Addressing weight stigma and anti-obesity rhetoric in policy changes to prevent eating disorders

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Weight stigma diminishes wellbeing and contributes to inequities across multiple domains. A 2020 report by the UK eating disorder charity Beat highlighted several ways that obesity prevention public health campaigns can unintentionally amplify risk of eating disorders and exacerbate symptoms.[1] This report made useful recommendations to minimise these harms and identified specific risk pathways—eg, promotion of dieting (an ineffective strategy for long-term weight loss, which also heightens risk for binge-eating behaviour), prioritising thinness in a way that falsely equates thinness with health (and correspondingly, higher weight with poor health), and engagement in weight-stigmatising actions, such as the use of body-mass index (BMI) report cards and problematic discourse in public health programming. Beat has also flagged problems with other well intentioned efforts such as calorie labelling on menus and food labels, which can exacerbate eating disorder thoughts, behaviours, and distress, and a weight-loss app introduced by the UK National Health Service, which emphasises dietary restriction with insufficient safeguards by age, BMI, and medical considerations.[2] We agree and contend that in certain ways anti-obesity campaigns could fundamentally be at odds with efforts to prevent eating disorders. Indeed, some have argued that to reduce the risk of eating disorders, the world needs to be made safe in terms of reducing stigma and discrimination for higher-weight individuals[3] and that the programmatic goals of eating disorder prevention and obesity prevention campaigns are incompatible, given that the underlying premise of anti-obesity campaigns is that higher weight is harmful. However, greater attention to shared experiences of weight stigma, epidemiology, genetic features, and environmental factors could serve to reduce this seeming incompatibility and benefit public health.

Weight stigma is inextricably linked with treatment processes for people with eating disorders. A defining feature of many eating disorders is fear of fatness and anticipating the negative consequences of weight gain—eg, social rejection and public shaming—which can serve as a barrier to recovery.[4] Although eating disorders affect individuals of all bodyweights, shapes, and sizes,[5] patients who are of higher weight may not be detected as being ill or not deemed “ill enough” to access care, whether due to their own internalised weight bias, diagnostic bias among clinicians, or limited capacity and prioritisation of services that provide treatment for eating disorders.[6,7] Indeed, people with eating disorders may even avoid health care because of past negative experiences.[8] Furthermore, for patients with weight loss goals, weight stigma does not motivate change behaviours, but rather confers additional stress and increases risk for overeating, avoidance of physical activity, and further weight gain.[9]

Most higher-weight individuals do not have eating disorders, but there are parallels between eating disorders and weight status in terms of epidemiology, genetic underpinnings, and environmental factors that exacerbate difficulties.[10–12] For example, epidemiological data indicate increases in early manifestations of distress and effortful weight management such as through dieting and overexercise and overestimated weight perception in children.[13] Such behaviours are likely to be driven by societal weight stigma as well as increased prevalence of higher weight among young people.[14] Moreover, in a WHO study that collated evidence from several countries, 32–41% of adults with binge-eating disorder met BMI criteria for obesity.[15] Furthermore, an Australian study has shown the rising prevalence from 1995 to 2015 of obesity (32%), binge eating (12·5%), and comorbid obesity and binge eating (5·7%).[16] Several studies suggest that there could be some shared genetic

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and environmental features for disordered eating and weight status. For example, longitudinal studies show a trajectory of overeating and disrupted weight systems for binge-eating disorders with opposite pathways for anorexia nervosa,[17] genetic commonalities in obesity and binge eating but not anorexia nervosa,[12] and shared exposure to environmental stressors, such as traumatic experiences and marginalised identities, among higher-weight individuals and those with eating disorders.[10,18,19]

We suggest that it may be wise to redirect public health attention toward health promotion, such as wider access to nutritious food options and safe, varied, and joyful physical movement rather than on obesity reduction per se. Additionally, greater scrutiny of environmental and biological factors could help to reduce emphasis on body size and shape and instead draw attention to those factors that more broadly shape health and wellbeing for people across the spectrum of body sizes and shapes. This approach calls for increased research and policy attention to food industry practices that proliferate highly processed and diet foods, which increase loss-of-control eating, food cravings, dietary restriction, and physiological responses resembling addiction, and it could serve to mitigate the risk of disordered eating.[20] Finally, we propose there is an urgent need to consider intersectionality in relation to weight stigma with other forms of stigma. Research suggests that internalisation of weight bias and the behavioural and health impacts of such bias vary across racial and gender identities.[21] A focus on weight stigma alone is insufficient. Instead, health professionals must explore weight stigma within a broader sociodemographic and intersectional framework, with increased attention and support directed towards those with multiple marginalised identities who may be harmed by public health efforts that do not consider their unique circumstances and needs. Indeed, it is time to generate consensus across a range of experts to identify empirically supported, weight-inclusive policy needs.[22] Crucially, those who work in eating disorders and advocacy and particularly those who represent multiple social identities and bodies should have a seat at the table before launching new public health campaigns that target obesity.

JT is a signatory on the Beat report that is discussed in this Comment. SA declares no competing interests.

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