To Truly Reduce Weight Stigma and Eating Disorder Risk, We Need to Stop Promoting Weight Loss

To the Editor:

We are writing to address several points made by Cardel and colleagues[1] in their Research Commentary, "Patient-Centered Care for Obesity: How Health Care Providers Can Treat Obesity While Actively Addressing Weight Stigma and Eating Disorder Risk." Their purpose was to demonstrate that we can treat obesity while avoiding weight stigma and eating disorders and bridge the often-opposing fields of obesity and eating disorders. However, having extensive experience as clinicians and scientists in both fields, we believe that obesity treatment's focus on weight loss is a direct contributor to weight stigma and a gateway to eating disorders.

First, the authors state that obesity and eating disorder treatments both "actively promote diet quality without restriction." However, a key tenet of obesity treatment is caloric restriction.[2,3] Lower-calorie foods and small food portions are promoted to create the caloric deficit necessary to lose weight. This is antithetical to eating disorder treatment, which opposes caloric restriction and emphasizes renourishment, regulation of eating patterns, and increasing caloric intake, when necessary, for weight restoration.[4,5] We agree that both treatments regulate eating patterns, but unless the weight-loss focus is eliminated, caloric restriction remains a part of obesity treatment.

Second, there is strong empirical evidence showing long-term weight loss is not possible for most, even when receiving supervised obesity treatment. Studies show that 80% to 90% of individuals are not able to maintain weight loss after 1 year,[6,7] and a meta-analysis of obesity treatments showed that more than 80% of weight lost was regained after 5 years.[8] Despite the authors' statement that it is unethical to withhold treatment if a patient desires to lose weight, prescribing treatment with a low success rate is harmful and leads to weight cycling.[9] A result of weight cycling is an increase in internalized weight stigma, increases in shame, and poor overall health outcomes.[9-11] Furthermore, we cannot disentangle the desire to lose weight from the influence of diet culture, in which thin is ideal and weight stigma is pervasive.[12] Diet culture messaging often overlooks factors outside the control of the individual, such as genetics, institutional racism, and food insecurity, which impact weight, eating disorder risk, and health.[13-15]

Third, we agree with the statement that "many behavioral changes can improve health in the absence of weight loss, such as increases in physical activity and consumption of fruits and vegetables, and improvements in sleep and stress management." If these were the primary targets of treatment instead of weight loss, weight stigma and eating disorder risk would be lower.[16] However, achieving this requires shifting toward adoption of a weight-inclusive paradigm, which assumes that health is achievable regardless of weight and that all patients are given access to non-stigmatizing care.[16,17] Weight is not viewed as the treatment target or a behavior to change, and treatments consider a patient's social and environmental context.[16,17] To truly offer a patient-centered approach to health care that lowers the risk for weight stigma and eating disorders, we need to change the existing weight-centric paradigm and stop promoting weight loss.

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