987). *Illness and Self in Society*. Baltimore, MD: Johns Hopkins University Press.

[13] For a historical discussion of health as a reflection of character, see Sontag, S. (1979). *Illness as Metaphor*: New York, NY: Vintage Books.

[14] See Appendix for more detail about the two samples used for this report.

[15] Volmert, M. G.-P. & Kendall-Taylor, N. (2016). Talking about poverty: How experts and the public understand poverty in the United Kingdom. Washington, DC: FrameWorks Institute.

[16] This pattern of thinking obscures the fact that public information campaigns designed to improve individual behaviour always benefit members of the middle classes more than poorer sections of the population and can unintentionally exacerbate experiences of stigma and shame for people with poor health. On this issue, see, for instance, Smith, K. E. & Anderson, R. (2017). Understanding Lay Perspectives on Socioeconomic Health Inequalities in Britain: A Meta-Ethnography. *Sociology of Health & Illness*. See also Herzlich & Pierret. (1987). *Illness and Self in Society* (p. 234).

[17] See notably Shanto Iyengar, *Is Anyone Responsible?: How Television Frames Political Issues*, American Politics and Political Economy (Chicago: University of Chicago Press, 1991).

[18] For visual discourse on environmental drivers that can easily lead to individualistic interpretations, see, for instance, Thomas Moore's reimagining of William Hogarth's *Gin Lane*, commissioned by the Royal Society for Public Health: Moore, T. (2016). Gin Lane 2016. *Royal Society for Public Health*. Retrieved from https://www.rsph.org.uk/about-us/news/gin-lane-2016-iconic-artwork-reimagined-for-the-21st-century.html.

[19] In FrameWorks' research on criminal justice reform in the United Kingdom, we found that acknowledging the value of punishment is unhelpful, but that raising opponents' points and actively countering them can be helpful. See O'Neil, M., Kendall-Taylor, N. & Volmert, A. (2016). New narratives: Changing the frame on crime and justice. Washington, DC: FrameWorks Institute.

[20] Swinburn et al. (2011). The Global Obesity Pandemic.

[21] The Lancet. (2011). Urgently Needed: A Framework Convention for Obesity Control. *The Lancet* 378(9793), 741. https://doi.org/10.1016/S0140-6736(11)61356-1.

[22] See, for example, Simon, A., Volmert, A., Bunten, A. & Kendall-Taylor, N. (2014). The value of explanation: Using values and causal explanations to reframe climate and ocean change: *A FrameWorks Research Report*. Washington, DC: FrameWorks Institute.

[23] For advice about how to construct effective step-by-step explanations, see, for instance, L'Hôte, E., Fond, M. & Volmert, A. (2017). Beyond awareness of stigma: Moving public understanding to the next level: Mapping the gaps between expert and public understandings of mental health in Colorado: *A FrameWorks Strategic Report*. Washington, DC: FrameWorks Institute.

[24] Quinn, N. (2005). *Finding Culture in Talk: A Collection of Methods*. New York, NY: Palgrave Macmillan.