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# Weight Discrimination: Why Current Perceptions Need to Change

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# WEIGHT DISCRIMINATION: WHY CURRENT PERCEPTIONS NEED TO CHANGE

by

**Kelsey Rae Eller** 

Thesis submitted in partial fulfillment of the requirements for the degree

of

HONORS IN UNIVERSITY STUDIES WITH DEPARTMENTAL HONORS

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Dietetics in the Department of Nutrition, Dietetics, and Food Sciences

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#### **Abstract:**

Discrimination based on weight has been labeled the last form of socially acceptable prejudice. Weight discrimination is becoming more and more prevalent in schools, the workplace, social settings, the media, and even in healthcare. Overweight and obese individuals are often stereotyped as lazy, addicted to food, and lacking self-discipline and initiative, and as a result may struggle with decreased employment opportunities, fear and shame in public, attempting dangerous weight loss methods, or even eating disorders.

This project seeks to identify and examine research that has been done on this subject in order to increase awareness of weight bias and to help prevent it in the future by promoting the fact that thin does not necessarily equal a healthy lifestyle, being large does not necessarily equal an unhealthy lifestyle, and that there are a variety of body shapes and sizes that can be perfectly healthy.

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#### **Introduction:**

Weight discrimination, also known as weight prejudice or weight bias, refers to the unfair treatment of overweight or obese individuals based on preconceived opinion or without sufficient knowledge of facts (1). Discrimination based on weight has been labeled the last form of socially acceptable prejudice (2). The overweight and obese are often stereotyped as lazy, addicted to food, and lacking self-discipline and initiative, and as a result may struggle with decreased employment opportunities, fear and shame in public, attempting dangerous weight loss methods, or even eating disorders.

On the other hand, the rising incidence of obesity in America has also been labeled an epidemic, something that is currently viewed by some as synonymous with slow suicide. Obesity has been linked with mortality and many chronic ailments, including diabetes, heart disease, hypertension, hyperlipidemia, and some cancers (3). However, those who fight against weight prejudice and advocate for size acceptance believe that overemphasizing those health risks is a mistake that leads to increased social discrimination and size harassment (4).

So where is the balance? In a society that passionately rejects any form of discrimination, what makes weight so different? How can we eliminate weight discrimination and fight obesity as a condition at the same time? One possible solution would be to view obesity from a different perspective. Rather than focusing on weight loss alone, instead focus on achieving the best weight possible in the context of overall health. After all, health is defined as the condition of being sound not only in body, but also in mind and spirit (5).

If we are truly seeking health and wellness as a society, then we must first rid ourselves of prejudice. It has been said that, "The discovery of truth is prevented more effectively, not by the false appearance things present and which mislead into error, not directly by weakness of the

reasoning powers, but by preconceived opinion, by prejudice (2)." When weight prejudice is forgotten, then we will realize the truth that weight is only one part of health, and that healthy individuals come in all shapes and sizes.

The goal of this paper is to present research that has been completed on the subject of weight bias in order to increase awareness of weight bias and to help prevent it in the future by promoting the fact that thin does not necessarily equal a healthy lifestyle, being large does not necessarily equal an unhealthy lifestyle, and that there are a variety of body shapes and sizes that can be healthy.

# Why is the study of weight discrimination important?

The research on weight prejudice is limited and has not been able to affect social or public policy to any great extent. Without public policy prohibiting discrimination based on weight, and with it being a largely socially acceptable practice to look down upon the overweight and obese, little is being done to reverse weight bias in our society.

Weight discrimination is a very real issue, with a very real impact on human lives. But often the consequences of weight discrimination are not fully understood unless put into context. Perhaps nothing can illustrate this point better and help explain exactly why research into weight discrimination is an essential and important issue than a true account:

"Gina Score, a 14-year-old girl in South Dakota, was sent in the summer of 1999 to a state juvenile detention camp. Gina was characterized as sensitive and intelligent, wrote poetry, and was planning to skip a grade when she returned to school. She was sent to the facility for petty theft--stealing money from her parents and from lockers at school "to buy food." She was said to have stolen "a few dollars here, a few dollars there," and paid most of the money back. The camp, run by a former Marine and modeled on the military, aimed, in the words of an instruction manual, to "overwhelm them with fear and anxiety." On July 21, a hot humid day, Gina was forced to begin a 2.7 mile run/walk. Gina was 5'4" tall, weighed 224 lbs., and was unable to complete even simple physical exercises such as leg lifts. She fell behind early but was prodded and cajoled by instructors.

A short time later, she collapsed, lay on the ground panting, with pale skin and purple lips. She was babbling incoherently and frothing from the mouth, with her eyes rolled back in her head. The drill instructors sat nearby drinking sodas, laughing and chatting, accusing Gina of faking, within 100 feet of an airconditioned building. After 4 hours with Gina lying prostrate in the sun, a doctor came by and summoned an ambulance immediately. Gina's organs had failed and she died" (2).

Stories like this are why we need to become more aware of the prejudice among us and make the necessary social and political changes in our society so that stories like this will not be overlooked or allowed to be repeated.

# The Many Definitions of Weight:

The most common definitions that exist for overweight and obesity are determined by Body Mass Index (BMI). BMI is a mathematical formula that correlates with body composition and is expressed as weight in kilograms divided by height in meters squared (BMI = kg/m2) (3). A BMI of 18.5 to 24.9 is considered to be the *normal* or *healthy* weight range, while a BMI under 18.5 indicates underweight. The term *overweight* is defined as having a BMI score between 25 and 29.9, and the term *obese* is defined as having a BMI greater than 30.

The BMI system works well for comparisons between large groups and overall assessment of health risk because on average, those with higher BMI scores tend to have higher levels of body fat, which is associated with increased health risks. However, the BMI system does not work well for individuals because it is unable to discriminate between excess body fat and lean muscle mass, and therefore might not adequately reflect total adiposity (6). Without this distinction available, it is safe to assume that within each weight group total body fat percentages may vary greatly. Unfortunately, body fat is not easy to measure accurately, so the assumption remains that higher weight equals higher percentage of body fat, which in turn equals higher health risk (4). But because research has shown that it is excess body fat and the location of fat

that determines risk for health problems, we can conclude that the definitions of overweight and obesity that are based upon the BMI system may not accurately reflect the risk for health problems (7). The conclusion that simply the classification of "overweight" or "obese" by the BMI scale is equal to an unhealthy lifestyle, an addiction to food, and many other assumptions that come along with it that is contributing to weight prejudice.

From a non-discriminatory standpoint, healthy weight should be individually defined. It should be defined as the natural weight that the body adopts, given a healthy diet and meaningful levels of physical activity. For some this weight will be higher, and for others it will be lower. This point of view rejects the idea that a healthy weight can be defined in a BMI system with rigid cut-off points, a system that disregards the health of athletes, the stage of physical maturity in children, family history, genetics, percent body fat, and even current evidence that shows some types of obesity are not associated with health risk. In fact, many children and adults who are classified as overweight according to their BMI are in good health (4). Weight management and health in general should go well beyond the number on the scale (8).

#### Myths:

In order to understand weight discrimination better, a better understanding of the myths that it is based on is essential. There are many myths that exist about weight, and especially weight loss in American society today. They exist mainly because of the 50 billion dollar weight loss industry that has been spawned due to the increase in obesity in recent years (9).

One of the most widely believed myths about weight is that short term dieting is able to provide long term weight loss. *Learn the secret to losing 18 pounds in 4 days!* Sound familiar? There is certainly not a shortage of diets out there that tell you that it is possible to lose huge amounts of weight in an extremely short amount of time, and the truth is many of them do result

in weight loss. However, the common complaint with dieting is that there is no lasting significant weight loss, and individuals often end up regaining most, if not all of the weight they had lost (10).

In reality, research has raised serious doubts about the benefits of dieting, and has actually shown that repeated dieting may result in a higher set point for body weight, meaning that the body adjusts to this modern type of famine by storing more fat than it did before your diet (4,11). In the end, maintaining long term weight loss requires a fundamental lifestyle change that goes beyond energy-restricted diets and increased physical activity in the short term, a change that could have been implemented without the use, or cost for that matter, of diet books, pills, or programs.

The tragedy is that when these short term diets fail to produce long term weight loss, individuals, especially the overweight/obese, may blame themselves instead of blaming their diet. This is not where the blame is due! It is a stereotype that the overweight/obese do not have enough willpower to stay on a diet and lose weight (2). Dieting itself is the problem, not the individuals who have been convinced that it could work for them.

Another widely believed myth that contributes to weight discrimination is that long term weight loss is a simple process. In reality, there are multiple biological mechanisms that make weight loss extremely difficult (2), not to mention that making a fundamental lifestyle change is also very difficult.

Just the fact that not one theory has been able to explain every manifestation of obesity or apply consistently to all individuals demonstrates the extreme complexity of the situation (3). But despite the considerable evidence that shows our own biology makes weight loss extremely difficult, overweight people are still held accountable for their weight (2). They are not given

enough credit, or compassion for that matter, for how easy our society has made it to gain weight, and for how difficult nature has made it to lose weight.

Also, with all of the emphasis that is being placed on weight loss we ignore the fact that every single human body is different, and are designed to be that way. Some are designed to be small and others are designed to be larger. Indeed, depending on the type and severity of the existing obesity and the age and lifestyle of the individual, successfully reducing body weight varies from being a relatively simple matter to being virtually impossible (3).

The human body is amazingly able to maintain a consistent temperature even when the weather is extremely cold or when excess heat is generated through exercise. It can also maintain consistent sodium concentrations in the blood despite dehydration, salty diets, and perspiration. Body weight and body fat seem to be programmed and defended at a particular level for each individual (4).

A third myth that is contributing to weight discrimination is that thinness is equal to a healthy lifestyle and being large is equal to living an unhealthy lifestyle. This myth is based on the research that has associated overweight and obesity with increased health risks, and in particular the risk for cardiovascular disease. While it is true that obesity is associated with increased health risks, not all people who are thin are devoid of these risks, and not all obese individuals share these risks.

In fact, a cross sectional study of 5440 participants of the National Health and Nutrition Examination Surveys (NHANES) from 1999-2004, published in the Arch Internal Medicine in 2008 found that "there is a high prevalence of clustering of cardiometabolic abnormalities among normal-weight individuals and a high prevalence of overweight and obese individuals who are metabolically healthy." This study measured six metabolic cardiovascular risk factors, elevated

blood pressure, elevated triglycerides, elevated glucose levels, insulin resistance, systemic inflammation using C-reactive protein, and decreased HDL cholesterol, with <2 of these factors considered metabolically healthy, and >2 considered metabolically abnormal. Their findings included that among the US population >20 years of age, 17.9% (~35.9 million adults) were overweight yet metabolically healthy, 9.7% (~19.5 million adults) were obese yet metabolically healthy, and 8.1% (~16.3 million adults) were normal weight but metabolically abnormal. And as a group, 51.3% of overweight individuals were metabolically healthy, 31.7% of obese individuals were metabolically healthy, and 23.5% of normal weight individuals were metabolically abnormal (12).

Over *half* of the overweight population and nearly *one third* of the obese population in the US were metabolically healthy! In contrast, *one fifth* of individuals considered normal weight had more metabolic risk factors for cardiovascular disease than their overweight or obese counterparts.

Another study published in The Journal of Clinical Endocrinology and Metabolism in 2004 also examined overall research that has been conducted on metabolic risk factors for cardiovascular disease in normal weight and overweight/obese individuals. It also found that there are subtypes of the obese and normal weight population that are both metabolically healthy and unhealthy. Specifically, metabolically healthy but obese individuals "have large quantities of fat mass, but demonstrate remarkably normal to high levels of insulin sensitivity and rather favorable cardiovascular risk profiles" while metabolically obese but normal weight individuals "have normal weight and body mass index, but display a cluster of obesity-related abnormalities." One conclusion presented was that weight loss attempts in the metabolically healthy but obese individuals could actually be counterproductive and potentially harmful, and

the need for treatment at all in these individuals was questioned (13). In fact, in another study that involved a six month calorie restriction where at-risk obese and metabolically healthy obese people achieved similar weight loss, insulin sensitivity improved by 26% in at-risk individuals, but actually deteriorated by 13% in the metabolically healthy but obese individuals (14).

Each of these studies challenges the idea that thin people are healthier than large people. What we learn is that assumptions about health cannot be made from physical appearance, and the goal of achieving an "ideal" body weight for all overweight and obese individuals is not always desirable or even realistic, and under many circumstances weight loss may not be appropriate at all (3).

# **Stereotypes:**

Many stereotypes exist involving overweight and obese individuals, including being lazy, mean, greedy, dishonest, stupid, and lacking self discipline and initiative. Even overweight people themselves dislike others who are overweight. These stereotypes are widespread in our society. Even in a study of medical students, obesity was even linked with multiple derogatory adjectives such as worthless, unpleasant, bad, ugly, awkward, unsuccessful, and lacking self-control (2).

Overweight people are also often stereotyped as addicted to food and that their weight is simply due to over-consumption. It is important that we not assume a food addiction simply based on body size, especially because other multiple factors that make obesity such a complex condition are often overlooked. Over-consumption may only be a small part of the problem, especially when factors such as sedentary living, stress, disruption of normal eating, chronic dieting, babies semi-starved in the womb by dieting moms, excess weight gain in pregnancy, bigger babies, multiple pregnancies for teenage moms, smoking cessation, and medications are

considered. All of these factors, not to mention the pressure that our culture places on thin as the ideal, has an effect on our metabolism, hunger and satiety, and how the calories we do eat are used and stored as fat (4).

Perhaps the most widely held stereotype is that of controllability. Unlike those who are blind or paralyzed or dark-skinned, the obese are assumed to hold their fate in their own hands, and they are held responsible for their weight and any of the negative outcomes that come with it. Despite the evidence that shows weight loss is an extremely difficult process, we tend to believe that if they were only a little less lazy, or if they just had greater self-control, or if they just had a little more initiative, then they would restrict their excessive food intake and resort to exercise and lose the weight. "While blindness is considered a misfortune, obesity is branded as a defect (2)."

Forms of discrimination include staring, pointing, laughing, teasing, harassment, avoidance of eye contact, even examining a larger individual's grocery cart for "unhealthy" foods, among many others. Possibly the most distressing part of weight based stereotypes is the treatment that larger people endure on a regular basis, which is thought to be warranted and even deserved. Somehow belittlement and harassment of individuals has become acceptable if it is in the name of weight loss.

One form that is perhaps not given as much thought but still damaging are the labels that are given to people of larger size. Terms such as "obese" and "morbidly obese" themselves can be seriously damaging, especially when involving children. Pediatric experts advise against this labeling, saying that labeling children as obese or morbidly obese can result in fear, shame, humiliation, disturbed eating, and increased size harassment (4). So instead of using terms such as 'fatness', 'excess fat', or 'obesity', acceptable terms such as 'weight' or 'excess weight' could

be used (2) to avoid further stigma.

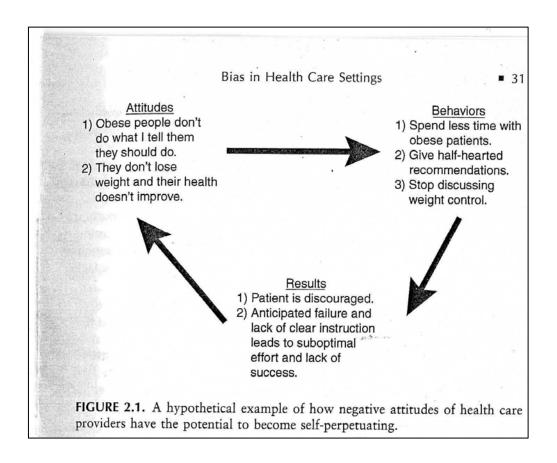
Due to the many forms that weight discrimination can take, our society has created an environment of stigma where larger people are humiliated because of their size. Even when larger people sincerely seek a healthy lifestyle by exercising at a gym or outdoors, it isn't easy for them because public places are often very unfriendly and sometimes even hostile environments (2). So perhaps our focus should be to create an environment where seeking and maintaining a healthy lifestyle is embraced and encouraged no matter what our sizes might be.

# Where do these stereotypes exist?

Stereotypical beliefs about overweight individuals exist almost everywhere, from the schoolyard to the workplace, from social settings to healthcare settings and especially in the media.

Bias against larger patients exists in health care. Some healthcare providers may believe that larger patients may deserve more experimental treatment than others and some may believe that high-risk methods of weight loss are justified due to increased health risks, even if the weight loss is only temporary (4). One study of nutrition professionals found that 70% believed that obesity was caused by emotional problems, which may lead them to the conclusion that their patients need psychotherapy rather than nutritional counseling (2). However, some research has shown that obese patients report less discrimination in health care settings than would be expected based on some literature. Figure 2.1 on the next page is found in the book <u>Weight Bias:</u>

Nature, Consequences, and Remedies, and explains weight discrimination in health care settings, and how the process can actually become a cycle (2).



Weight bias has also been shown to exist in students studying to become healthcare professionals. In a study published in the March 2009 Journal of the American Dietetic Association, students studying dietetics were more likely to report that obesity resulted from noncompliance to healthcare advice, poor goal setting, emotional issues, and low likelihood of adherence to diet/exercise recommendations. The study concluded that sometimes the default for students is to blame a large individual for their weight, but students need to recognize the major environmental factors that contribute to obesity and be unbiased when treating patients (15).

As mentioned earlier, weight discrimination has been labeled the last form of socially acceptable prejudice. A good portion of why this is true may be due to the value that our society places on thinness as the ideal, and how this ideal is portrayed by the media. Research has supported this hypothesis, suggesting that weight-based stereotypes are transmitted via the

idealization of being thin (2). Some could even argue that this ideal is so powerful that obesity is now sometimes considered to be a moral issue, where being obese is wrong and conforming to the ideal standards of behavior (i.e. thinness) is right.

Thinness in and of itself isn't a bad goal. However, the thin ideal has become a problem for our society not only in terms of weight discrimination, but also because of how that ideal has changed how we now look at weight and what is considered to be a normal weight for individuals. The average American woman is 5'4" tall and weighs 140 pounds, while the average American model is 5'11" tall and weighs 117 pounds. Most fashion models are thinner than 98% of American women (16). This is probably why women are currently more prone to try losing weight no matter what their body weight is, and are more likely to consider a normal weight as being overweight (11).

The powerful messages that can be found in books, magazines, music, television shows, internet sites, and films promoting the thin ideal can become internalized and damaging to self-esteem, especially in larger individuals and adolescents, and can result in a lifelong negative self-image (4). In fact, it has been shown that adolescent girls receive their main sources of information for women's health issues from the media (17), and according to the National Eating Disorders Association, the media contributes to the prevalence of eating disorders that occur among ten million females and one million males in America today, and the fact that 80% of women are dissatisfied with their appearance. This thin ideal affects both females and males alike. Male stars, especially athletes, nearly always appear thin, muscular and fit, while the media presents far more thin women than otherwise (2).

With the average adolescent watching 3-4 hours of television per day (18), the average US resident exposed to approximately 5,000 advertising messages a day, (19), and one out of

every 3.8 commercials sending some form of message telling viewers what is or is not attractive, it is safe to say that we are affected by the messages the media is sending out (18, 20).

There are many examples of weight-based stereotypes in the media. One study showed that stigma in television, when defined as the devaluing of an individual due to excess body weight, was often verbal, directed toward another person, and often presented in the presence of the overweight individual. The study also noted that male characters are three times more likely to engage in fat stigmatization and fat humor than female characters (21).

Another example comes from the book *Harry Potter and the Sorcerer's Stone*, Harry (the hero) has a cousin Dudley who is portrayed as a mean, selfish, fat boy. Later in the book, Hagrid (a magical giant who befriends Harry) tries to turn Dudley into a pig, but all that happens is a curly pig's tail sprouts out of Dudley's trousers. Hagrid says, "meant to turn him into a pig, but...he was so much like a pig anyway there wasn't much left to do" (22).

Another example of an overweight character that is portrayed as greedy and selfish is from the popular 1971 film *Willy Wonka and the Chocolate Factory* (23). When the character of Augustus Gloop, who is the only overweight child to visit the chocolate factory, is first introduced, he is eating at a restaurant. While being interviewed by a reporter at the restaurant, instead of answering the questions he bites the top off of the reporter's microphone and continues eating. Later in the movie, this character is the first to vanish from the factory because he falls into the chocolate river while eating from it.

Weight discrimination also occurs in our government. There is a disconnect in what guidelines they have implemented in regards to overweight and obesity. On one hand, there is an attempt to limit fat people's use of disability remedies and on the other hand they engage in campaigns via the Surgeon General that label fat people as diseased, a dangerous drain on our

economy, and a major threat to the nation's health. The overweight and obese are treated as damaged in the doctor's office and by health insurance companies, but are treated as able-bodied in the courtroom (2).

### Why do these stereotypes need to change?

In our struggle to find the "answer" to obesity, we have developed a fat phobia. As a society, we are so afraid of fat that we reject almost everything that has anything to do with fat, both in the diet and on the body. Our fear is so intense that fat phobia may even be considered the stem of all weight-based stereotypes and even one of the main causes of weight discrimination today. This fear is not only affecting society through weight discrimination, but it is also wreaking havoc on our bodies, our eating patterns, our stress levels, our professional lives, our relationships, and especially our children.

Many examples of fat phobia appear throughout society. Health professionals sometimes use the term fear-of-obesity-syndrome to describe children who are stunted and underfed because their parents are so afraid they will get fat that they keep them half-starved. Fat phobia is also causing children to grow up with skewed attitudes toward food, leading to food restrictions and chaotic eating and even contributing to the development of eating disorders. Research also suggests that fear of fat, instead of preventing weight gain, has actually escalated the rates of obesity through increases in dieting, dysfunctional eating and weight cycling (4). Walter Willett, a renowned researcher from the Harvard School of Public Health, has even said that "diets high in fat are not the primary cause of the high prevalence of excess body fat in our society, nor are reductions in dietary fat a solution" (24).

The prejudice and the fear that society currently holds against weight needs to change.

Reliance on this prejudice, especially the stereotype of personal responsibility for weight, has not

only contributed to weight discrimination but also hindered the implementation of public health strategies for obesity intervention and prevention (2). It has also been the cause of many adverse social, emotional, physical, and even political consequences.

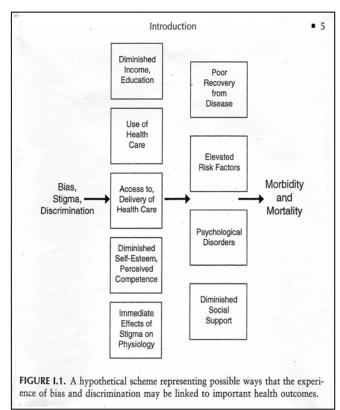
# **Consequences of Weight Discrimination:**

Due to the bias against them, overweight individuals often struggle with discrimination in education, employment, health care, and social relationships (4). Educational and employment opportunities are reduced, interactions with healthcare providers become difficult, and even complete strangers provide cruel and judgmental comments in social situations like grocery shopping (2). Other consequences include impaired health, hunger and food insecurity, dysfunctional eating and eating disorders, dangerous weight loss methods, and emotional and psychological damage, not to mention the effect prejudice has on children. These consequences are important to consider because they represent the very real impact that weight discrimination

has on individual lives.

#### Health

An interesting point that can almost be considered ironic is that weight bias can affect the health of the stigmatized individual. So when discrimination is used as a form of incentive for the overweight or obese person to lose weight, it has actually been proposed to be detrimental to weight and health. Figure 1.1 demonstrates how this link may occur (2).



#### Decreased Employment Opportunities

There have been many studies that show discrimination in employment, both in the prevention of employment itself and in the ability to progress within a company while employed, and demonstrate how that bias may affect income and poverty level regardless of intelligence. For example, one study of teenage girls in the United Kingdom showed that women who were in the top 10% of the BMI range at 16 years old earned 7.4% less income than their non-overweight counterparts seven years later, regardless of whether the women were still overweight or not (2). In another study of over 2000 men and women, wage growth was found to be 6% lower for heavier employees in a three year period of time when compared to their normal weight coworkers (25).

Many more studies of weight bias in employment include findings that heavier workers are on average paid \$1.25 less an hour, and that in a 40-year career they will earn up to \$100,000 less than normal weight individuals (26). Hiring staffs were also more likely to choose thinner applicants than overweight applicants with equal qualifications because of unfounded assumptions such as difficult to work with, less productive, and less determined even if they had never met with the applicants in person (27, 28). Findings of weight bias in employment are especially surprising in women. Slightly heavy women have been shown to make 6% less wages, while very heavy women make 24% less wages (29). Women between the ages of 18 and 25 earn 12% less wages and are more likely overall to have lower paying jobs (30).

Women are not only more likely to suffer in employment opportunities, but they have also been shown to complete fewer years of schooling, are less likely to be married, have lower household incomes and higher rates of poverty "regardless of their baseline socioeconomic status and aptitude-test scores" (2).

## Hunger

Another example of a possible consequence of weight bias is food insecurity. It has been shown that there is an association between food insecurity and obesity. But does this mean that food insecurity causes obesity or that obesity causes food insecurity. In American society it is more popular to believe that men and women become fat because they do not have access to nutritious food or have safe places to exercise, which in some cases may be true. But in other cases it is also may be very possible that fat people become poor because of discrimination which then leads to food insecurity (2).

For example, a study published in 2008 recognized that there is an association between food insecurity and obesity, but there is little known about the direction of the causation related to that association. This study followed 622 healthy adult women from early pregnancy through two years postpartum and found that "obesity appears to lead to food insecurity rather than the converse. Obesity combined with food insecurity presents the greatest risk for major weight gain in this sample of...women" (31).

But even though evidence shows that weight discrimination may lead to hunger through poverty and food insecurity, the argument could also be made that bias can also lead to hunger of a different kind. One theory could be that due to discrimination against eating in public places such as work, restaurants and social settings (2, pg 156), that overweight or obese individuals can be literally fearful of eating in front of other people, and so instead stay hungry all day and wait to eat in their own home.

# Emotional Consequences

Due to the many stereotypes about weight that exist in our culture, overweight can become a serious social challenge to the point that it may result in long-term damage to self esteem and body image. Abuse and scorn are often seen as charitable gestures because somehow it might drive the person to lose weight. The fear and shame that overweight people often feel because of this treatment can be so intense that the individual themselves begin to have negative attitudes toward themselves and believe that they are deserving of harsh treatment (2, 4).

Some researchers even believe that in children, emotional and psychological damage are greater problems than health risks. This must beg the question of whether the problem actually lies with the child or with the culture that makes this stigma so powerful (4).

### Effects on Children

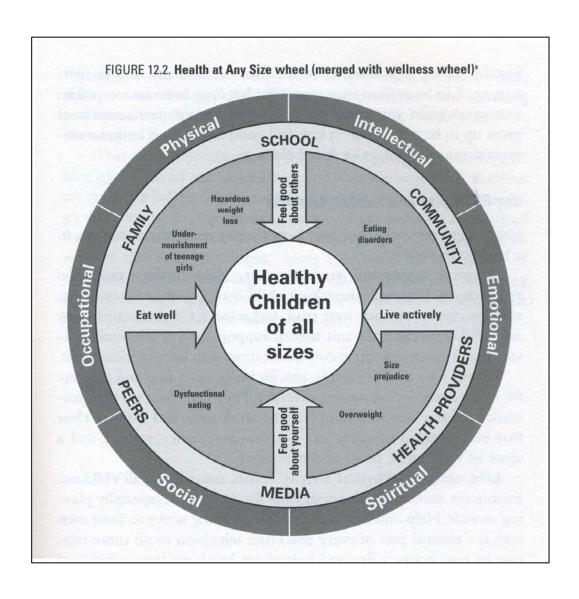
One of the most important reasons to combat bias is to protect overweight children (2). Both the physical and emotional effects that occur as a consequence of weight-based prejudice are especially evident in children. "There is a strong prejudice, harassment, and even oppression against large youngsters regardless of age, sex, race, and socioeconomic status, which can interfere with their ability to grow into self-assured, successful adults" (4). The sources of bias against obese children are many, including classmates, health professionals, teachers, and even their own family members (2).

What is interesting about weight bias in children is that not even average weight children are considered to be as favorable as thin children. In a study with young children, girls rated not only overweight children, but also average weight children as less favorable than a skinny child.

(2). In response to this belief, many overweight children and teens are often willing to attempt anything to lose weight, including dangerous methods of weight loss that may even result in injury or possibly death (4). Indeed, "over one half of teenage girls and nearly one third of teenage boys use unhealthy weight control behaviors such as skipping meals, fasting, smoking cigarettes, vomiting, an taking laxatives" (32).

If we continue to provide a culture where even our children believe that thinness is the ultimate ideal we will not only create more stigma, but also lay the path for more and more children to adopt dangerous eating patterns or even develop eating disorders.

Figure 12.2 below represents the different environmental factors that can either contribute to or interfere with healthy children of all sizes (4).



### Eating Disturbances

Dysfunctional eating, chronic dieting, and eating disorders are often the result of the internalization of the thin ideal, and the effects that these can have on the body are significant.

At first appearance, dieting seems to be a praiseworthy activity because it is often in the name of losing weight and becoming healthier. But upon closer examination, it is clear that dieting nearly always fails because it does not bring lasting change. Ninety-five percent of all dieters will regain their lost weight in 1-5 years (33). The cycle of weight gain and loss can even be harmful. In fact, some research shows that weight cycling is associated with higher death rates (4).

Dieting is even more troublesome when it occurs in children and adolescents because it can seriously affect healthy development to adulthood (4). Dieting has even been observed in young elementary kids, especially in girls. Forty-two percent of first to third grade girls want to be thinner (34), 46% of 9-11 year olds are "sometimes" or "very often" on diets (35), 81% of 10 year olds are afraid to be fat (36), and 90% of high school junior and senior girls diet regularly (37).

One of the shocking truths in our society today is that "over half of teenage girls do not eat enough for health, energy, and strength. They do not eat enough to feel or look their best. They do not eat enough for optimal bone growth, for energy, or even to warm themselves normally. They do not eat enough to be their best selves or to reach their greatest potential, and they don't eat enough to support a healthy pregnancy" (4).

Other shocking statistics include that 35% of normal dieters become chronic dieters, and of those, 20-25% progress to eating disorders (38). Girls who chronically diet are 12 times more likely to participate in bingeing than girls who do not diet (32).

But what does all of this research mean? How are eating disorders and dieting related to weight discrimination? What needs to be realized is that "overweight, size prejudice, the undernutrition of teenage girls, hazardous weight loss, eating disorders and dysfunctional eating are not separate issues. They are all part of the same problem, and our diet mentality and unnatural obsession with weight affect them all" (4). When all of these factors are considered, we realize that our drive to be thin, and therefore our stigma against overweight, is actually pushing us in a direction that does not lead to health.

#### Less Healthcare Utilization

Another damaging side effect of weight discrimination is that overweight and obese individuals may refrain from seeking health care in order to avoid stigma from doctors, nurses, dietitians, etc. The research shows that this hesitation may not be due to a perceived hostility, but instead a perceived lack of empathy. In one particular study, 87% of women said their physicians were never or rarely critical or insulting about weight, but 60% reported feeling that most doctors do not understand how difficult it is to be overweight (2, p.35-36). Whether weight bias may actually result in reduced care for obese individuals deserves more attention in future research.

#### **Interventions to Combat and Prevent Bias:**

In order to combat current prejudice and prevent it in the future, we must first recognize that stigma does exist, and is embedded in our society. It is likely not realistic in our culture to completely abandon the view that an individual's worth is dependent upon their physical appearance. However, it should be realistic for all individuals to have a positive body image no matter what their size, and to discard the belief that being overweight or obese makes an individual worthless (2). Becoming focused on health rather than weight, and gaining the ability to view weight as only one portion of what health means could even be viewed as the ultimate

ideal. But how do we achieve this new ideal?

There are many interventions that are possible, but all must begin with individual action. Individuals have the ability to influence laws and public policy, encourage schools to discourage bias among students and teachers, influence companies to include weight bias in diversity training, and to encourage changes to eliminate weight prejudice in health care (2).

In health care specifically, research shows that professionals need to become more educated about treating different subsets of the overweight and obese population, such as the metabolically healthy but obese population discussed earlier. The current tendency to treat obese individuals with a one-size-fits-all approach will be counterproductive to the metabolically healthy but obese people (14). Also, the tendency to emphasize drastic health consequences from obesity rather than emphasizing benefits from modest weight loss and improved lifestyle behaviors can be discouraging rather than motivating for patients. Overemphasizing health risks may actually contribute to further discrimination and size harassment (4). It is also important for health care professionals to use appropriate terms such as "weight" instead of "fatness" or "morbid obesity" which can be offensive (2, pg 37-38). And perhaps most importantly, professionals must treat the patient with respect at all times (2, pg 39), communicate empathy for the difficulties that accompany being overweight including the difficulty of weight loss, and ultimately do no harm (4).

Another area for potential intervention is in public policy. Currently, discrimination based on weight is only prohibited in four places in the United States, Michigan, the District of Columbia, San Francisco CA, and Santa Cruz CA (37). Policies not only in local, state, and federal government, but also in companies to discourage unfair treatment of employees and in unfair hiring practices can be effective at combating bias and preventing it in the future.

A less direct intervention comes in the form of a recent movement called "Health At Every Size." This movement focuses on pursuing health rather than the "ideal weight"; it promotes size acceptance and normal eating behaviors by listening to hunger and satiety cues (37), and encourages active living through all physical activities rather than prescriptive exercise (39). It also promotes gradual lifestyle change instead of sudden change so that the changes will be lasting, and that beauty, health and strength come in all sizes (4).

In this movement, health is defined by physical, mental, and social well-being rather than by body weight, and it rejects the idea that thin equals healthy and being large is unhealthy by promoting that different sizes are a perfectly normal characteristic of the human race. It also rejects the idea that all bodies should be in an "ideal weight range" and that weight loss is necessary to be healthy for overweight and obese individuals (4).

A good graphical depiction of what the "Health At Every Size" movement represents can be found from a campaign that Health Canada launched in the 1990's called *Vitality*, which illustrates the shift from a weight-centered health approach to a health at any size approach. This is shown in Figure 12.1 on the next page (4).

Weight Centered Approach	Vitality
DIETING	HEALTHY EATING
Restrictive eating     Counting calories,     prescriptive diets	Take pleasure in eating a variety of foods     Enjoy lower-fat, complex-carbohydrate     foods more often
Weight cycling (yo-yo diets)	Meet the body's energy and nutrient needs through a lifetime of healthy enjoyable eating
• Eating Disorders	Take control of how you eat by listening to your hunger cues
EXERCISE	ACTIVE LIVING
No pain, no gain	Value and practice activities that are moderate and fun
Stringent workout regimens     Burn calories	Be active your way, every day     Participate for the joy of feeling your     body move
High attrition rates for exercise programs	Enjoy physical activities as part of your daily lifestyle
DISSATISFACTION WITH SELF	POSITIVE SELF/BODY IMAGE
Unrealistic goals for body size and shape     Obsession and preoccupation with weight	Accept and recognize that healthy bodies come in a range of weight, shapes/sizes     Appreciate your strengths and abilities
Fat phobia and discrimination against overweight people	Be tolerant of a wide range of body sizes and shapes
Striving to attain impossible "ideal" body size	Enjoy the unique characteristics you have to offer
Accepting the fashion, diet, and tabacco industries' emphasis on slimness	Be critical of messages that focus on unrealistic thinness (in women) and muscularity (in men) as symbols of success and happiness

The effectiveness of the "Health At Every Size" position has been recently researched. In an article that was published in the November 2009 issue of the Journal of the American Dietetic Association, the effect that a Health At Every Size (abbreviated HAES in the study) approach had on eating behaviors was examined.

The study was a randomized controlled trial conducted in 144 premenopausal women from September 2003 through August 2006. The women were separated into a HAES group, a social support group, and a control group. The HAES group received information following the HAES approach, while the social support group received only group discussions on nutrition. Eating behaviors, appetite, anthropometrics, and physical activity factors were measured before

the study, after the intervention period at four months, and then at 10 months and 16 months. Results showed that women involved in an HAES intervention experienced sustainable improvements in eating behaviors related to susceptibility to hunger and disinhibited eating. "Significant associations were observed between eating behaviors changes and body weight changes only in the HAES group. This suggests that long-term behavior changes observed in women from the HAES might be related to a better regulation of energy balance" (11). These results show that a HAES position can be effective at not only improving eating behaviors, but also a better regulation of energy balance and an ability to maintain these behaviors over time.

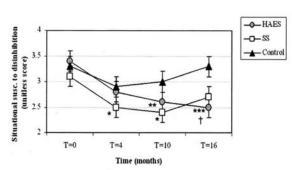


Figure 1. Between- and within-group pairwise differences for situational susceptibility to disinhibition at baseline (T=0), at post-treatment (T=4 months) and at follow-up (T=10 months and T=16 months) in Health-at-Every-Size intervention (HAES), social support (SS), and control groups. Values are mean ± standard error. Number of participants at each time point: T=0: n=48 in the HAES group; n=46 in the SS group; n=46 in the control group. T=4 months: n=44 in the HAES group; n=39 in the SS group; n=38 in the control group. T=10 months: n=43 in the HAES group; n=36 in the SS group; n=34 in the control group. T=16 months: n=40 in the HAES group; n=34 in the SS group; n=32 in the control group. \*Significant within-group changes (in comparison to baseline) at P<0.05. \*\*Significant withingroup changes (in comparison to baseline) at P<0.01. \*\*\*Significant within-group changes (in comparison to baseline) at P<0.0001. †Significant between-group differences (in comparison to the control group) at P<0.05. NOTE: Information from this figure is available online at www. adajournal.org as part of a PowerPoint presentation.

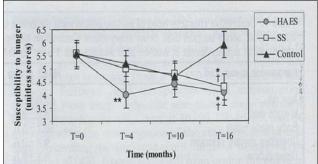


Figure 2. Between- and within-group pairwise differences for susceptibility to hunger at baseline (T=0), at post-treatment (T=4 months) and at follow-up (T=10 months and T=16 months) in Health-at-Every-Size intervention (HAES), social support (SS) and control groups. Values are mean ± standard error. Number of participants at each time point: T=0: n=48 in the HAES group; n=46 in the SS group; n=46 in the control group, T=4 months: n=44 in the HAES group; n=39 in the SS group: n=38 in the control group. T=10 months: n=43 in the HAES group: n=36 in the SS group: n=34 in the control group. T=16months: n=40 in the HAES group; n=34 in the SS group; n=32 in the control group. \*Significant within-group changes (in comparison to baseline) at P<0.05. \*\*Significant within-group changes (in comparison to baseline) at P<0.01. †Significant between-group differences (in comparison to the control group) at P<0.05. NOTE: Information from this figure is available online at www.adajournal.org as part of a PowerPoint presentation.

#### **Conclusions:**

The topic of weight has become, excuse the pun, a very weighty issue in our society. Obesity is associated with diabetes, heart disease, hypertension, hyperlipidemia, some types of cancer, and even increased mortality (3), which has caused many to believe quite reasonably that weight alone constitutes health. The rates of overweight and obesity in the United States are at such levels that is has even been labeled an epidemic. But with this label comes another: overweight and obesity are equal to laziness, lack of self-discipline, and an overall unhealthy lifestyle, and that thinness is our ultimate ideal (2). What makes these labels risky is that they are not widely challenged to be assumptions, but instead generally considered to be reality, so much so that discrimination and harsh treatment of overweight and obese individuals in the name of weight loss is very often socially acceptable, and even considered to be warranted and even encouraged.

The limited research that has been completed on weight bias has shown that discrimination is especially prevalent in social settings, education, employment, healthcare, and the media (4). But despite the increasing amount of evidence, neither public policy nor social beliefs have been affected to any great extent (cswd). More research on weight discrimination needs to be conducted and more individual action needs to be taken in order to increase awareness that it is a real issue with real consequences so that it may be prevented in the future.

The current perceptions that society holds against weight need to change. Reliance on this prejudice and our overall fear of fat has been the cause of many adverse social, emotional, physical, and even political consequences. The very real impact that this bias has had on individual lives has been largely overlooked (2). So rather than focus on weight loss alone as our main goal, the focus must be on achieving the best weight possible for every individual in the

context of overall health, no matter what that weight may be.

# **My Recommendations:**

My recommendation is that we ultimately need to separate the individual from the condition and separate our weight from our worth in order to discover a greater respect for our own bodies and the bodies of others. If we become able to seek health rather than weight in bodies that we genuinely enjoy, we may just find that the word health will take on a new, personal meaning and that the word weight doesn't have to be so weighty after all.

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Kelsey Eller was raised in Kaysville, Utah and attended Davis High School, from which she graduated in 2006. She entered Utah State University in fall of that year and declared a major in Nutrition, Dietetics, and Food Sciences with an emphasis in Dietetics. She then became actively involved in the Honors Program, served as an Honors Fellow in the 2007-2008 academic year, and also became a member of the Golden Key International Honour Society. In the spring of 2008, she was accepted into the Coordinated Program of Dietetics, and soon after became a student member of the American Dietetic Association. While in the Dietetics program she was able to complete a dietetics internship which included experiences in medical nutrition therapy at Primary Children's Medical Center, the University Hospital's Burn Center, and McKay-Dee Hospital.

After graduation in May 2010 she plans to take the registration exam to become a Registered Dietitian, and then plans to begin Graduate School at USU in Fall 2010 to seek a Masters degree in Nutrition Science.