



# Weight Stigma in Youth: Prevalence, Consequences, and Considerations for Clinical Practice

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## Abstract

**Purpose of Review** This review summarizes recent evidence on weight stigma experienced by youth with overweight or obesity. We examine the prevalence and sources of weight-based victimization targeting youth, consequences of these stigmatizing experiences for their psychological and physical health, and considerations for addressing weight stigma in clinical practice and pediatric care.

**Recent Findings** Weight stigma is highly prevalent among youth with high body weight, who are targets of weight-based victimization from peers, parents, and teachers. These experiences place youth at risk for psychological distress (primarily depressive symptoms, low self-esteem, and suicidal ideation), worse social and academic outcomes, and adverse physical health consequences including maladaptive eating behaviors, lower physical activity, substance use, and weight gain.

**Summary** Healthcare professionals and clinicians have important roles to play in efforts to help reduce weight stigma and support youth with obesity. Fundamental to these efforts is the use of supportive, compassionate, and non-stigmatizing communication with youth and their families.

**Keywords** Weight stigma · Bullying · Teasing · Victimization · Youth · Adolescence

## Introduction

For more than 60 years, researchers have documented societal stigma, prejudice, and discrimination toward people with obesity who deviate from stringent societal ideals of thinness. Individuals with overweight or obesity are negatively stereotyped as being lazy, lacking willpower and self-discipline, unmotivated to improve their health, and personally to blame for their weight [1]. Reinforcement of these inaccurate stereotypes in multiple societal settings, coupled with a lack of systematic efforts to challenge and counteract these views, has created a foundation for social disapproval, stigma, and unfair treatment of people with obesity [2]. Despite increased

attention to the prevalence of weight stigma [3] and harmful consequences [4], obesity remains a highly stigmatized disease.

Many people who experience weight stigma are exposed to it throughout their lifetime, including the vulnerable developmental periods of childhood and adolescence. For youth, experiences of weight stigma can be particularly damaging, with long-lasting consequences that negatively affect their life course emotional and physical well-being. Weight stigma in youth occurs most frequently in the forms of teasing and bullying about body weight. This narrative review summarizes recent evidence (published in the last 5 years) of weight-based teasing and bullying (also called “weight-based victimization”; WBV) experienced by youth and adolescents with overweight or obesity. We examine recent prevalence rates of WBV toward youth, including groups of youth who may be particularly vulnerable to these experiences and the most common interpersonal sources of WBV (peers, family members, and teachers). We also examine recent evidence linking WBV with adverse outcomes in youth, including psychological distress, social and academic consequences, and worsened physical health. Finally, we consider these issues in the broader context of pediatric obesity care, where weight stigma is also

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present and where there are important and much-needed opportunities for pediatric providers to reduce weight stigma in clinical practice and increase support for youth with obesity.

## Prevalence of Weight Stigma in Youth

Weight stigma is highly prevalent in the lives of youth across sociodemographic groups. Across samples of adolescents [5], teachers [6], and adults across countries [7], body weight is consistently reported to be the primary reason youth are teased and bullied. In the USA, a large sample of ethnically diverse adolescents ( $N=162,034$ ) found that girls and boys were more likely to be bullied for their weight or physical appearance than for their race/ethnicity, sexual orientation, or disability status [8]. Recent prevalence estimates indicate that nearly a quarter to a half of all youth have been bullied for their body weight [8, 9, 10, 11], and 13 to 32% of youth report that they have been discriminated against based on their weight [12, 13].

Weight-based mistreatment is especially common among youth with high body weight [8, 14]. A nationally representative sample of US second graders ( $N=18,130$ ) found that those with overweight or obesity had a 32% greater chance of being verbally bullied by peers than their counterparts without overweight or obesity [15]. These weight-related disparities in mistreatment also manifest in adolescence; middle and high school students with obesity are 66% more likely to cyberbullied [16]. Cross-national work has paralleled these findings, showing that girls and boys with overweight or obesity are more likely to be made fun of because of their physical appearance than those with “normal” weight [17] and are also bullied on a more frequent basis [18]. Longitudinal evidence further underscores the heightened risk of mistreatment among those with high weight. Specifically, adolescents whose weight remains high across middle school report both the highest levels and steepest increases in peer victimization [19].

In addition to higher body weight, research has linked certain sociodemographic factors to a heightened vulnerability of experiencing WBV. Notably, compared to heterosexual youth, those who are identified as LGBQ (i.e., lesbian, gay, bisexual, questioning) are disproportionately targets of weight-based bullying, irrespective of their weight [8]. A recent study of diverse sexual and gender minority (SGM) adolescents in the USA ( $N=9838$ ) found that rates of WBV from peers and family were greater than 50% [20]. Additionally, gender differences in weight-related mistreatment among youth have been frequently examined in studies; however, these findings remain mixed. In general, girls have been found to experience more weight stigma, as evidenced by higher rates of weight teasing among girls as compared to boys [9, 11, 21]. Yet, other studies have found boys to be more

frequently teased about their weight by peers [5]; and still others have documented no gender differences in the rates of peer weight-based discrimination [13].

Relative to gender, considerably less research has examined racial/ethnic differences in weight-based mistreatment, and existing evidence has yielded mixed findings. While some studies suggest similar rates [13] and consequences [22] of weight-related mistreatment, other evidence indicates dissimilarities across racial/ethnic groups. For example, nationally representative data from the US based Early Childhood Longitudinal Study ( $N=18,130$ ) documented that white children (second graders) with overweight or obesity were more likely to experience verbal bullying compared to their Hispanic counterparts [15]. Among adolescents, a diverse population-based study in the USA ( $N=1577$ ) found that Hmong boys and girls were more likely to report weight teasing from family members than those who were Latinx, Somali, and white [22]. Thus, whereas current evidence underscores youth with high body weight and those who are identified as a sexual minority to be especially vulnerable to weight-related mistreatment, more work is needed to better understand differences in stigma based on gender and race/ethnicity.

## Sources of Weight Stigma

Peers are among the most prevalent sources of weight stigma [5]. As early as age four, children possess negative biases and judgments of their peers with high weight [23]. Young children report preferring to be friends with “normal” weight story book characters compared to story book characters with overweight, whom they judge even more negatively than those in a wheelchair [23]. Among first graders living in rural Oklahoma ( $N=1164$ ), those with obesity were rated by their peers as less popular and were the least preferred playmates relative to those with lower body weight [24]. A recent study of 367 children (aged 7 to 14 years) found that youth rate photographs of children with high body weight more negatively than those of average or thin weight [25]. Such negative biases and attitudes persist in adolescents, especially following exposure to stigmatizing television content [26]. Thus, across developmental periods, children and adolescents are vulnerable to negative weight-related judgment and stigma from peers.

Weight bias among teachers has also been established in the literature [27]. Recent experimental research shows that teachers assign lower grades to students with overweight relative to their “normal” weight counterparts for comparable school work [28]. Notably, these biases are not only implicit, but also explicit [29]. For example, in a qualitative study of 22 K-12 teachers in the USA, the majority reported believing that obesity is associated with reduced school performance [21].

Another recent study of US middle and high school educators ( $N = 246$ ) found that more than half endorsed assumptions that those with high weight are “slow” and have “no endurance” [30]. Such overt weight bias is noticeably recognized by youth themselves. Indeed, adolescent girls with obesity indicate that they feel ignored and unsupported by their physical education (PE) teachers [31].

Beyond the school setting, youth are additionally vulnerable to negative weight-related judgments and mistreatment at home. Parents have been identified as a main source of weight stigma among youth. Among a large national sample of LGBTQ (i.e., lesbian, gay, bisexual, questioning, transgender) adolescents in the USA ( $N = 9261$ ), over half (54.6%) reported being teased or made fun of by family members because of their weight [32]. Similarly, a recent study of adolescent military dependents ( $N = 128$ ) found that more than 1-in-5 were teased about their weight by their parents [33]. Such vulnerability to familial weight teasing aligns with research documenting parents’ negative biases against children with high weight. Not only have parents been shown to implicitly associate “fat children” with negative words (such as “bad” and “stupid”), but one study of parents ( $N = 658$ ) found that nearly all (93%) moderately or strongly agreed with at least one explicit weight bias indicator (e.g., “One of the worst things that could happen to a child would be for him to become obese”) [34].

## Consequences of Weight Stigma for Health and Well-Being

### Psychological Distress

The prevalence of weight stigma—and its manifestation across multiple interpersonal sources—is highly problematic due to the harmful toll it takes on the psychological health of children and adolescents. Evidence has documented elevated depression, anxiety, body dissatisfaction, and lower self-esteem among youth who are teased or bullied about their weight [13, 22, 33, 35]. These associations are maintained after accounting for factors such as age, sex, and BMI and are consistent across weight stigma sources. For example, one recent study found that adolescent military dependents ( $N = 128$ ) teased by family members about their weight have lower self-esteem and more depressive symptoms, over and above BMI [33]. Additionally, even if youth are not being targeted themselves, exposure to weight stigma is psychologically taxing. For example, girls (but not boys) exposed to greater weight-related teasing content on TV feel more dissatisfied about their bodies, regardless of their weight status [36].

Particularly concerning are the risks of self-intentional harm and suicidality associated with WBV. The odds of engaging in self-mutilation (i.e., physically hurting oneself) and

suicidal behaviors are approximately double among adolescent males and females who have experienced unfair treatment based on their body weight [37]. Recent evidence implicates victimization as the mechanism linking high body weight to suicidality. Specifically, among a large sample of adolescents in the Netherlands ( $N = 13,740$ ), bullying at school was found to mediate the association between overweight (and obesity) and suicidal thoughts [38•]. That is, youth with high body weight think about ending their life more often in part due to their elevated risk for victimization.

Increasing longitudinal research emphasizes the stigma of weight, rather than weight itself, as the origin of psychological distress. For example, cross-lagged prospective models of data from the Quebec Longitudinal Study of Child Development ( $N = 1042$ ) revealed that weight status and loneliness are not associated concurrently, but that youth with high weight become lonelier over time [39]. This distress has been shown to develop by way of social mistreatment. For example, a study of ethnically diverse middle school students in the USA ( $N = 5128$ ) found that, after accounting for baseline distress, those with higher BMI in the sixth grade became increasingly socially anxious, dissatisfied with their bodies and lonelier by eighth grade due to more frequent weight discrimination by their peers [13•]. Without such social mistreatment, youth with high weight are unlikely to experience elevated distress. Indeed, longitudinal findings across 26 urban California middle schools show that girls ( $N = 2101$ ) and boys ( $N = 1985$ ) with higher BMI experienced increased social-emotional problems only in schools where students with high body weight are vulnerable to victimization [40]. Given established links between obesity and adverse psychological functioning (such as depression) in youth [41], additional longitudinal studies are warranted to determine and clarify the role of WBV as an underlying mechanism in this relationship.

The psychological consequences of weight-based mistreatment may be partly driven by “weight bias internalization” (WBI), or the process of acknowledging negative weight-based stereotypes and applying these to oneself, engaging in self-blame and self-devaluation for weight. When youth are teased or bullied for uncontrollable and/or stable personal characteristics, such as body weight, they are more likely to blame themselves for such mistreatment in ways that heighten corresponding distress [42]. Thus, given that research on the consequences of engaging in self-stigmatizing processes have focused predominantly on adult samples [43], investigating the role WBI plays in the development of psychological distress among youth is likely to be an important target for future research.

### Social and Academic Consequences

Weight stigma also takes a toll on youths’ social lives. As early as first grade, children with severe obesity experience

greater rejection by their peers and are least likely to be popular relative to those with “normal” weight [24]. Such social challenges persist across development, with evidence from the National Longitudinal Study of Adolescent Health ( $N=14,935$ ) demonstrating that adolescents with overweight are less socially accepted and have fewer friends compared to their non-overweight counterparts [44]. The friendships that adolescents do have are less emotionally supportive among those aged 15 to 17 years old [45]. Furthermore, data from the Victoria Healthy Youth Survey ( $N=662$ ) indicate that youth with overweight are half as likely to be in a current romantic relationship between the ages of 15 and 21 [45]—a time when establishing supportive romantic relationships is a key developmental task. Recent evidence implicates weight stigma as the root of such social difficulties. Specifically, among a sample of adolescent military dependents, over and above BMI, weight teasing was associated with greater social difficulties across multiple interpersonal domains (e.g., friends, romantic relationships) [33].

These negative social experiences largely account for the academic consequences of weight stigma [27, 46]. A study across 26 urban California middle schools found that students with higher BMI performed worse on standardized test scores only when they attended schools where weight stigma may be heightened (i.e., schools with little body weight diversity among students) [47]. Reinforcing that academic difficulties stem from weight stigma rather than weight itself, a systematic review on obesity and academic achievement pointed to psychosocial experiences such as weight-related bullying mediating the association between obesity and academic achievement [31]. Recent findings similarly indicate that sexual and gender minority (SGM) adolescents ( $N=17,112$ ) who were bullied more frequently for their weight received lower grades, even after accounting for BMI [48]. Frequent bullying and negative evaluation from peers due to one’s weight may discourage classroom engagement and exhaust cognitive resources in ways that impair academic functioning. Indeed, K-12 teachers report that students with high weight participate less in class to avoid potential added ridicule from peers [21]. Related experimental evidence among 600 children (aged 8 to 11 years) suggests that weight-based stereotypes hamper executive functioning (i.e., working memory) [49]. Moreover, even youth not directly targeted experience impaired school adjustment due to weight stigma. For example, one study found that adolescent boys ( $N=1985$ ) attending schools with a negative weight climate (i.e., where high weight increases risk of peer victimization) had a lower sense of school belonging, regardless of their body weight or personal victimization experiences [40]. Thus, weight stigma at school has the potential to harm academic well-being across youth of all body weights and sizes.

## Physical Health Consequences

Adverse health implications for youth who experience WBV include maladaptive eating behaviors, weight gain, lower physical activity, and substance use. Similar to the literature examining weight stigma and psychological distress, studies assessing links between WBV and health behaviors in youth typically account for BMI, suggesting that negative physical health consequences stem from WBV rather than obesity per se.

### Maladaptive Eating Behaviors

A recent meta-analysis of 22 studies examining associations between eating disorders and bullying/teasing found that individuals with eating disorders were 2–3 times more likely to have been teased or bullied about their appearance prior to the onset of their disorder [50]. Additionally, a systematic review examining correlates of binge eating in childhood found that weight-related teasing in families was a consistent correlate of binge eating in children [51]. Cross-sectional studies have consistently demonstrated these associations in diverse samples of youth for a range of eating behaviors, such as binge eating [52] and disordered restrictive eating [53]. For example, in SGM adolescents ( $N=9679$ ), WBV from peers and family members were both associated with maladaptive eating (binge eating, unhealthy weight control behaviors) and dieting, and these relationships remained after accounting for BMI, age, sex, race, and gender/sexual identity [52]. In addition, recent evidence has documented links between eating pathology and experiences of weight stigma among adolescents from low-income backgrounds [54] and adolescent military dependents [33], even after accounting for BMI [33]. Of concern, these associations are present for even younger children, as a recent Canadian study of 874 children (8–12 year olds) showed that WBV mediated the relationship between BMI and disordered eating behaviors for both girls and boys [55].

Longitudinal evidence from US studies indicates that experiences of weight stigma may have concerning implications for eating behaviors that persist over time. Findings from Project EAT-IV (the Eating and Activity in Teens and Young Adults study) demonstrated that weight teasing in adolescence ( $N=2516$ ) predicted higher odds of binge-eating and unhealthy weight control behaviors for females and eating to cope with stress in both females and males, 15 years later in adulthood. These findings remained after accounting for baseline weight status, age, race/ethnicity, and SES [9]. Similarly, a study of adolescent girls ( $N=2036$ ) found that those who were called “too fat” by others at age 14 had increased odds of engaging in unhealthy weight control behaviors 5 years later compared to girls who were not labeled as “too fat”; findings persisted after accounting for BMI, race, SES, and baseline



eating behaviors [56]. Jendrzyca and Warschburger found evidence of longitudinal associations between weight stigma and maladaptive eating behaviors even in younger children (ages 6–11;  $N=1486$ ); experiences of weight stigma in girls (but not boys) predicted external and restrained eating 1 year later [57]. Outside of the USA, data from the Longitudinal Study of Australian Children found that, among 14–15 year olds ( $N=2955$ ), those who reported weight mistreatment in the last 6 months were more likely to report unhealthy dieting behaviors (loss of control over eating, extreme weight loss behaviors such as vomiting or using medicine to control weight or going all day without eating) [58]. In addition, longitudinal data of 685 female twins from the Australian Twin Registry reported that as weight-related peer teasing increased, both genetic and environmental influences on disordered eating strengthened, especially for genetic sources, suggesting that weight teasing is a risk factor that moderates genetic vulnerability for disordered eating [59].

Finally, just as with psychological distress, youth may be vulnerable to maladaptive eating behaviors if they internalize weight stigma. Among adolescents with obesity, weight bias internalization (WBI) has been linked to binge eating [60, 61] and eating to cope with stress [60]. In adolescents with binge eating disorder, recent evidence showed that parental weight teasing was associated with eating disorder pathology but that WBI fully mediated this relationship [62]. Among younger children, a 2-year longitudinal study of over 1000 German children (ages 7–11) found that both experiences of weight teasing and WBI were associated with higher levels of restrained eating (regardless of weight and gender); and these forms of weight stigma mediated relationships between weight status and restrained eating, independent of gender or weight status [63]. This recent evidence indicates that more attention is warranted to determine the role of WBI in unhealthy eating behaviors.

### Weight Gain

Recent longitudinal evidence points to an increased risk of weight gain for youth who experience WBV. In a recent study of youth at risk for overweight or obesity ( $N=110$ ), those who reported weight teasing at baseline experienced a 33% increased gain in BMI and 91% increased gain in fat mass 8 years later compared to youth who were not teased about their weight [14]. Findings from Project EAT suggest that implications of weight gain may be particularly long lasting, as 15-year longitudinal associations were observed between weight teasing in adolescence and increased risk of obesity in adulthood for both females and males, even after accounting for baseline weight and demographic characteristics [9•]. Moreover, an examination of 1147 girls from Project

EAT who were followed for 10 years found that those who reported being bothered by weight teasing at baseline had higher BMIs at follow-up compared to girls who reported no weight-teasing or not being bothered by this teasing [64].

While very little research has studied links between WBV and weight loss in youth, a systematic review examining motivations for weight loss in adolescents with overweight or obesity found that avoiding bullying was one of the main motivations that adolescents identified for weight loss [65]. This may have implications for unhealthy weight loss behaviors, as evidence from the National Health and Nutrition Examination Survey found that among youth attempting to lose weight ( $N=6117$ ), those who were motivated to lose weight because of teasing were more likely to engage in unsafe weight loss behaviors than youth who wanted to lose weight for reasons of improved health or sports performance, who were more likely to engage in healthier weight loss behaviors [66]. Much more work is needed to determine if WBV plays a role in weight loss outcomes for youth and adolescents.

### Physical Activity

Comparatively less research has examined links between WBV and physical activity in youth, and the handful of recent studies in this area has documented somewhat mixed findings. In a recent study of 334 treatment-seeking adolescents with obesity, those who reported less frequent weight-related teasing were more confident and determined to overcome challenges and be physically active than adolescents who reported more frequent teasing about weight (findings remained after controlling for demographics and BMIz scores) [67]. Similarly, Maiano and colleagues found that among adolescents with obesity ( $N=144$ ), those who reported more frequent WBV while participating in school-based physical activities had lower levels of perceived physical education (PE) performance and perceived physical abilities, which were in turn related to lower perceived PE performance and lower involvement in physical activities outside the school setting [68]. Results remained after accounting for sex and age. In contrast, other studies have failed to observe significant relationships between weight teasing and physical activity in youth [69] or have reported mixed findings, such as a study of 4–5th grade students ( $N=307$ ) showing that weight criticism during physical activity was associated with more negative attitudes toward physical activity, but not lower engagement in physical activity [70]. These mixed findings highlight the need for more research to determine the extent to which WBV affects physical activity in youth and whether factors like weight status, age, or gender may play a role in this relationship.

## Substance Use

While studies assessing links between substance use and WBV in youth are scarce, four studies published since 2019 suggest that WBV has negative implications for substance use. In a recent study of 1344 children (11–14 years old), those who reported more frequent appearance-related teasing reported greater increases in total alcohol consumption and binge-drinking frequency (but not marijuana use) 1 year later. Findings remained after accounting for age, gender, race/ethnicity, BMI, depressive symptoms, and substance use at baseline [71]. Among SGM adolescents ( $N=9838$ ), WBV was significantly associated with increased odds of alcohol use, binge drinking, marijuana use, and cigarette use, independent of adolescents' age, race, BMI, sexual identity, gender identity, and geographical location [72]. Among adolescent girls in Project EAT ( $N=1147$ ), unhealthy weight control behaviors at baseline predicted substance use at 10-year follow-up only for girls who had reported being bothered by weight teasing at baseline, but not for girls who reported no teasing or not being bothered by teasing [64]. Finally, Sutin and colleagues found that adolescents ( $N=2955$ ) enrolled in the Longitudinal Study of Australian Children who reported being treated unfairly because of their body size or shape in the last 6 months were more likely to report trying nicotine, alcohol, and marijuana, and there was little evidence that gender or BMI moderated these associations [58]. Collectively, this initial evidence suggests that attention to substance use is warranted as a potential consequence of WBV in youth.

## Considerations for Clinical Practice and Pediatric Care

Increased recognition of the prevalence and harm of weight stigma have led to recent calls for the medical field to take active steps to reduce weight stigma in the clinical care environment. In 2017, the American Academy of Pediatrics published the first policy statement on weight stigma in youth with obesity, highlighting clinical practice recommendations for pediatricians to model best practices for nonbiased behaviors and language, use empathetic counseling strategies, assess weight stigma and bullying during clinic visits, advocate for training and education about weight stigma, and empower families to address weight stigma in the home and school settings [73•]. More recently, in March 2020, the first international consensus statement on weight stigma was endorsed by more than 100 medical and scientific organizations worldwide, who have pledged to reduce obesity stigma and its harmful effects [74•]. Together, these initiatives reflect important milestones and acknowledge the essential roles of healthcare professionals and clinicians in efforts to help

reduce weight stigma. For youth with obesity, these efforts are especially critical in light of evidence of WBV from parents [9, 32, 51] and negative weight talk and criticism within families [75], suggesting that pediatric providers may be one of few allies to support these vulnerable youth.

For pediatric providers to effectively address weight stigma, there needs to be acknowledgement that weight stigma is present in the healthcare environment and that pediatricians themselves are not immune to these biases. Considerable evidence has documented weight-biased attitudes and stereotypes endorsed by healthcare professionals [76], including evidence documenting these weight biases among pediatric providers [77], pediatric nurses, and clinical support staff [78]. Furthermore, reducing weight bias in the healthcare setting is not simple or straightforward. A systematic review of weight bias reduction interventions tested in health professionals concluded that evidence of effectiveness is poor and that long-term effects are primarily unknown [79]. Thus, there is a clear need for increased methodologically rigorous experimental research to test and compare multiple strategies to reduce weight bias among clinicians. While pediatric providers have received little attention in this stigma reduction research, there have nevertheless been increasing calls for pediatricians to address weight stigma through patient-centered approaches to childhood obesity [80], to use respectful language in the care of childhood obesity [81], and for implementation of educational initiatives to help reduce weight stigma among pediatric physicians [82] and residents [83].

Fundamental to these efforts is the use of supportive, compassionate, and non-stigmatizing communication with youth and their families. A recent review of studies examining preferences for weight-based language suggests that adolescents with obesity have different preferences for language that parents and healthcare providers use when referring to their weight [84•]. These preferences varied by gender, BMI, internalized weight bias, and emotional responses, suggesting that pediatric providers should carefully consider language they use to discuss weight with youth, avoid making assumptions about what language is best, and instead ask youth what words/terminology they feel most comfortable using in discussions about weight-related health. Motivations to avoid bullying may be a key driver for why some adolescents seek obesity treatment in the first place [85], underscoring the responsibility of pediatric providers to ensure their patients experience support rather than shame or stigma in clinical care. This recognition has prompted scholars and practitioners to develop resources to promote positive weight-related conversations between healthcare providers and children [86]. With increased recognition of weight stigma and its damaging consequences for youth, pediatricians can ensure stigma-free clinical care settings where youth of all body sizes are supported and treated respectfully.

## Conclusions

Youth with overweight or obesity are vulnerable to victimization because of their weight from multiple interpersonal sources including peers, family members, and educators. Certain sociodemographic factors may increase their vulnerability to weight-based teasing and bullying, such as having a higher body weight and identifying as a sexual minority, but more research is needed to better understand the nature and extent of differences in weight stigma based on gender and race/ethnicity. Experiencing weight stigma is harmful to youth in a range of ways that can negatively impact their psychological, social, academic, and physical well-being. Collectively, these experiences contribute to considerable emotional distress and unhealthy behaviors that exacerbate poor weight-related health. Longitudinal evidence highlights the lasting health consequences stemming from weight stigma and underscores the need for early intervention and support of youth who are vulnerable to mistreatment because of their weight. Healthcare professionals, and pediatric providers in particular, have an essential role to play in these efforts. By engaging in supportive, non-stigmatizing communication with youth, assessing youth for teasing and bullying during clinic visits, and educating families about weight stigma in home and school settings, clinicians can help reduce weight stigma and improve the culture of care for children and adolescents with obesity. More broadly, the obesity field must require a high standard of care that corrects—rather than contributes to—damaging weight stigma and ensures respectful, compassionate treatment of youth regardless of their body size.

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