

Weight Stigma



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KEYWORDS

• Weight stigma • Weight bias • Obesity • Health care

KEY POINTS

- Weight stigma is pervasive across all levels of society, including health care.
- Individuals who experience weight discrimination are at risk for serious health consequences, both physical and psychological.
- There is a discrepancy between societal perceptions of individuals living with obesity and the extensive research demonstrating that obesity is a chronic disease.
- Health care professionals should adopt a weight-inclusive approach when caring for patients with obesity.

BACKGROUND

Weight stigma, defined as misconceptions and stereotypes associated with higher body weight,¹ is pervasive across all levels of society, including health care. It manifests at the individual and interpersonal levels, influences community and institutional settings, and extends to cultural norms. Stigmatizing an individual based on their body weight is a form of human discrimination, yet it continues to be a widely accepted practice. Those who are a victim to weight stigma are at risk for serious health implications, including physical and psychological.^{1,2} Research shows that victims of weight discrimination compared to their counterparts demonstrate high levels of cortisol, inflammatory markers such as C-reactive protein, cardiometabolic risk, and mortality. The mental health consequences for youth are dire when they undergo weight-based teasing and bullying, as adolescents are more prone to social isolation, anxiety, and depression. Similarly, among adults, victims of weight discrimination are at increased risk for higher anxiety levels, depressive symptoms, social isolation, substance abuse, and disordered eating.^{2–4}

It's a paradox that weight stigma, as a social determinant of health, exacerbates the worsening obesity pandemic, with each reinforcing the other. The persistence of weight stigma not only deepens health disparities but also perpetuates societal misconceptions. However, we may be at a turning point where change is possible.

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With the recent surge in pharmacologic treatments for obesity, particularly following the Food and Drug Administration (FDA)'s approval of semaglutide in 2021 for the indication of obesity, discussions about obesity have become increasingly prominent. This is a pivotal moment in history for reshaping societal perceptions of obesity and potentially changing the prevailing narratives. Understanding the current climate of weight stigma and exploring ways to eradicate it from all levels of society is essential.

DISCUSSION

Terminology

Before diving into the current state of weight stigma, it's crucial to first define the key terms that shape our understanding of this topic. Negative perceptions and social devaluation of individuals with higher body weight is weight stigma. The downstream effects of weight stigma include negative attitudes, stereotypes, and discrimination. When an individual holds negative attitudes toward individuals with obesity, be it overt or subconscious, this is explicit and implicit weight bias, respectively. Weight bias can lead to weight discrimination, where individuals who hold these biases treat people with higher body weight unfairly. Common societal weight-based stereotypes are that individuals living with obesity lack willpower, are lazy, and non-adherent to medical recommendations. Hence, they are perceived to be in control of their weight and personally to blame for living at a higher body weight. For people with obesity who agree with these societal stereotypes and participate in self-blame and shame, this is a form of weight bias internalization.²

Current Controversies

There is a discrepancy between societal perceptions of individuals living with obesity and the extensive research demonstrating that obesity is a chronic, complex disease influenced by both controllable and uncontrollable factors. In the following paragraphs are 3 commonly held misconceptions, followed by evidence that debunks each one.

Misconception #1: obesity is solely a matter of personal volition and is reversible by eating less and moving more

It is a common societal narrative that obesity is within a person's control¹ and due to an individual's choice to overeat and be sedentary. However, this perception is rooted in weight stigmatization. Obesity is multifactorial in origin, with a confluence of uncontrollable and controllable variables. Every patient's story is different. There are numerous contributors to adult obesity, including genetics, social determinants of health, prenatal, perinatal, and postnatal health, trauma, smoking cessation, medication-induced weight gain, inadequate sleep, endocrine disruptor chemicals, the environment, menopause, pregnancy, and that is just to name a few. Similarly, pediatric obesity, which is also a multifactorial medical disease, is influenced by genetic, prenatal, perinatal, and postnatal development, early development, environmental factors, diet quality, inadequate physical activity, social determinants of health, and more.⁵⁻⁷ Weight stigma leads to adverse health consequences through biopsychological distress, which has been found to contribute to obesity as well.¹ Lastly, when considering the rapid rise of the obesity pandemic in the latter half of the twenty-first century, it would be overly simplistic to attribute it solely to poor diet and sedentary behavior. A more comprehensive view is necessary to fully understand the complexity of this issue.²

There are complex, biological underpinnings to obesity. On a cellular level, adipocytes undergo oxidative stress, mitochondrial dysfunction, immune dysfunction, chronic inflammation, and metabolic dysfunction that all contribute to the pathogenesis of obesity. This is where healthy adipocytes become dysfunctional adipocytes,

and excessive energy storage occurs in the form of fat. Although the body's homeostatic mechanisms for maintaining weight within a narrow range around a specific set point are highly effective, when these systems become dysregulated, they can significantly undermine an individual's attempts to lose weight.^{8,9} Thus, reducing caloric intake and increasing energy expenditure alone are often insufficient to overcome the underlying biological forces driving weight gain. And arguments that obesity is merely an energy imbalance ruled by the law of thermodynamics, is wrong, as this hypothesis overlooks adipose as a dynamic tissue.¹⁰

Misconception #2: obesity is not a disease

The American Medical Association (AMA) and numerous other health organization designated obesity a disease over a decade ago.¹¹ The World Health Organization, the US National Institutes of Health, and the US Food and Drug Association have defined obesity as a disease.¹² Assessing if obesity is a disease should be based on objective data that assesses the medical and biologic origins of obesity and it meets the definition of a "disease." To qualify as a disease, 3 criteria must be met according to the AMA: the presence of outward signs or symptoms, the potential to cause morbidity or mortality, and impaired function of a tissue or organ. In 2013, the AMA officially defined obesity as a disease process. Obesity satisfies all 3 criteria, as it involves increased adiposity, is associated with over 200 related medical conditions,¹³ reduces lifespan, and results in impaired function of adipose tissue. It is imperative that obesity is recognized as a disease by all, especially health care systems, policy makers, and payers who influence access to weight management care services.

Some argue that defining obesity as a disease is problematic because it may discourage individuals from adopting healthy lifestyle behaviors.² In contrast, similar challenges are rarely posed regarding the classification of diabetes or hypertension as diseases. This discrepancy suggests that the bias against recognizing obesity as a disease is significant. It's essential for health care professionals, patients, and the broader community to reflect on this bias to address it effectively.

Misconception #3: anti-obesity medications and metabolic and bariatric surgery are the easy way out

Adjunct treatments to lifestyle are sometimes viewed as the easy way out because it is assumed that lifestyle modification is adequate to reverse obesity.¹⁴ Historically, this bias held true for metabolic and bariatric surgery (MBS) that was viewed as a surgery that simply led to mechanical restriction to prevent individuals from overeating. However, surgical interventions like MBS do much more than restriction and research demonstrates that surgery leads to numerous metabolic changes. For example, changes in gastrointestinal hormones, the gut microbiome, insulin sensitivity, gut-nutrient signaling, and more. These complex metabolic alterations ultimately help to overcome the body's compensatory physiologic response to weight loss.^{15,16}

Similarly, early data suggest that recent public interest in glucagon-like peptide-1 (GLP-1) receptor agonists had led to a growing societal stigmatization of individuals taking anti-obesity medications.¹⁷

GLP-1 receptor agonists have been watered down to appear as solely drugs to suppress appetite, with the assumption that individuals living with obesity cannot control their appetite without the adjunct of a medication. However, these medications operate through a plethora of biological actions involving the gut-brain axis. GLP-1 receptor agonists not only reduce appetite but also stimulate insulin secretion, effect brain regions associated with reward and feeding behavior, slow gut transit, and offer cardioprotective effects through direct and indirect physiologic effects on

the cardiovascular system.¹⁸ The health promoting effects of GLP-1 receptor agonists are the important part to focus on and can help to shift the focus on what is means to lose weight with adjunct pharmacotherapy.

Individuals who experience discrimination in the form of weight bias are at risk for serious health consequences, both physical and psychological.

COMPASSIONATE AND BIAS-FREE APPROACH TO PATIENT CARE FOR OBESITY

Broaching the Topic of Obesity and Weight Management

It is the responsibility of health care professionals (HCPs) to provide bias-free, patient-centered care to each and every patient, no matter their race, ethnicity, religion, body shape and size, etc. When it comes to discussing obesity with patients, there is no universally established methodology to introducing the topic of weight.¹⁹ Still, recommended strategies do exist. Evidence indicates that individuals with obesity who experience weight bias and stigma have increased morbidity and mortality, regardless of their weight or BMI.⁴ Therefore it is helpful to use a framework when broaching the topic of weight with patients with the goal of generating a mutually respectful conversation.

Providers are encouraged to ask patients for permission to discuss their weight, as it is not assumed that all patients with obesity are ready to have such discussions. Notably, asking permission to have a discussion is designated as the first “A” in the counseling framework, the 5 A’s, that has been adapted for obesity treatment. The 5 A’s framework was originally created to help guide providers on how to broach the topic of smoking cessation with patients.¹⁹ Various organizations have created concise communication strategy aids that are excellent references. For example, the Strategies to Overcome and Prevent Obesity Alliance developed a toolkit, “Why Weight? A Guide to Discussing Obesity & Health With Your Patients,” that is a recommended resource to consider.²⁰ Also, Obesity Canada developed a roadmap for managing obesity in primary care that uses the 5 A’s framework.²¹

Gauging a patient’s readiness to discuss and consider weight management treatment options is a fundamental aspect of history taking for a patient with obesity. It is important for providers to recognize that not all patients living with obesity are prepared to initiate obesity management. The Transtheoretical, or Stages of Change Model, explains that patients fall into 1 of 5 stages of change at any point in time: pre-contemplation, contemplation, preparation, action maintenance, and relapse.²² Assessing the patient’s stage can better customize the intensity of the interventions agreed upon for the management plan through a patient-centered plan.

Use Person-First Language

As with any chronic condition, using person-first language is crucial when discussing obesity with patients. The words HCPs choose sets the stage for a respectful conversation, especially important when addressing a sensitive topic like weight.^{23,24} To avoid stigma, opt for non-labeling language such as “patient with obesity” instead of “obese patient” or “patient affected by obesity” instead of “patient is obese.” HCPs can access excellent, free resources through the Obesity Action Coalition to support these conversations.²⁵

Respect Individual Language Preferences

Language sets the stage for a mutually respectful conversation between a patient and HCP. A 2020 systematic review²⁶ systematic review of 33 studies (23 quantitative, 10 qualitative) published from 1999 to 2019 that evaluated participants’ preferences for

weight-related terminology examined people's preferences for weight-related terminology. Findings suggested that neutral terminology such as "weight" or "unhealthy weight" is preferred and less preferred are terms such as "obese" and "fat." Also, the study found that language preferences varied by the participants' gender, race/ethnicity, and weight status. This underscores the significance of providing personalized care for each patient and remembering to make the distinction between the person and the disease when communicating to patients.²⁶

Body mass index is a screening tool and not a diagnosis

If HCPs continue equate weight and body size with health, it perpetuates weight stigma.¹ Body mass index (BMI) has inherent limitations as it does not directly assess body adiposity. While BMI serves as a screening tool, especially at the population level, it is not a definitive diagnosis. In discussions about a patient's health in relation to obesity, incorporating other data points is critical as this provides a more evidence-based and comprehensive understanding of the importance of addressing obesity, rather than depending solely on BMI. A recent 2023 AMA policy statement recommended HCPs use BMI in conjunction with other valid measures of risk, for example, measurement of body composition and metabolic outcomes.^{27,28}

Promote overall health

Due to the societal norms of a weight-obsessed culture, many patients often come to us with a specific target weight in mind, whether in pounds or kilograms. Helping an individual address and treat obesity is not with the sole intention of changing the number on the scale. The discussion should be broadened beyond weight, acknowledge social determinants of health, and empower individuals to make choices that support their health outcomes, functionality, and quality of life.²⁹ When the topic of weight is something that a patient is particularly focused on, it is important to shift the conversation to overall health promotion and discuss other data points that are reflective of the individual's health status, such as cardiometabolic parameters.

Deliver weight-inclusive care

A weight-inclusive approach promotes overall health and well-being while providing non-stigmatizing care to patients. There is an emphasis on respect for body diversity, with advocacy for body size acceptance and body positivity. In clinical practice, emphasizing patients that the ultimate goal we are striving for is improved health and not a particular number on the scale or particular body type.

This approach supports equal treatment and access to health care for all individuals. At its core, the weight inclusive paradigm is a holistic, nonbiased approach to all patients, regardless of body size. It is recommended to use a patient-centered treatment plan with patients that is comprehensive, multipronged, and considers all tools available in the toolbox indicated for that individual. At the same time, it will be important not to swing into healthism, whereby those who are not healthy or those who do not pursue health are stigmatized as being less-than. Preserving dignity means accepting patient autonomy and choices.³⁰

SUMMARY

Weight stigma is widespread across all levels of society, including health care. Misconceptions persist that obesity is solely a personal choice, easily resolved through lifestyle changes, and that using adjunct therapies is an "easy way out." However, research shows that obesity is a chronic disease with a complex pathophysiology requiring a multidisciplinary, multifaceted approach to treatment. Therefore, health

care professionals should adopt a weight-inclusive approach when caring for patients with obesity.

CLINICS CARE POINTS

- HCPs are encouraged to ask patients for permission to discuss obesity with their patient and to be mindful of the importance of language, ensuring person-first language.
- A weight-inclusive approach fosters overall health and well-being while delivering care that is free from stigma and it is a standard HCPs should aim to uphold in their practice.
- It is essential for HCPs to engage in empathetic, respectful conversations with patients about obesity and its treatments, ensuring these discussions are free from judgment and bias.

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DECLARATION OF AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

During the preparation of this work, the author used Generative AI. After using this tool/service, the author reviewed and edited the content as needed and takes full responsibility for the content of the publication.

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REFERENCES

1. Nutter S, Eggerichs LA, Nagpal TS, et al. Changing the global obesity narrative to recognize and reduce weight stigma: a position statement from the World Obesity Federation. *Obes Rev* 2024;25(1):e13642.
2. Rubino F, Puhl RM, Cummings DE, et al. Joint international consensus statement for ending stigma of obesity. *Nat Med* 2020;26(4):485–97.
3. Tomiyama AJ, Carr D, Granberg EM, et al. How and why weight stigma drives the obesity 'epidemic' and harms health. *BMC Med* 2018;16(1):123.
4. Sutin AR, Stephan Y, Terracciano A. Weight discrimination and risk of mortality. *Psychol Sci* 2015;26(11):1803–11.
5. Hampf SE, Hassink SG, Skinner AC, et al. Clinical practice guideline for the evaluation and treatment of children and adolescents with obesity. *Pediatrics* 2023; 151(2). <https://doi.org/10.1542/peds.2022-060640>.
6. Fitch A, Fox C, Bauerly K, et al. Prevention and management of obesity for children and adolescents. 2013. p. 94. Available at: <https://jesse.tg/ngc-archive/summary/10019> (Accessed August 2024).
7. Kumar S, Kelly AS. Review of childhood obesity: from epidemiology, etiology, and comorbidities to clinical assessment and treatment. *Mayo Clin Proc* 2017;92(2): 251–65.

8. Corrêa LH, Heyn GS, Magalhaes KG. The impact of the adipose organ plasticity on inflammation and cancer progression. *Cells* 2019;8(7). <https://doi.org/10.3390/cells8070662>.
9. Harvey I, Boudreau A, Stephens JM. Adipose tissue in health and disease. *Open Biol* 2020;10(12):200291.
10. Torres-Carot V, Suárez-González A, Lobato-Foulques C. The energy balance hypothesis of obesity: do the laws of thermodynamics explain excessive adiposity? *Eur J Clin Nutr* 2022;76(10):1374–9.
11. American Medical Association House of Delegates. *Recognition of obesity as a disease*. 2013. Resolution 2013;420(A-13).
12. Bray GA, Kim KK, Wilding JPH. Obesity: a chronic relapsing progressive disease process. A position statement of the World Obesity Federation. *Obes Rev* 2017;18(7):715–23.
13. Centers for Disease Control and Prevention. How overweight and obesity impacts Your health. 2024. Available at: <https://www.cdc.gov/obesity/adult/causes.html>. Accessed September 28, 2024.
14. Garcia FK, Mulder BC, Hazebroek EJ, et al. Bariatric surgery stigma from the perspective of patients: a scoping review. *J Adv Nurs* 2024;80(6):2252–72.
15. Cummings DE, Rubino F. Metabolic surgery for the treatment of type 2 diabetes in obese individuals. *Diabetologia* 2018;61(2):257–64.
16. Batterham RL, Cummings DE. Mechanisms of diabetes improvement following bariatric/metabolic surgery. *Diabetes Care* 2016;39(6):893–901.
17. Post SM, Persky S. The effect of GLP-1 receptor agonist use on negative evaluations of women with higher and lower body weight. *Int J Obes (Lond)* 2024;48(7):1019–26.
18. Li Y, Yao W, Wang T, et al. Association of semaglutide treatment with coronary artery inflammation in type 2 diabetes mellitus patients: a retrospective study based on pericoronary adipose tissue attenuation. *Cardiovasc Diabetol* 2024;23(1):348.
19. Kushner R, Velazquez A. Classification and evaluation of the patient with obesity. In: Bray GA, Bouchard C, editors. *Handbook of obesity two volume set*. 5th edition; 2023. chap 6.
20. Obesity Alliance. Weight can't wait. Guide for management of obesity in the primary care setting. . STOP strategies to overcome and prevent.
21. Wharton S, Lau DCW, Vallis M, et al. Obesity in adults: a clinical practice guideline. *CMAJ* 2020;192(31):E875–91.
22. Prochaska JO, Velicer WF. The transtheoretical model of health behavior change. *Am J Health Promot* 1997;12(1):38–48.
23. Puhl R, Peterson JL, Luedicke J. Motivating or stigmatizing? Public perceptions of weight-related language used by health providers. *Int J Obes (Lond)* 2013;37(4):612–9.
24. National Institutes of Health. The practical guide: identification, evaluation, and treatment of overweight and obesity in adults. NIH Publication; 2000. Number 00-4084.
25. Obesity action coalition. OAC resources. Available at: <https://www.obesityaction.org/education-support/resources/>. Accessed October 12, 2024.
26. Puhl RM. What words should we use to talk about weight? A systematic review of quantitative and qualitative studies examining preferences for weight-related terminology. *Obes Rev* 2020;21(6):e13008.
27. Berg S. Use of BMI alone is an imperfect clinical measure. American Medical Association; 2023. Available at: [Descargado para Daniela Zúñiga Agüero \(danyzuag@gmail.com\) en National Library of Health and Social Security of ClinicalKey.es por Elsevier en marzo 13, 2025. Para uso personal exclusivamente. No se permiten otros usos sin autorización. Copyright ©2025. Elsevier Inc. Todos los derechos reservados.](https://www.ama-assn.org/delivering-care/public-

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- [health/ama-use-bmi-alone-imperfect-clinical-measure](#). Accessed September 29, 2024.
28. American Medical Association. New recommendations on BMI and weight assessment. *JAMA* 2023;329(11):1115–6. <https://doi.org/10.1001/jama.2023.10443>.
 29. Mauldin K, May M, Clifford D. The consequences of a weight-centric approach to healthcare: a case for a paradigm shift in how clinicians address body weight. *Nutr Clin Pract* 2022;37(6):1291–306. <https://doi.org/10.1002/ncp.10885>.
 30. Velazquez A. Promoting a weight-inclusive approach to treat obesity. *Medscape* 2024.