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Weight Bias and Stigma:

Impact on Health

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HELPFUL RESOURCES

Obesity Action Coalition: https://www.obesityaction.org/
Stop Obesity Alliance: https://stop.publichealth.gwu.edu/
Obesity Care Advocacy Network: https://obesitycareadvocacynetwork.com/
National Obesity Care Week: https://www.obesitycareweek.org/
Obesity Medicine Association: https://obesitymedicine.org/
The Obesity Society: https://www.obesity.org/
Rudd Center for Food Policy and Obesity: https://uconnruddcenter.org/
Health at Every Size Approach: https://asdah.org/health-at-every-size-haes-approach/
National Eating Disorder Association: https://www.nationaleatingdisorders.org/

WEB SITES

Centers for Disease Control and Prevention: Pediatric obesity tips for parents: https://www.cdc.gov/healthyweight/children/index.html.
Centers for Disease Control and Prevention: Healthy eating tips https://www.cdc.gov/healthyweight/healthy_eating/index.html.
Centers for Disease Control and Prevention: Preventing weight gain https://www.cdc.gov/healthyweight/prevention/index.html.
Centers for Disease Control and Prevention: Physical activity for a healthy weight https://www.cdc.gov/healthyweight/physical_activity/index.html.
Mayo Clinic: Childhood obesity: https://www.mayoclinic.org/diseases-conditions/childhood-obesity/diagnosis-treatment/drc-20354833.
Parents: Help kids lose weight: https://www.parents.com/kids/teens/weight-loss/help-kids-lose-weight/
National Institute of Health: Helping your child who is overweight: https://www.niddk.nih.gov/health-information/weight-management/helping-your-child-who-is-overweight.
Very Well Health: Weight loss help for kids who are not losing weight: https://www.verywellhealth.com/help-with-weight-loss-for-kids-who-cant-lose-weight-2633987.
Very Well Family: Weight management guide for children with preobesity: https://www.verywellfamily.com/weight-management-guide-2632244.

Weight bias and stigma exist in a variety of realms in our society, and it is sad that it is often viewed as a socially acceptable form of discrimination.[1–3] For decades, those in the Western culture have had trouble understanding and accepting preobesity and obesity as a disease state, considering it a condition brought on by lack of willpower or self-control, and thus, we find both implicit and explicit forms of bias being perpetuated in an assortment of landscapes when it comes to discussing weight.[1,4,5] As researchers and health care providers, it is important to delineate the differences between weight bias and weight stigma, and the differences between implicit and explicit forms of bias. Awareness and sensitivity of these personal issues surrounding weight should be approached in a culturally competent and inclusive manner.

Brownell and colleagues[6] suggest that although both bias and stigma are connected to prejudice, the experience of prejudice differs based on whether one is stigmatized or the target of bias. Weight bias refers to instances wherein individuals receive negative or unreasonable judgments about their person based on their body size or weight, with prejudice being a potential outcome.[6] Typically, weight bias manifests as a negative attitude, assumption of a stereotype, or a verbal or physical attack toward someone of differing body size.[7] In addition, weight bias may be embedded in our physical[8] and social environments,[1] specifically when considering elements such as medical equipment and furniture, physical examination space, and language.

Comparatively, weight stigma refers to situations in which an individual is labeled with certain personality or behavioral characteristics because of their perceived body size or weight. Therefore, an individual becomes a target of prejudice.[6] Those that are stigmatized for having a larger body size are devalued, ostracized, and often criticized in society because they do not fit the societal standard for beauty or the socially constructed norm of an ideal body.[2,6,9] The resulting prejudice further leads to weight-based discrimination, which may present as microaggressions or explicit inequitable treatment.[10] Occurrences of weight stigma are not uncommon and have been documented in numerous settings, including, but not limited to health care, education, employment, and media portrayals.[1,2,6] The problem with the pervasiveness of weight stigma is that it ultimately results in the unfair treatment of those with larger body sizes, negatively impacting physical health, mental health, self-esteem, and well-being. In recent years, weight bias and weight stigma have evolved into social justice issues. We must view misconceptions regarding body size through this lens to best address the issues plaguing our society and develop best practices that are inclusive and supportive of body diversity.

Both weight bias and stigma can occur implicitly or explicitly. Implicit bias refers to instances wherein the bias operates at the subconscious level. Individuals form negative preconceptions about individuals of larger body sizes.[11] Frequently, implicit bias is an automatic, unconscious response and might occur as an initial thought or reaction toward viewing someone in the audience of question. For example, several researchers[12–14] have used the Implicit Association Test (IAT) to measure implicit weight bias in a variety of contexts. The IAT measures how quickly individuals can pair concepts with specific attributes—in this case, pairing the attributes of “good” and “bad” with the target variables of “fat” and “thin.”[15,16] When measuring implicit weight bias, researchers assess the speed

and accuracy in which each participant can correctly categorize the attributes and words together (eg, categorize fat/good and thin/bad). Implicit weight bias becomes evident when participants are able to categorize “fat” with “bad” attributes more efficiently than being able to accurately and quickly categorize “fat” with “good” attributes.[16] Owing to our own bias and societal perceptions, what many researchers have found is that we make automatic associations more easily when categorizing “thin” with “good” words and “fat” with “bad” words,[11,16,17] thus perpetuating implicit bias toward those with preobesity or obesity. While implicit bias often occurs only at the subconscious level (meaning this is not bias on which we outwardly act), those negative thoughts, feelings, and attitudes are still present and influence our perceptions toward individuals of larger body sizes.

Explicit bias, on the other hand, refers to actions (physical, verbal, or nonverbal) or thoughts that are outward, intentional, and operate at a conscious level.[11] Those engaging in explicit bias hold negative attitudes and prejudices toward groups of individuals and are well aware of the opinions, beliefs, and perceptions they hold.[18] Explicit bias often occurs in the form of discrimination as a result of a deliberate thought. Much of the explicit bias experienced by individuals of larger body sizes comes in the form of stereotyping, specifically, believing that individuals with preobesity or obesity are lazy, lack willpower and self-control, and are unmotivated.[5,6,12,19] Many of these stereotypes stem from decades of socially constructed norms about ideal body sizes and our society’s continual celebration of those meeting the “thin” or “muscular” ideal.[20] The result of explicit bias for those with larger body sizes varies, but researchers have documented that bias impacts employment, communication, and treatment in a variety of settings, including health care.[1,2,6,16]

Despite society’s unrealistic ideal standards for bodies, the rates of preobesity and obesity have been on the rise for the past decade, so much so that our country has deemed obesity to be an epidemic.[1,21,22] As the rates of preobesity and obesity have increased, so too have the rates of bias and stigmatization toward individuals of larger body sizes.[1,10] Unlike racial bias or bias against those with physical or mental disabilities, there has been no Civil Rights Act or Americans with Disabilities Act to protect individuals of larger body sizes against discrimination in the workplace, education, or health care (to name a few). In fact, weight bias remains a common form of discrimination in our nation.[10] Individuals rationalize that weight is an acceptable form of discrimination because of the perception surrounding the controllability of one’s weight.[5,10] Weight is believed to be an attribute of our bodies over which we have control, and it is, therefore, our personal choices, self-control (or lack thereof), and lifestyles that influence our body weight and size.[2,5] The belief that weight is in one’s control is true to an extent, yet, it is important to understand the multifaceted and complex nature of obesity to gain a full understanding of this condition. Weight is influenced by a multitude of factors, including, but not limited to, personal behaviors, the environment, social factors, genetics/biology, and cultural elements.[6] It is trivial to believe that weight is the sole result of someone’s personal choices and lack of self-control when they find themselves in an environment that is laden with energydense food that is affordable, accessible, and convenient. Despite recognizing that obesity is a complex issue, society still discriminates against those with preobesity and obesity because of the group norms that are embedded in our infrastructure. Weight discrimination has resulted in negative physical and mental health outcomes, avoidance of health treatment, unfair treatment by doctors and

nurses, loss of employment opportunities, and decreased academic performance.[1,2,6,10,16] As long as society continues to encourage unrealistic body standards, the prevalence of weight discrimination will persist, because those in larger body sizes will not fit the norm of a body that is socially acceptable.

WEIGHT BIAS AND STIGMA IN SPECIFIC ENVIRONMENTS

Media

One arena in which we witness substantial explicit weight bias is within the media. Television shows and movies are notorious for depicting those with larger body sizes as disheveled, unorganized, lacking in personality, undesirable, and deserving of poor treatment.[12,23,24] Those with preobesity and obesity are often the target of many jokes in the media, further perpetuating the stereotype that larger bodies are unacceptable and not welcome in our society.

In both traditional and social media, the normalization of weight bias, stigma, and discrimination are evident and falsely infer social acceptability of bias and stigma. Pearl and colleagues[25] noted the stigmatization of individuals with obesity in media and entertainment sources, including talk shows, cartoons, movies, and comedies. In addition, weight stigma is often portrayed in movies and television shows that are popular among children and teens.[26] Much entertainment created for children upholds stereotypes of body size, planting the seeds of both implicit and explicit bias early in life. In print media, acceptability and practice of weight bias toward obesity and people with obesity increased when participants were given fictional scientific news articles that promoted negative perceptions of obesity as a whole when compared with participants provided with news articles that did not promote negative scientific information.[27]

Jeon and colleagues[28] determined that the cloak of anonymity on social media emboldened some commenters on YouTube videos of individuals with obesity in online dating. Two-thirds of the comments were negative and attacking, frequently using words that were insulting, derogatory, mocking, and profane.

Education

Children with preobesity or obesity often experience weight stigma presented as bullying. Teachers and parents have noted that bullying based on body size is more prevalent than bullying based on other characteristics, including sexual orientation and disability.[29,30] In postsecondary education, the higher a female students' body mass index (BMI), the less likely she was to be in a romantic relationship.[31]

Children experience weight bias from educators in addition to their peers. Educators in middle schools and high schools assigned lower grades on the same papers to students they believed to have preobesity compared with those without obesity or preobesity.[32] The teachers also perceived that students with preobesity needed more tutoring assistance, had to put forth more effort, and had lower grades than students without obesity or preobesity. Individuals enrolled in health and physical education programs at a university had both

implicit and explicit bias against children with obesity, rating the children as being more self-conscious and less healthy and having lower self-satisfaction and confidence.[33]

Employment

Despite equal or higher qualifications for a position, applicants with obesity seeking employment are frequently overlooked compared with other applicants without obesity.[34] Employees with obesity have higher rates of discrimination than individuals with a typical weight and often report lower wages, fewer promotion opportunities, and increased termination.[34] Remarkably, there is no federal protection for those who experience weight bias in employment because weight is not an included characteristic under US Civil Rights protections unless obesity contributes to disability. However, there is one state (Michigan) that has enacted protections against weight discrimination in the workplace. Lack of protection by federal law is consistent in most nations of the world.[34]

Health Care

Health care providers, including those who work specifically in obesity care, are not immune to demonstrations of weight bias and stigma.[35–38] Indeed, bias and stigma are evident across all professionals in the health care industry, including physicians, nurses, dietitians, and mental health care providers.[13,14,39,40] Individuals with obesity ranked physicians as the second, after family members, most frequent source of weight bias.[41]

Unfortunately, weight bias and stigma may be learned behaviors from educational programs of health care professions. Medical students reported witnessing weight bias by faculty when observing interactions with patients with obesity.[11] Even more disturbing, some faculty used negative, stigmatic language referring to patients with obesity during the medical students' education. In the same study, third-year medical students with higher levels of weight bias were less likely to provide appropriate, patient-centered care to patients with obesity.[11] Nurse practitioner (NP) students witnessed similar patterns with family NP preceptors.[42] In addition, these NP students identified areas of stigma by other members of the health care teams, such as calling out weights of patients without discretion and using judgmental, stigmatic adjectives and language when referring to the patients.[42]

As discussed previously, weight bias exists both explicitly and implicitly. Although both forms of bias interfere with a compassionate, patient-centered relationship between an individual with obesity and his/her health care provider,[14,40] it is possible that implicit bias can be a more insidious obstacle. Individuals with obesity who perceive bias are less likely to seek care, including preventive care and screening.[40,43] Women with obesity report higher levels of avoidance in seeking health care,[40] potentially delaying early detection of breast or cervical cancer, hypertension, and/or diabetes. Additionally, perceived weight stigma often prevents seeking care for obesity and other obesity-related conditions, including musculoskeletal pain and mobility concerns.[40] Health care providers often report a perception that patients who have obesity are less likely to adhere to wellness plans,[44] often attributing the characteristics of laziness, lack of motivation, and noncompliance.[11]

Through implicit bias, well-meaning providers who want to encourage patients with obesity to improve their health cannot conceptualize that their bias may prevent therapeutic, patient-

centered care.[45] Individuals with obesity who experience and internalize weight stigma are more likely to exhibit unhealthy eating and weight control behaviors, such as increased binge eating, frequency of eating, and portion sizes and are less likely to engage in physical activity.[46–49] Thus, the relationship between the patient and the health care provider can become counterproductive in the goal of improving the health of the patient. There is also evidence that people who experience weight bias have a higher incidence of development of obesity and increased weight and body size.[50,51]

Individuals who experience weight bias have higher levels of stress compared with those who do not,[52] accompanied by increased levels of cortisol and inflammation. Physiologic actuation of bias, thus, places recipients at a higher risk for cardiovascular disease.[52]

The physical environment of health care also presents a bias. Health care offices that are not appropriately suited for the care of an individual with obesity introduce bias for individuals with obesity, occurring with the sizes of gowns, the sizes of blood pressure cuffs, and the setting, atmosphere, and procedure by which an individual is weighed.[42]

PEDIATRIC OBESITY BIAS

According to the United States Centers for Disease Control and Prevention, prevalence of obesity in children and adolescents is 18.9% for those in the lowest income group.[53] The middle-income group is at 19.9%, and the highest income group is at 10% prevalence for having obesity.[53] Non-Hispanic Caucasians and Asians, as well as Hispanic pediatric patients, were also in the lowest category of having obesity. The National Health and Nutrition Survey confirms that children/adolescents with obesity are measured by a BMI at or more than the 95th percentile for their ages.[54] In 2017 to 2018, the cumulative average of children/adolescents with obesity was 19.3%, with boys at 20.5% and girls at 18%. Adolescents aged 12 to 19 years had the highest cumulative numbers, with 21% having obesity. Males again had a higher prevalence at 21.2% and females at 19.2%.[54,55]

In 2013, the American Medical Association recognized obesity as a disease and not just a result of personal choices.[56] This way of understanding obesity, unfortunately, has not been adopted by all medical professionals.[57] Severe obesity is the most rapidly growing disease, affecting as many as 5 million children. If this trend continues, as many as 57% of children today may have obesity as adults by the age of 35 years, creating significant health risks.[58]

When a pediatric patient has obesity, there is often a stigmatized experience that follows. Puhl and colleagues[59] found that when children/adolescents experience weight bias or stigma, they begin to internalize their feelings related to their weight status, weight loss attempts, and eating habits. Adverse outcomes may result leading to psychological, behavioral, and physical manifestations. Many children/adolescents may experience weight stigma from well-meaning family members who do not know how to properly help their children/adolescents manage their weight.[60,61] Furthermore, stigma or bias can come from peers, teachers, school nurses, health care professionals, social media, and traditional media.[11,43] Pediatric health care providers and office support staff may consider that the child/adolescent's weight gain is controllable. To further complicate the issue, many

professional health care workers do not use “people-first” language (eg, using “the child who has obesity” instead of using “the overweight, obese, morbidly obese, or fat child”).[62]

Palad and colleagues[26] encourage health care professionals who are providing medical care when working with pediatric patients to provide support, acceptance, and appreciation for their individual and unique personalities. Some children and adolescents may prefer their weight status to be described as “plus-size” instead of being called “fat, large, or obese.”[63] Working with anyone who has a weight issue required adaptation of the intervention to individual characteristics and preferences. When implementing weight management with a child or adolescent, there must be multiple factions addressed in the treatment process including psychological, physical, mental, and emotional health. Otherwise, issues such as stigma, negativism, and unwillingness to participate in a program may greatly affect the treatment process.[64]

Weight-Related Teasing

Often when children or adolescents have obesity, they may be teased or bullied in the school, neighborhood, or even church. This type of detrimental treatment can cause psychological harm, which can be more damaging than the physiologic harm of obesity.[65] Some adults may think gently teasing children about their weight may nudge the child to eat less, exercise more, and motivate the child to be mindful of his or her weight. Instead, this talk from a loved one can propagate the opposite behavior, causing some children/adolescents to eat more, hide food, or binge eat to soothe the negative feelings that are created from the ongoing, sometimes relentless teasing.[66,67]

In a systematic review, Day and colleagues[68] found that when adolescents are teased or victimized because of their weight, they have a greater likelihood of having body image disturbances and other psychological issues such as binge eating, purging, dietary restriction, and unhealthy weight control. Being bullied and not getting regular exercise were significantly associated with poor physical and psychosocial quality of life.[69] Furthermore, having difficulty finding size-/age-appropriate clothing was also significantly correlated with lower quality of life in children.[69]

CLINICAL IMPLICATIONS

It is important for health care providers to support individuals diagnosed with preobesity or obesity and their families. Providers need to be mindful to use people-first language (Table 1). Specific strategies can be used by providers in their practice setting to reduce obesity bias and stigma (Box 1). Therapeutic conversations with patients can be started by providers by carefully choosing their words (Box 2; Table 2).

Patients with these diagnoses are at risk for stigma and bias, specifically toward individuals of larger body sizes. The risks for these individuals are not a new occurrence or phenomenon. Society continues to blame the individual’s lack of control or willpower that reinforces weight as an acceptable form of discrimination, despite the many attempts to explain preobesity and obesity as a disease resulting from a myriad of complex social, environmental, and biological influences. Thus, health care providers continue to care

for individuals with larger bodies who have been devalued and shamed, resulting in negative physical and mental health outcomes. Health care providers should ensure spaces or equipment support for individuals of larger body sizes (Box 3). As nurses, we can connect health care providers working in our environments with the education and resources available related to reducing weight bias This step may help improve the understanding of weight bias and change the way we look at individuals who have preobesity or obesity.

When health care providers care for children or adolescents diagnosed with obesity, it is important to understand the home environment of the patient through communication with parents/caregivers. It is critical that parents and other adults close to the child do not use weight-based teasing or shaming with children. Weight-based teasing plays a role in negative mental health and may lead to increased eating and long-term emotional problems. Parents often think that they are helping the child through teasing and shaming. This form of teasing is detrimental and should never be used on any individual.

Health care providers should offer parents education and resources necessary to create a healthy home environment (see Fruh and colleagues[70]). It is vital to address the importance of a healthy home environment. Having healthy activity patterns, healthy home food offerings, and specific bedtime routines may make a significant difference in obesity management.[71] If counseling, psychological therapy, and behavioral changes are not included in the plan of treatment, efforts to change habits that have started at a very early age may be futile. A review by Alman and colleagues[72] found that treating pediatric patients with a lifestyle intervention that included diet, exercise, and behavioral modification therapy was the most successful. Other researchers also recommend examining weight status, weight bias, bullying, and other barriers to successful treatment such as economic status. If a family cannot afford healthy foods or lives in a neighborhood where there are few stores to purchase healthy food, it may be difficult to change the weight status of a child without significant efforts by a caring and actively involved health care professional.[73] Srivastava and colleagues[73] further recommend using the socioecological framework so that all areas of potential barriers to treatment can be examined before starting a treatment program. When assessing children or adolescents, completing a screening measure related to any form of bullying, teasing, or victimization is an important first step to understand what the child may be experiencing.[74]

It is vital for programs training health care providers and continuing education opportunities to include content related to obesity bias, obesity prevention, and obesity management. It is important for nursing programs to implement the most current evidence related to obesity bias prevention, obesity prevention, and obesity management in course objectives and student learning outcomes for undergraduate and graduate programs. In addition, nursing faculty may also consider including this content in the clinical course components. Students will have an opportunity to care for patients of all body sizes across the lifespan and from primary care/wellness and acute care settings, including the intensive care unit.[75] Including the latest evidence-based obesity management care is essential for nursing education.

Within the health care setting, continuing education for nurses and health care providers is a good place to begin to strategically focus on reducing obesity bias and providing

high-quality obesity management and care. Continuing education objectives that are relevant to health care providers caring for patients with obesity is paramount. Encouraging the directors of workplace environments to become educated on obesity bias may be an initial place to start with helping to change bias at an organizational level. Educating health care providers with the latest evidence and guidelines on obesity management is a core strategy to be implemented throughout the clinical setting.[75]

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Box 1

A general list of strategies to reduce obesity bias and stigma

1. *Identifying your own bias:* The Obesity Society has helpful questions to identify bias; the Rudd Center has an 8-module tool kit self-assessment course to help prevent obesity bias in providers.
2. *Promoting positive perceptions of individuals with obesity:* When individuals are provided with information regarding obesity as a complex disease with multiple causes (genetic, biological, and no controllable aspects), their negative attitudes decreased.
3. *Advancing your knowledge:* Providers who have greater knowledge in obesity management offer more comprehensive care and treat patients confidently.
4. *Understanding the patient's point of view:* Patients may have a long history of negative experiences with health care providers in nonsupportive office environments; they may have also tried to lose weight repeatedly and feel frustrated trying once again.
5. *Taking online educational programs:* When health care providers and students complete online educational materials, it can help reduce obesity bias.
6. *Motivational interviewing:* This effective strategy viewed by patients as less threatening is associated with greater patient adherence and outcomes.
7. *Demonstrating respect and compassion:* Providers need to communicate with patients respectfully and compassionately.

Data from Puhl RM, Schwartz MB, Brownell KD. Impact of perceived consensus on stereotypes about obese people: a new approach for reducing bias. Health Psychol 2005;24(5):517–25 and Fruh SM, Nadglowski J, Hall HR, et al. Obesity stigma and bias. J Nurse Pract 2016:12(7);425–32.

Box 2

Language to be considered before discussing weight with patients; improved health should be made the reason for the discussion

What words would you like me to use when we talk about weight?

How do you feel about your weight?

Can we talk about your weight today?

Do I have permission to discuss your weight?

Would you be willing to have a discussion about your weight?

Data from Fruh SM, Nadglowski J, Hall HR, et al. Obesity stigma and bias. J Nurse Pract 2016;12(7):425–32.

Box 3

Strategies to reduce obesity bias and stigma: clinic setting

Waiting room:

- Seating without armrests
- Wider chairs to accommodate all sizes
- Adequate space between each chair
- Avoid publications that contain offensive or discriminating images
- Respectful and compassionate communication with office staff

Equipment:

- Proper size gowns
- Sturdy, wide examination tables with sturdy stool or step with handles
- Measuring tape
- Appropriate vaginal speculum sizes
- Blood pressure cuffs in all sizes
- High-capacity weight scales (225–315 kg) in a private location (never call out weights)
- Hand-held Doppler assessment of the fetal heart rate may not be feasible in some cases before 16 to 20 weeks; sometimes, transabdominal ultrasonography is necessary.
- Bathrooms equipped with hand rails that can comfortably accommodate individuals of all sizes
- Laboratory draw chair that will comfortably accommodate all individuals

Data from Fruh SM, Nadglowski J, Hall HR, et al. Obesity stigma and bias. J Nurse Pract 2016;12(7):425–32.

KEY POINTS

- Weight bias and stigma is present in media, education, employment, and health care
- Weight bias and stigma are evident across all professionals in the health care industry, including physicians, nurses, dietitians, and mental health care providers.
- People-first language is critical to reducing bias and discrimination.
- It is important to use specific strategies to reduce obesity bias and stigma: clinic setting in the waiting room and the examination room.

CLINICS CARE POINTS

- Weight stigma results in the unfair treatment of those with larger body sizes, negatively impacting physical health, mental health, self-esteem, and well-being.
- Weight discrimination has resulted in negative physical and mental health outcomes, avoidance of health treatment, unfair treatment by doctors and nurses, loss of employment opportunities, and decreased academic performance.
- Individuals with obesity ranked physicians as the second, after family members, most frequent source of weight bias.
- Providers with higher levels of weight bias are less likely to provide appropriate, patient-centered care to patients with obesity.
- Individuals with obesity who perceive bias are less likely to seek care, including preventive care and screening (ie, routine care and cancer screening).
- Women with obesity report higher levels of avoidance in seeking health care.
- Individuals with obesity who experience and internalize weight stigma are more likely to exhibit unhealthy eating and weight control behaviors, such as increased binge eating, frequency of eating, and portion sizes and are less likely to engage in physical activity.
- Adolescents are teased or victimized because of their weight; they have a greater likelihood of having body image disturbances and other psychological issues such as binge eating, purging, dietary restriction, and unhealthy weight control.

Table 1

People-First Language is critical to reducing bias and discrimination

Example of People-First Language	Example of Non-People-First Language
A 43-y-old female patient with obesity	A 43-y-old obese female patient
A study related to children with obesity	A study of obese children

The term “obese” should never be used in conversations or written form. A helpful handout is available at People-First Language for Obesity: https://www.obesityaction.org/wp-content/uploads/People-First.pdf.

Table 2

Strategies to reduce obesity bias and stigma: compassionate and respectful communication

Encouraged terms	Discouraged Terms
Weight	Morbidly obese
Unhealthy weight	Obese
Overweight	Fat
Preobesity	Heaviness
Body mass index	Large size
Excessive energy stores	Chubby
Affected by obesity	Plump
Eating habits/nutrition	Big size
Physical activity	Diet
Healthy habits	Exercise

Adapted from Bays HE, et al. 2020. Available at: https://obesitymedicine.org/obesity-algorithm/. Accessed March 26, 2021.