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Executive Summary

This is a written evidence submission to the Health and Social Care Select Committee in response to the call for evidence relating to "the impact of body image on physical and mental health". The areas that this evidence talks to and suggests recommendations that focus on

1. The development, impact and need to address weight stigma and discrimination which is associated with body image concerns and negative self-perceptions
2. The development and impact of body image concerns
3. Recommendations to address weight stigma and discrimination and body image concerns

1. Evidence submitted by Dr Stuart W. Flint

Dr Stuart W. Flint is Associate Professor of Psychology at the University of Leeds, Director of Obesity UK, and President of Scaled Insights. Dr Flint is also an Honorary Academic for Public Health England. He is the Chair of the Obesity Policy Engagement Network (UK), and a contributing member to the All-Party Parliamentary Group (APPG) on Obesity and APPG on a Fit and Healthy Childhood. He contributes evidence to several other APPGs on health and inequalities experiences by marginalised groups. He has a specific interest and expertise in stigma and discrimination, leading work internationally and nationally to highlight the pervasiveness and impact of stigma and discrimination on obesity. He has developed interventions to reduce stigmatising attitudes and discriminatory behaviours working national and local governments, health systems, education, media, charities and the general population. Dr Flint has published widely in high impact journals including the Lancet, Nature and British Medical Journal series.

2. Weight Stigma and Discrimination

The formation of weight stigma attitudes

Weight stigma, typically referred to as negative attitudes towards someone based on weight status (Pearl, 2018), can be experienced by people across the weight spectrum. Indeed, people with a low weight status as well as those with a high weight status experience weight stigma – however, due to the societal focus, framing of obesity and indeed, the rhetoric used across all levels including Government policy, media portrayal, and education weight stigma is most commonly directed towards people with a higher weight status, falling within the overweight or obesity weight ranges. Weight stigma in the UK is pervasive.

People living with overweight or obesity are disrespected, stereotyped, openly stigmatised and are discriminated against. Whilst weight stigma attitudes is higher in some subgroups compared to others (e.g. younger adults compared to older adults), it is reported by people of all backgrounds and is both implicit and explicit (Flint et al., 2015). People with overweight and obesity report weight

stigma and discrimination on almost a daily basis, and is experienced across many settings including healthcare (Flint et al., 2021; Flint, 2015; Puhl & Suh, 2018) workplaces (Flint et al., 2016; Han et al., 2011; Täuber et al., 2018) and education settings (Langford et al., 2022; Nutter et al., 2019; Pont et al., 2017). Weight stigma is also experienced at the home from family and friends (Himmelstein et al., 2018; Vartanian et al., 2014) and a consistent and insidious source of weight stigma is media portrayal (Baker et al., 2020; Flint et al., 2016; Flint et al., 2018).

Given the rise in social media, experiences of weight stigma and indeed, influencers of body image concerns arise from content on these platforms (Lydecker et al., 2016; Jeon et al., 2018). For instance, within a 4-hour timeframe of tweets on the social media platform twitter, 4596 tweets were identified as that used the word "fat" of which 57% were negative including the stereotypes gluttony (48.58%), unattractive (25.14%), not sexually desirable (2.65 %), sedentary (13.80 %), lazy (5.86 %), and stupid (4.16 %) (Lydecker et al., 2016).

The role of policy cannot be understated in contributing to the development of weight stigma and discrimination with the majority of UK obesity policies focused on individual level solutions (Theis et al., 2020) which does not consider the complex, multifactorial nature of weight gain and obesity as demonstrated in the UK Government commissioned Foresight Report (2007) which evidenced over 100 different factors that contribute to obesity, many of which are outside of a person's control. Indeed, the framing and rhetoric of policy including healthcare policy has been highlighted as stigmatising, with clear differences in the way that policies are framed compared to other health conditions (Flint, 2021).

Key elements of weight stigma and discrimination is a the dominant societal message that people are fully individually responsible for their weight status, that weight can easily and rapidly be reduced, and that people should be valued and judged based on their weight status and appearance. This leads to blame, a belief that weight is controllable – importantly, research has demonstrated that stronger beliefs that weight is controllable is associated with higher weight stigma attitudes (e.g., Flint et al., 2015; Puhl et al., 2008), and negative emotions and perceptions of people with overweight and obesity; research has shown that disgust, contempt and hatred are commonly directed towards people with a higher weight (e.g., Rinaldi et al,., 2020; Wirtz et al., 2016; Vartanian et al., 2010).

The seriousness of weight stigma

Weight stigma and discrimination has been consider unimportant for decades, and even today, media portrayals that continue to ask if weight stigma is beneficial (questions often posed are 'is fat shaming beneficial?') and in many instances encourage weight stigma (e.g. suggesting that workplaces should discriminate people based on their weight).

To truly understand the importance of weight stigma and discrimination there is a need to consider

1) what these experiences represent

These experiences are bullying, teasing, victimisation, harassment and maybe both direct and indirect – all of which are part of the description of discrimination in the **Equality Act (2010)**. These experiences may be verbal, emotional and physical.

2) the impact of weight stigma and discrimination

There is vast empirical evidence that demonstrates that experiences of weight stigma and discrimination are associated with increased mental and physical health concerns including increased body image concerns, body shame and guilt, depression and anxiety, compromised psychosocial wellbeing, reduced self-esteem and self-concept, and increased cardio-metabolic risk

factors (e.g., Himmelstein et al., 2018; Hunger et al., 2015; Jackson et al., 2015; Papadopoulos & Brennan, 2015; Selensky & Carol, 2021; Wott et al., 2010; Wu et al., 2018).

Experiences of weight stigma and discrimination are also associated with maladaptive behaviours, which is contrary to the popular rhetoric that these experiences increase motivation and engagement in healthy behaviours. For instance, weight stigma and discrimination experiences are associated with avoidance or delay in healthcare seeking behaviour, avoidance of physical activity or exercise settings, withdrawal within the workplace, and disordered eating behaviour (Mensinger et al., 2018; O'Brien et al., 2016; Pont et al., 2017; Puhl & King, 2013; Vartanian & Novak, 2011).

Weight stigma experiences have also been associated with an increased risk of mortality, independent of a person's weight status (Sutin et al., 2015). Thus, the experience of weight stigma specifically irrespective of whether a person has a lower or higher weight increases risk of mortality – and thus, experiences of bullying, harassment, victimisation that leads to increased physical and mental health concerns increase risk of mortality. **Weight stigma and discrimination is therefore an independent risk factor – and by irradicating weight stigma and discrimination this can reduce the mental and physical health concerns and indeed, reduce the risk of morality that is associated with these experiences.**

Finally, exposure to weight stigma which can be continuous such as the almost daily weight stigma in media, and experiences of weight stigma and discrimination can lead to internalisation of weight stigma (often referred to as weight bias internalisation). Internalising weight stigma refers to the process of directing weight stigma towards oneself which is also a key contributor to the development of mental health concerns including body image concerns and reduced self-confidence (Latner et al., 2014; O'Brien et al., 2016; Puhl & Pearl, 2018).

Weight stigma across the life course

From an early age, children are exposed to sources that promote and encourage weight stigma attitudes, stereotypes and judgments about body shape and size. Research has identified that children as young as 3 years old report concerns about body image and are aware of stereotypes about people with a higher weight status such as laziness, slow and gluttony (Cramer & Steinwert, 1998; Spiel et al., 2012). Stigmatising experiences and further stereotyping of people with a higher weight status including children, parents and fictional characters continue to be reported in primary school aged children (5-11 years) where stereotypes including lacking friends and being socially inept, and clumsy are reported and are identified as part of bullying and teasing incidents. In secondary school (11-18 years) children report stereotypes of lacking intelligence, being physically unattractive, unhygienic and weak willed, and in later teenage and young adults, stereotypes of being sexually unattractive are reported. Adolescents report experiences of bullying, harassment and victimisation which are both verbal and physical and are experienced in person as well as through online/virtual platforms (Mannan et al., 2016; Waasdorp et al., 2018). These stereotypes are persistent throughout childhood, adolescence and into adulthood, where these stereotypes often strengthen due to the continuous and consistent exposure to these stereotypes, stigmatising and discriminatory portrayal and in some instances experiences. Indeed, the most commonly reported reason that children report instances of bullying and teasing relate to body shape and size.

In adulthood, weight stigma and discrimination continues with experiences in workplaces where for instance, people with overweight or obesity experience direct and indirect stigma from colleagues and management, maybe overlooked at the recruitment phase or in promotion rounds (e.g. Flint et al., 2016), and may experience lower starting salaries, are assessed as being less qualified, and work longer hours than healthy weight counterparts (Baum & Ford, 2004; Han et al. 2011). People with overweight and obesity are perceived as possessing less leadership qualities compared to healthy weight counterparts (O'Brien et al., 2008; Flint & Snook, 2014).

In healthcare, people report stigma from professionals including but not limited to GPs, nurses, dietitians, psychologists, physiotherapists and trainee students (e.g., Kristellor et al, 1997; O'Keefe et al., 2020; Phelan et al., 2015; Swift et all., 2013). Thus, healthcare professionals are not immune to weight stigma attitudes and behaviours. Research has demonstrated that clinicians openly stigmatise and discriminate people with overweight or obesity, overlook people for referral to weight management services, report that supporting people with a higher weight is a greater waste of their time compared to healthy weight counterparts, a lack of respect and dignity towards people with a higher weight, and that they are ambivalent about how to support people with a higher weight (e.g., Flint et al., 2021; Kristellor et al., 1997; Price et al., 1987; Phelan et al., 2015; Puhl & Suh, 2018). Experiences of weight stigma and discrimination in healthcare settings leads to avoidance or delay in healthcare seeking behaviours and reduced trust in healthcare professionals.

4. Body image, self-perception and weight stigma

Children, young people and increasingly vulnerable groups are exposed to a range of factors that influence the development of body image concerns, self-loathing and reduce self-esteem that lead to increased the risk of self-harming, lowered confidence, and engagement in healthy behaviours (Grossbard et al., 2009; O'Dea, 2012; Mellor et al., 2010).

Body image concerns are associated with 'weight control behaviours' including amongst primary school aged children (Pursey et al., 2021; Wardle et al., 2006). Exposure to body shape, size and appearance related media is contributing the high level of body anxiety, self-shaming, low body esteem and self-harming, as well as engagement in dieting related practices and over-exercising as a means to lose weight (Bartlett et al., 2008; Franchiina & Coco, 2018). Body concerns and negative perceptions of self and others appearance have been reported by children as young as three years old. Research has reported that children at this age are reporting body image concerns, stereotypes relating to body shape and size, and show biases towards children, adults and TV characters based on their body size. These stereotypes reflect those viewed in media portrayals relating to weight (both desire for thinness and stigmatisation of overweight and obesity). Children that are most likely to have suffer from body image concerns include high perfectionism, internalised appearance ideals, and low self-esteem (Nichols et al., 2018).

The increasing need amongst in particular, adolescents and younger people for approval from others often seen through social media platforms is a major concern (Hogue & Mills, 2019; Marengo et al., 2018; Saiphoo & Vahedi, 2019). Young people in particular are posting pictures of themselves many of which with an intention to meet societal standards of 'beauty' and subsequently, a hope that others will 'like' those images. Receiving this approval is viewed as extremely positive and when a lot of approval is received, and is something that is celebrated by the recipient. Indeed, influencers and celebrity figures will highlight how many 'likes' they have received almost like a badge of honour, and these discussions are often seen in the public including children and young people which is particularly pertinent to those looking for social recognition. Unfortunately, when young and vulnerable people do not receive this approval, it often leads to a negative emotional responses negative self-perceptions and self-devaluation – as well as increased desire to continue posting new images that may lead to a more vulnerable position that can and in some instances is exploited.

Research evidence has also demonstrated that contributors to perceptions of weight status, and body image concerns are the toys that children engage with (Worobey & Worobey, 2014; Boyd & Murnen, 2017). Overtime, the body shapes and sizes that children are exposed to have become more unattainable. Popular toy dolls such as barbie and ken dolls have changed in shape, barbie becoming smaller and ken more muscular, over time. Norton et al. (1996) reported that the probability of girls having a body shape akin to barbie was 1 in 100,000, whilst for boys having a body shape like ken, it was 1 in 50. Children exposed to images of the barbie doll reported lower body esteem and greater desire to for thinness compared to dolls that reflect the average female

body size (Dittmar et al., 2006). Thus, epitomizing an unrealistically thin body ideal may damage girls' body image, which would contribute to an increased risk of disordered eating and weight cycling. Likewise, action figures have become more muscular and lean over time (Baghurst et ., 2006), and for those children who played with the unrealistic action figures reported lower body esteem (Bartlet et al., 2006).

5. Recommendations

1. There is a need to intervene with media portrayal. It is recommended that efforts are made to work with the media to change its agenda relating to body shape and size and in doing so, do not contribute to lowered self-esteem, body confidence and increased risk of self-harming.
2. It is vitally important social media platforms take greater responsibility for the role of their platforms in the development and maintenance of body image concerns, weight stigma and discrimination and indeed, the impact that these experiences have on mental and physical health as outlined above. Recommended actions include restriction on children's use of social media and second, that children who meet the minimum age restrictions for social media – but where this is under the age of 18 years – are not able to access information that might increase body image concerns and other inappropriate content. Research evidence demonstrates that children are using social media in particular sites such as Instagram to 'learn' and follow actors/actresses and members of the public and in doing so, are exposed to body related information. Many of the people, pages and advertisements that children and young people access are based on unsubstantiated information and are not based on empirical evidence nor are many of the influencers, celebrities or people who communicate through these platforms qualified to advice, support or in some instance deliver services that are related to appearance, cosmetic procedures or surgery, eating behaviours, use of supplements, 'dieting', weight management and physical activity/exercise – these can be extremely dangerous and can lead to further harm and damage.
3. There is a need for schools and education centres to review current anti-bullying policies to ensure that they include experiences of stigma and discrimination relating to appearance, body size and shape.
4. It is recommended that NHS provide greater support for people experiencing who have internalised weight stigma. This should include services such as weight management and obesity services that are designed to support people with overweight or obesity as well as eating disorders services.
5. There is a need to reconsider the framing and rhetoric of public health policies including those focused on obesity. Weight stigma is often implicit and as such, unintentionally, policies that continue to focus on individual level change, simplifying weight to messages such as 'eat less, move more' are contributing to the development of weight stigma attitudes and behaviours.
6. There is a need to develop staff training relating to body image concerns and weight stigma for people working in healthcare including GPs, nurses and dietitians. Given the impact of experiences of weight stigma in healthcare, there is a need to train healthcare staff to avoid stigma and provide more effective, empathetic and compassionate support that is devoid of judgement and discrimination.
7. There is a need to develop weight inclusive settings including in healthcare which means addressing weight stigma and discrimination amongst healthcare professionals and considering the physical environment of healthcare.
8. For healthcare professionals supporting people with overweight or obesity, there is a need to provide education about the complex, multifactorial nature of weight gain and obesity, as well as ensuring that healthcare professionals are able to support and where relevant refer people appropriately.

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