**Title**: Foundations of understanding to challenge the stigma surrounding overweight, obesity, and bariatric surgery

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**Introduction**

Many illnesses are embedded and shaped within cultural meaning, which often influences how society responds to those living with the condition, and peoples’ lived experiences (1) . The social construction of illness may not always be rooted in medical knowledge but lie within the inherent beliefs and attitudes towards the condition, which may not always be positive. For people living with overweight and obesity, there are negative connotations associated with the condition. A higher body weight is a visually apparent condition, meaning immediate value judgements are more likely in terms of assumptions and presuppositions. These attitudes can impact on a person’s quality of life, and lead to stigmatisation. Bariatric surgery is an intervention which is not widely understood by society, and is often perceived as a contested intervention, described as cheating, taking the easy way out, and that surgery does the work, not the patient. These value judgements of bariatric surgery can lead to further stigma, despite the person achieving often significant weight loss (2). Understanding how overweight, obesity and bariatric surgery are socially constructed are key to identifying and being aware of roots of surrounding stigma, and how this can be challenged to support, and reduce discrimination against those living with excess weight who undergo bariatric surgical procedures.

**Defining stigma**

Stigma refers to a perceived negative attribute or characteristic held by society or people, which is discrediting, shameful and devaluing towards those affected , leading to a spoiled identity, and devaluation of that group of people (3). This is generally referred to as explicit stigma or bias where the conscious public or societal judgements of the attribute influence opinions and attitudes (4).

Implicit stigma or bias refers to the unconscious, biased attitudes and behaviours which often occur automatically and in contrast to explicitly held beliefs and without intentional control (5). This means these attitudes may be hidden and the person is not aware that their beliefs and attitude are potentially detrimental to those living with obesity and bariatric surgery, causing unintended harm.

Despite evidence to show that obesity is a complex health condition, with genetic, environmental and physiological factors at play (6), society generally continues to hold people living with overweight and obesity as moral failures, accountable for their condition, with a reductionist view that people should simply eat less and exercise more . The liminal shift from individual culpability to a more complex view of obesity by society remains in statis (7).

Evidence of the existence of obesity stigma has been present for over fifty years and increasing(8), with societal assumptions that people living with a higher body mass are lacking in willpower, undisciplined, culpable for their weight status, lazy and gluttonous (9). Much of this discourse is shaped by the media, perpetuating negative stereotypes (10, 11) when in fact the media could be reinforcing the changing perceptions of obesity (7) and supporting bariatric surgery as an societally acceptable method of weight-loss.

A third form of stigma, internal stigma, occurs when people living with overweight, and obesity accepts the negative weight-based attitudes and stereotypes and attribute these to themselves (12) which can influence help-seeking and lower psychological wellbeing.

**Impact of stigma on people living with obesity and undergoing bariatric surgery in healthcare settings**

Studies have shown that healthcare professionals may hold explicit and implicit bias and stigma towards those living with overweight and obesity (13, 14), although there is acknowledged variation in how weight bias is assessed. Within healthcare settings, evidence shows weight bias is strongly related to patient-professional interactions, decisions about care, treatment compliance and patient outcomes (15). People living with obesity want to be listened to without fear of bias, confident of good interpersonal communication with their healthcare providers (16).

**Points of reflection for bariatric surgical teams**

Weight stigma needs to be eradicated from healthcare settings, to support people to seek help and support without fear of discrimination. Explicit and implicit stigma needs to be addressed and effort made into ensuring all healthcare settings provide a context for care which accommodates and is understanding of those living with obesity. Bariatric surgical teams, with their expertise and experience, are well positioned to, and indeed should challenge stigma from both patients and other healthcare professionals to demonstrate how compassionate and initiative-taking patient care can be provided in a weight-friendly, supportive environment.

As stigma is a social construct, patients may not always feel this is an appropriate issue to raise in healthcare encounters. Bariatric surgical teams should consider how to ask questions in a non-judgemental manner to raise the issue of whether potential impact of weight stigma, especially internalised, into clinical encounters, thereby legitimising the issue of weight stigma, and honouring the individual experience, leading to a greater understanding of how stigma impacts on peoples’ everyday lives.

Care and attention should be made with our patients who have undergone bariatric surgery, to enquire about any stigma or judgements relating to the intervention and offer further support to ensure positive outcomes out with the weight loss.

**References**

1. Conrad P, Barker KK. The Social Construction of Illness: Key Insights and Policy Implications. Journal of Health and Social Behavior. 2010;51(1 suppl):S67-S79.

2. Graham Y, Hayes C, Small PK, Mahawar K, Ling J. Patient experiences of adjusting to life in the first 2 years after bariatric surgery: a qualitative study. Clinical Obesity. 2017:323-35.

3. Goffman E. Stigma: notes on the management of spoiled identity. London: Penguin; 1963.

4. Phelan SM, Burgess DJ, Yeazel MW, Hellerstedt WL, Griffin JM, van Ryn M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. Obesity reviews : an official journal of the International Association for the Study of Obesity. 2015;16(4):319-26.

5. Wyatt R, Laderman M, Botwinick K, Mate K, Whittington J. Acheiving Health Equity: A Guide for Healthcare Organisations. Cambridge: Institute for Health Improvement; 2016.

6. Foresight. Reducing obesity: future choices: project report. 2nd ed. London: The Stationery Office; 2007.

7. Stanford FC, Tauqeer Z, Kyle TK. Media and Its Influence on Obesity. Curr Obes Rep. 2018;7(2):186-92.

8. Puhl RM, Heuer CA. Obesity Stigma: Important Considerations for Public Health. American Journal of Public Health. 2010;100(6):1019-28.

9. Puhl RM, Heuer CA. The Stigma of Obesity: A Review and Update. Obesity. 2009;17(5):941-64.

10. Flint SW, Hudson J, Lavallee D. The portrayal of obesity in UK national newspapers. Stigma and Health. 2016;1(1):16.

11. Heuer CA, McClure KJ, Puhl RM. Obesity stigma in online news: a visual content analysis. J Health Commun. 2011;16(9):976-87.

12. Durso LE, Latner JD, White MA, Masheb RM, Blomquist KK, Morgan PT, et al. Internalized weight bias in obese patients with binge eating disorder: associations with eating disturbances and psychological functioning. Int J Eat Disord. 2012;45(3):423-7.

13. Lawrence BJ, Kerr D, Pollard CM, Theophilus M, Alexander E, Haywood D, et al. Weight bias among health care professionals: A systematic review and meta-analysis. Obesity (Silver Spring). 2021;29(11):1802-12.

14. Alberga AS, Pickering BJ, Alix Hayden K, Ball GDC, Edwards A, Jelinski S, et al. Weight bias reduction in health professionals: a systematic review. Clinical Obesity. 2016;6(3):175-88.

15. Hall WJ, Chapman MV, Lee KM, Merino YM, Thomas TW, Payne BK, et al. Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. Am J Public Health. 2015;105(12):e60-76.

16. Crompvoets PI, Cramm JM, van Rossum EFC, Nieboer AP. Views of patients with obesity on person-centred care: A Q-methodology study. Health expectations : an international journal of public participation in health care and health policy. 2022;25(6):3017-26.