Weight stigma as a risk factor for suicidality

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In this issue, Daly et al. [1] show that subjective perceptions of “overweight” were associated with increased risk of suicidal ideation, plans, and attempt in a large sample of US adolescents, even when controlling for participant age, gender, race/ethnicity, body mass index (BMI), and depression. These findings are consistent with existing research demonstrating that subjective weight perceptions were positively associated with suicidality in a large sample of young women in the US [2]. In this study, the association between self-perceived weight and suicidal ideation held even when controlling for covariates such as participant age, race/ethnicity, BMI, depression, risky behavior involvement, self-reported health status, history of familial suicidal behavior, and parent education. Thus, it appears as though the association between weight perceptions and suicidality is robust, and that self-perceived weight status is more strongly associated with suicidality than BMI.

Recent research suggests that the subjective experience of living in a higher-weight body is a stronger risk factor for suicide than objectively or subjectively measured weight status. This work examines the association between different aspects of weight stigma and suicidality from the perspective of the interpersonal theory of suicide [3]. According to the interpersonal theory of suicide, two interpersonal constructs of thwarted belongingness and perceived burdensomeness predict the desire to engage in suicidal behavior. Thwarted belongingness encompasses the extent to which one feels socially isolated, lonely, rejected, or as though they are lacking reciprocally caring relationships, whereas perceived burdensomeness entails the extent to which one feels as though they are expendable or so flawed that they are a liability to close others. Across two

studies, Hunger et al. [4] show that perceived weight-based discrimination is associated with increased suicidal ideation among adult community members living in the US. The association between perceived weight discrimination and suicidal ideation was mediated by perceived burdensomeness but not thwarted belongingness. This mediation model held across samples when controlling for participant BMI, depression, age, gender, education, income, relationship status, and employment status. The researchers argued that negative social interactions associated with weight were a more critical risk factor for suicidal ideation than BMI itself.

In addition to social experience of weight discrimination and stigmatization from others, weight bias may be internalized. Weight bias internalization involves derogation of the self because of one’s weight, as well as the application of negative weight stereotypes to the self [5]. Research out of my own lab that is currently invited for revision at a peer-reviewed journal highlights the association between weight bias internalization and suicidality in a community sample of adults living in the US. In this study, the association between weight bias internalization and suicidality was mediated by both thwarted belongingness and perceived burdensomeness, even when controlling for participant BMI, subjective weight status, age, gender, and race/ethnicity. Thus, psychosocial experiences associated with weight, including perceived weight discrimination and weight bias internalization, are associated with increased suicidality above and beyond BMI and subjective weight perceptions. In fact, some research suggests that weight bias internalization may be more detrimental to health and well-being than experiences of weight discrimination, although it is generally agreed that both are damaging [5].

In addition to suicidality, according to a recent review by Pearl and Puhl [5], weight bias internalization is associated with a number of mental and physical health outcomes including depression, anxiety, low self-esteem, poor body image, disordered eating, emotion dysregulation, perceived stress, maladaptive coping, psychological distress, low quality of life, and cardiometabolic risk. Approximately 20% of adults in the US population endorse high levels of

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weight bias internalization; among people with “obesity,” over 50% endorse high levels [5]. Phenomenological research suggests that weight discrimination is an almost daily experience for people of higher body weight [6]. Weight discrimination is associated with many of the same consequences on physical health and psychological well-being [7]. For example, Hunger and Tomiyama [8] demonstrated, in a large sample of adolescent girls in the US, that being labeled as “too fat” by parents, siblings, friends, peers, or teachers at age 14 years increased the risk for disordered eating cognitions (e.g., drive for thinness and body dissatisfaction) and behaviors (e.g., bulimia and unhealthy weight control behaviors) as measured 5 years later at age 19. Mechanisms underlying the association between weight stigma and health include increased stress, unhealthy behavior changes, health care underutilization, and social disconnection [7], many of which are reflective of the interpersonal constructs of perceived burdensomeness and thwarted belongingness. Negative social interactions because of high weight occur across a range of domains of daily living, including health care, employment, education, interpersonal relationships, and the media. Notably, weight discrimination is evident across a variety of health care settings and professionals, including physicians, nurses, eating disorder specialists, psychologists, and mental health counselors.

Although weight stigma is not typically addressed in health care training programs, evidence indicates that it can be effectively reduced in such settings [9]. Programs that provide training on body shape diversity, weight bias, and the complexity of weight and health, as well as opportunities for positive intergroup contact with patients of higher weight, show effectiveness in reducing weight bias. In addition, emerging research demonstrates that psychological interventions designed to reduce weight bias internalization are effective [5]. These interventions include acceptance and commitment therapy and cognitive behavioral therapy, and improve mental health outcomes, quality of life, and health behavior engagement. To date, however, the effectiveness of these interventions has not been tested on outcomes related to suicidality or adolescent samples.

One foundational approach for reducing weight stigma involves adopting weight-inclusive models of health that shift focus from body weight and weight loss to health and well-being for people of all sizes [10]. This approach encourages health care professionals to eradicate weight bias in their offices, target internalized weight bias by

helping patients reduce self-blame, look for signs of diminished well-being and disordered eating, and sustain health promoting behaviors by helping patients reconnect with food and their internal bodily cues. The non-maleficent and beneficent perspective of weight-inclusive approaches would likely improve suicide prevention efforts and suicide risk assessment. Weight stigma is a modifiable risk factor. Let us do something about it.

Compliance with ethical standards

Conflict of interest The author declares that she has no conflict of interest.

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