Are people with obesity to be blamed for their obesity? Uncovering obesity stigma: a Narrative review

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Abstract

Obesity is one of the leading epidemics worldwide. Despite its prevalence, individuals with obesity often face significant weight bias and discrimination across various settings. Bias can manifest in various forms, including teasing, bullying, unfair treatment, disrespect, and misjudgment. It affects people of all ages, regardless of gender, race, or educational background. The consequences of obesity stigma are enormous. It impacts people with obesity at the socioeconomic level, psychologically and physically, which eventually harms their health. In healthcare, obesity stigmatization leads to reduced and delayed access to health services and a lower quality of care. Many strategies and recommendations have been proposed to reduce and hopefully end obesity and weight stigma.

In this review, we discuss definitions, prevalence, biases among healthcare providers, perceptions of bias among people with obesity, the consequences of stigma, and recommended strategies to minimize obesity stigmatization in healthcare.

Keywords: obesity stigma, weight bias, weight discrimination, weight stigma

Introduction

Obesity is one of the leading epidemics worldwide. It is a global public health concern, as it affects both high-income and low-income countries, resulting in a significant economic burden. According to WHO, in 2022, 1 in 8 people are living with obesity worldwide [1]. Moreover, it is estimated that by 2035, 51% of the population aged five and above will be either overweight (BMI ≥ 25 kg/m²) or obese (BMI ≥ 30 kg/m²) worldwide [2]. Obesity is a chronic, relapsing, and multifactorial disease with serious health consequences. It cannot solely be attributed to an individual's diet or lifestyle choices [3,4]. It is defined as abnormal and excessive fat accumulation, which poses a significant health risk [5]. However, despite the high prevalence of obesity in the population, the prevalence of weight discrimination against people with obesity is equally high [3,6]. The World Obesity Federation defines weight stigma as "the discriminatory acts and ideologies targeted towards individuals because of their weight and size" [7]. Weight stigma, also known as obesity stigma, refers to negative social beliefs, attitudes, and behaviors that are directed towards people with obesity. It stems from the belief that people with obesity are at fault for their obesity. In a meta-analysis conducted in 2016, not only was there a high prevalence of weight discrimination; 19.2% of those with class 1 obesity (BMI 30—34.9 kg/m²) and 41% of those with obesity class 2 and above (BMI ≥35 kg/m²); but higher BMI correlates with higher perceived weight stigma [3,8]. In addition, it was shown that women were subject to higher weight discrimination [3,8].

People with obesity face discrimination in their workplace, community, and in healthcare. It affects both men and women, regardless of socioeconomic status, race, or educational level. It also affects people from different obesity categories, from overweight to morbid obesity. There are various forms of bias: teasing, bullying, exclusion, unfair treatment, and shaming. There are common stereotypes and misconceptions about people with obesity, including lack of self-control, laziness, lack of compliance or commitment, poor health/food choices, and lack of hygiene [4]. Despite evidence from research proving that obesity is predominantly due to genetic and environmental factors, obesity continues to be viewed as an individual's wrong choices and decisions about their diet and health [4].

Media is the main culprit behind the stereotypes and the stigmatization; besides, it promotes obesity stigma as a socially acceptable norm [4,9]. In media, whether it is in kids' cartoons, movies, or popular TV shows, obese people are portrayed as ugly, less intelligent, lazy, unsuccessful, and lonely [4]. At the same time, individuals who are underweight or of a healthy weight are often portrayed as successful, smart, socially acceptable, and have friends [9,10]. On the other hand, in a study where people with obesity were positively portrayed, there were fewer weight-based stigmatizing perceptions held by the public —reconfirming the crucial impact of media on obesity stigma [9].

The consequences of this weight stigma are enormous [4]. It affects different domains of life in people with obesity. In relationships, it can lead to feelings of exclusion, teasing, bullying, and name-calling. In education, it can be in the form of lower expectations and achievements. In the work environment, it leads to unequal opportunities, wage discrepancies, and exclusion from co-workers; in healthcare, receiving poor-quality care, incorrect diagnoses, and feeling judged.

Moreover, experiencing weight bias can lead to negative feelings, such as depression, shame, and guilt. It also results in poor self-esteem, body dissatisfaction, stress, and anxiety. This in turn leads to either avoidance behavior, disregard of their health, unhealthy weight loss regimes, or substance abuse. Furthermore, it can lead to increased mortality due to not receiving timely age-appropriate screening tests [11].

Health care providers bias:

Counterintuitively, multiple studies have shown that healthcare providers hold both explicit and implicit negative attitudes toward people with obesity [4,6,11]. In a study among 2,449 adult women on the source of obesity stigma and perceived negative attitudes towards people with obesity, 69% were from doctors, 46% were from nurses, 37% were from dietitians, and 21% were from mental health professionals [12]. Physicians have a strong preference for thin people rather than fat people. Moreover, a strong correlation was found between the physician's own BMI and their bias level. If the physician had a non-obese BMI, their bias towards people with obesity was more substantial, compared to physicians with obese BMI, where their bias was of a moderate level [13]. Additionally, in a study among nurses (N=398), those with lower BMI hold higher negative attitudes towards people with obesity [6].

Furthermore, in a study conducted by Ferrante et al. on family physicians and their attitudes and knowledge of obese patients, it was found that the majority of physicians find dealing with obesity frustrating (66%), while 51% find it useless and ineffective. Moreover, while the majority of physicians were aware of weight loss exercise regimens (60%) and diets (57%), only 19% of physicians knew of community resources for severely obese patients or helpful techniques for examining them (24%) [14].

Multiple studies have shown that obesity stigma leads to less patient-centered care for people with obesity. In a study done among primary care providers (PCP), it was shown that PCP believed that obese patients are less likely to be adherent to treatment or self-care recommendations, are lazy, and are weak-willed. Moreover, they reported having less respect for those who are obese compared to those who are not, which was later reflected in their practice, as obese patients had less time allotted for them in the clinic and less patient education as they perceived this as 'wasted time' [6,11,12]. Another study showed the same healthcare attitudes, where people with obesity have less patient-centered communication, thereby resulting in a 19% higher risk of non-adherence [11].

This is a serious concern as it can result in physicians missing a critical diagnosis since they were likely to attribute grave symptoms to obesity rather than looking beyond obesity as a diagnosis. This, in turn, results in delaying the appropriate referral for further diagnostic tests [11].

Not only can the HCPs, but the healthcare setting can be the source of the stigmatization of people with obesity. Examples of Institutional and structural discrimination include discriminatory policies, a non-inclusive culture, denial of care, or inadequate physical accommodation. Multiple studies have shown that most clinics fail to accommodate individuals with obesity, such as missing extra□large blood pressure cuffs, gowns, appropriate scales, and inadequate chairs in the waiting area, thereby making the healthcare setting environment seem unwelcoming for people with obesity [15].

People with obesity perception of bias:
A study was conducted to examine the public's attitudes towards the weight terminology used by healthcare providers. It demonstrated that the terms: "morbidly obese", "fat", and "obese" were perceived as stigmatizing and blaming and were undesirable, while the terms: 'weight' and 'unhealthy weight' were the most desirable terms by the public. Moreover, the terms 'unhealthy weight' and 'overweight' were perceived as non-judgmental terms that were motivating for the public to lose weight [16].

In a study conducted in Australia, among pregnant women coming for their maternal care, it was found that women with higher BMI were more likely to report a negative maternal care experience during pregnancy and after birth compared with women with lower or normal BMI. This is a significant concern, considering that pregnant and postpartum women are a vulnerable population that is at increased risk of depression [17]. In a trial among obese patients who were candidates for either bariatric surgery or medication for weight loss 43% of 105 bariatric candidates and 21.6% of 214 non-surgery candidates reported disrespectful treatment from healthcare providers due to their weight. Nevertheless, 43% of bariatric surgery candidates and 22.5% of non-surgery candidates reported feeling upset due to comments made by doctors about their weight, and 70% of all candidates felt misunderstood and misjudged [6].

A patient who experiences weight stigma has a high-stress level, which thereby increases the level of cortisol, which is also an obesogenic hormone. This, in turn, makes it harder for them to lose weight and negatively affects their health as it increases their risk of heart disease, stroke, and mental health disorders [11].

In terms of healthcare services, people with obesity feel unwelcome, disrespected, and devalued in the clinical setting. People with obesity frequently report feeling ignored and mistreated in healthcare settings. Moreover, people with higher BMI are three times more likely to say that they have been denied appropriate medical care [18]. Moreover, obese women are less likely to go for routine screening tests for cancer [19]. A study among women (N=216) showed that women with obesity are likely to avoid or delay going to preventative health appointments. Their reasons were weight gain since the last appointments, not wanting to be weighed, having to undress and expose their body, and fear of being told that they need to lose weight [6].

The Consequences and Impact of Obesity stigma on health

The consequences of obesity stigma are enormous. It affects people with obesity psychologically, physically, and socioeconomically [4].

Psychological consequences:
Obesity stigma significantly impacts mental health and results in poor mental health outcomes. Many studies have shown that people with obesity who are exposed to obesity stigma are 32% more likely to develop depression compared to those with normal weight [4].

In a systematic review that looked at mental health associated with weight stigma, it was found that weight bias causes depression, anxiety disorder, and eating disorders [4, 20]. In another study, it was found that obesity stigmatization strongly affects body image dissatisfaction, quality of life, dysfunctional eating, and the severity of depression and anxiety [4]. Studies also show that obesity is associated with social isolation, depression, and an increased likelihood of suicidal thoughts and suicidal attempts [12]. It also has a detrimental effect on self-esteem and body image [20]. A large cross-sectional study (N=22,231) looked at weight discrimination and the prevalence of mental health disorders. It was reported that women were significantly more likely to report weight discrimination compared to men. Moreover, those who perceived weight discrimination were 3.2 times more likely to have perceived stress.

Contrary to common belief, having social support did not buffer the adverse effects of weight discrimination. Additionally, 56% of those who perceived weight discrimination and bias met the criteria of at least one Axis-I disorder, which includes mood disorders, anxiety disorders, eating disorders, psychotic disorders, and dissociative disorders. Furthermore, those who have experienced weight stigma were 2.4 times more likely to have three or more mental health disorder diagnoses compared to those who have not [21].

Health consequences:
In a study of 1,064 participants that examined attitudes towards weight stigma, it demonstrated that 19% of the participants would avoid future medical appointments, while 21% would seek a new doctor if they felt stigmatized by their weight [16].

Another consequence of obesity stigma is poor healthcare services utilization, such as screening programs. Due to previous discrimination experienced in such settings,

obese individuals tend to avoid healthcare facility visits [19]. Multiple studies showed mirroring results where people with obesity are less likely to go for colorectal, cervical, or breast cancer screening [6] in a study that looked at the reasons behind low gynecological cancer screening in white and black African Americans. It was found that obese women were more likely to delay getting routine screening services. Moreover, as the BMI increases, the rate of those women getting routine Pap smears is even lower. In the study, only 68% of women with a BMI of 55 kg/m² had a Pap smear done, compared to 86% of women with lower BMI. The main barriers to getting the screening services were being subjected to disrespectful treatment, embarrassment about getting their weight checked, small medical equipment that was nonfunctional, unsolicited advice about weight loss, and a negative attitude of the doctor. This study has excluded financial reasons since more than 90% of women had health insurance [19]. Similarly, another study done among white women (N=6,419) found that women with severe obesity were significantly less likely to go for cervical cancer screening due to embarrassment and discomfort in a healthcare setting [6]. These are concerning findings, as obesity is a risk factor for cancer, and avoiding age-appropriate screening will increase the incidence of cancer, morbidity, and mortality of people living with obesity.

Counter to public misconception, obesity stigma leads to weight gain rather than weight loss [4, 22]. Chronically pressuring individuals to lose weight triggers an increase in their stress hormone (cortisol); thereby resulting in increased obesity-related mortality. A high cortisol level not only makes weight loss difficult but also worsens glycemic control, increases blood pressure, and causes immune dysfunction [4]. Moreover, individuals who felt stigmatized by their weight were less likely to engage in exercise [23]. This is again demonstrated in a study that examined overweight patients (BMI > 25 kg/m²) who had consulted their primary care physician to discuss weight loss. It was demonstrated that those who felt 'judged' about their weight by their physician were less likely to lose weight, despite the multiple attempts, compared to those who did not [20]. Moreover, more studies are showing medication non-adherence because of obesity stigma [4].

Socioeconomic consequences:
Studies show that obesity stigma leads to wage discrimination. In employment, not only does it lead to wage discrepancies, but it also affects promotion opportunities and career progression and increases the risk of being fired [4,6]. Moreover, in high-income countries, such as in the USA, people with obesity are less likely to be hired, while in Korea, overweight women are paid less than normal-weight women. It also appears to impact educational opportunities [4]. In a survey among overweight and obese women (N=2,249), 25% reported experiencing job discrimination due to their weight [6].

Additionally, they reported that the sources of weight stigma were 54% from co-workers and 43% from supervisors and employers [6]. Regarding education, two studies conducted in Sweden and England have shown that individuals with obesity are less likely to attain higher education [6]. Reasons could be the exposure to bullying in the form of prejudice, rejection, and harassment, thereby making the educational institute a less safe environment for people with obesity [4].

Strategies to End Obesity Stigma in Healthcare

Now that multiple studies have established the existence of weight and obesity stigma in healthcare, we should focus on remediation strategies [24,25]. Besides, healthcare providers are frequently identified as the source of weight bias by people with obesity [26]. While some studies have examined strategies to reduce weight stigma through education and inducing empathy, their evidence on efficacy is lacking, as many have only assessed short-term effects [15]. Therefore, more research and studies are needed to understand which interventions and strategies are effective [24].

Some proposed recommendations for clinicians to reduce bias and stigma are:

1) Assess for any personal weight bias, such as Surveys or Questionnaires with experimental manipulations to identify stereotypes, beliefs, and prejudices [24,26].
2) Provide appropriate education about the complexity of obesity as a disease – it is not only a food problem; genetics, environment, and other factors also play a significant role in obesity. Understand the difference between body size and obesity. It is important to change the narrative on obesity, as it is a complex, chronic, and relapsing disease. Moreover, it is essential to raise awareness about obesity stigma, especially among healthcare providers [15, 25, 26].
3) Appropriate communication: use of a person's first language rather than stigmatizing diagnoses, such as referring to an individual as an "obese patient". Instead, use terms like "patient with obesity". Moreover, obtain patient consent to discuss their weight and inquire about their preference for the language used to refer to it, such as "curvy" instead of "large" and "fat" [15,26,27].
4) Provide a welcoming clinic environment: appropriate waiting areas with comfortable, sturdy furniture. Appropriate size doors and restroom facilities. Appropriate and validated medical equipment such as beds, scales, and blood pressure measuring cuff sizes; privacy when weighing the patients and appropriate gown sizes in the exam rooms [15, 26].
5) Seek staff training, as many negative attitudes towards people with obesity could stem from frustration at treatment failure and lack of progress with the patients [26,28].
6) Screen patient for trauma and bullying and assess their mental health status to provide appropriate support [26].
7) Enlist the help of board-certified obesity medicine specialists [26].
8) Involve policymakers and healthcare stakeholders in reframing the obesity policies and strategies [25].

Conclusion

In conclusion, despite the high prevalence of obesity in the population, the prevalence of obesity and weight bias are equally as high. People with obesity face discrimination in their workplace, community and healthcare settings, too. This discrimination results in detrimental consequences, such as significant negative mental health impact, increased morbidity and mortality due to delay and avoidance of preventive health care and at a socioeconomic level, too. Society should take a firm stand towards reducing obesity stigma as it is not only unethical but worsens and increases obesity. Starting with addressing obesity bias in healthcare is appropriate as HCPs should be more understanding of the chronic and relapsing nature of obesity as a disease.

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