

Internalization of Weight Stigma: Psychological Mechanisms, Health Consequences and Intervention Measures: A Narrative Review

Wong Siew Kin¹, Bustang Bustang², Yee Cheng Kueh³, Garry Kuan¹

¹Exercise and Sports Science Programme, School of Health Sciences, Universiti Sains Malaysia, Kubang Kerian, Kelantan, Malaysia.

²Biostatistics and Research Methodology Unit, School of Medical Sciences, Universiti Sains Malaysia, Kubang Kerian, Kelantan, Malaysia.

*Corresponding e-mail: garry@usm.my

Abstract

This narrative review systematically examines the psychological mechanisms, health consequences, and intervention measures of internalized weight stigma. By searching the literature in PubMed, PsycINFO, and Web of Science, English empirical studies that included core measurements of internalized weight stigma (WBI, such as WBIS) were included. The review clearly states that weight stigma is the prejudice and discrimination an individual faces due to their weight not conforming to societal ideals, and it can be divided into perceived and internalized types. It exists in various fields such as the workplace, healthcare (with an incidence rate of nearly 69%), and education. It can be measured using tools like AFAT, WBIS, and IAT. Its negative impact on individuals is significant: it lowers self-esteem and causes depression and anxiety in terms of mental health; it increases binge eating and reduces physical activity in terms of health behaviours; and it raises BMI and inflammation risks in terms of physical health, forming a vicious cycle of “stigma - stress - weight gain” through the COBWEBS model. There are mainly three types of intervention strategies: reducing public stigma (educational interventions are difficult to change implicit attitudes in the short term), weight loss interventions (such as the NEW-R project, where more than half of the participants regained weight within 12 months), and positive psychological interventions (such as mindfulness therapy, which can alleviate symptoms). Current research has shortcomings such as shallow mechanisms and few interventions. Future research needs to deepen the empirical studies on mechanisms and interventions.

Keywords: Weight stigma internalization; Psychological mechanisms; Health consequences; Binge eating; Physical activity; Intervention strategies.

1. Introduction

In contemporary society, negative weight-related evaluations and unfair treatment have gradually become a social and health issue that cannot be ignored. This phenomenon is widely defined as weight stigma, that is, individuals suffer from prejudice, discrimination, negative stereotypes, and unfair treatment because their weight does not meet the “ideal weight” standard generally advocated by society (Dennison et al., 2025). This stigmatization phenomenon is not limited to a single scenario but permeates multiple dimensions of an individual's life: In the medical scenario, overweight or obese individuals may be defaulted by medical staff to attribute health problems to their weight, resulting in the neglect of other potential causes during the diagnosis and treatment process; in the educational and workplace environments, students or practitioners with a larger body weight may face unfair treatment such as implicit exclusion by others and fewer promotion opportunities; in daily social interactions and media dissemination, negative weight-related labels (such as “lazy” and “lack of self-control”) appear frequently, further strengthening society's stereotypical perception of weight (Fikkan & Rothblum, 2012).

From the perspective of health impacts, weight stigma is not simply an “attitude problem” but has been proven by numerous studies to have multi-dimensional and long-term negative impacts on an individual's physical and mental health. At the physiological level, individuals who have long suffered from weight stigma may experience abnormal physiological indicators such as metabolic disorders and elevated blood pressure due to stress responses, and may even have an increased risk of chronic diseases such as cardiovascular diseases and diabetes (Heitmann, 2025); at the psychological level, weight stigma directly leads to a decrease in an individual's sense of self-worth, the breeding of negative emotions such as anxiety and depression (Wu et al., 2025). Some individuals may even fall into “self-stigmatization”. In recent years, with the increasing attention from the public to “body diversity” and “health equality”, the research on weight stigma has gradually shifted from “phenomenon description” to “mechanism exploration” and “intervention practice”. However, there are still research gaps in the current academic community

regarding the formation mechanism of weight stigma (such as the interaction of social culture, individual cognition, and family environment), the key influencing factors in the internalization process, and the effectiveness of targeted intervention measures (Kramer et al., 2025). Therefore, systematically sorting out the relevant research findings on weight stigma and clarifying its impact path on individual health can not only provide a theoretical basis for subsequent academic research, but also offer a scientific basis for formulating practical strategies to reduce weight stigma and promote health equality in fields such as healthcare, education, and public health. It has important theoretical value and practical significance (Sabo et al., 2024).

2. Method

The literature search for this study was centred around three core databases, including PubMed, PsycINFO and Web of Science, to ensure that the search covered relevant research results in the fields of medicine, psychology and comprehensive academic studies. To precisely locate the research topic, a search formula was constructed using a combination of multiple sets of keywords, specifically: (“weight stigma” OR “weight bias” OR “weight discrimination”) AND (“internal*” OR “self-stigma” OR “weight self-evaluation” (“mechanism” OR “pathway” OR “intervention” OR “outcome” OR “health”) “internal*” uses truncation to cover related derivatives such as “internalization” and “internalized” to avoid missing key references.

The included literature must meet the following conditions simultaneously: the research type is empirical research, including cross-sectional studies, longitudinal studies, experimental studies, and intervention studies, to ensure the objectivity and scientific nature of the research conclusions; The literature should be published in English and peer-reviewed to ensure that the quality of the literature meets academic standards; The core measurement of the study was Weight Bias Internalization (WBI), and it was necessary to explicitly use standardized scales for measurement, such as the Weight Bias Internalization Scale (WBIS). To ensure consistency and comparability of the measurements.

3. Concepts, manifestations, and measurements of weight stigma

3.1 The concept of weight stigma

The concept of Stigma was first proposed by Goffman, who in “Stigma: Notes on the Management of Impaired Identities” defined stigma as the “impaired identity” that an individual acquires without social approval. According to his perspective, weight stigma belongs to the first category, that is, stigma received due to physical defects or characteristics (Goffman, 1963). Weight stigma refers to negative attitudes, views, and discriminatory behaviour towards obese individuals (Puhl & Heuer, 2009; Wu et al., 2025). Brewis (2014) argued that weight stigmatization is the process of linking certain arbitrary moral judgments to body type, ultimately leading to social defamation, exclusion, and marginalization. Similarly, Tomiyama (2014) defines weight stigma as the social devaluation and defamation of overweight and fat groups, which leads to biases, negative stereotypes and discrimination against these people. Weight stigma can be divided into perceived weight stigma and internalized stigma. The former often refers to stigmatized experiences that come from the external environment, where the public imposes negative evaluations and labels on overweight and obese groups; The latter refers to the signatories group identifying with such labels and stereotypes and accepting themselves as such (Papadopoulos & Brennan, 2015), believing themselves to have “bad traits” such as laziness and lack of effort. Weight stigmatization also includes a dynamic process and outcome of associating negative stereotypes and evaluations with overweight and obese groups, leading to social discrimination and prejudice against this group and ultimately putting them in a socially disadvantaged position.

3.2 Manifestations of weight stigmatization

Puhl and Heuer (2009) pointed out that the phenomenon of weight stigma is widespread in the workplace, healthcare, education and other fields, and made a systematic summary based on previous empirical studies. Based on this, scholars have further explored the research methods and perspectives.

Weight discrimination in the workplace is mainly manifested as unequal employment, promotion opportunities and salary levels. As Flint and Snook (2014) used a cross-sectional comparison study comparing the reported data of employees of normal weight with those of obese employees, it was found that obese people were often perceived as lacking leadership skills, having more difficulty finding work or getting promoted in their careers. Pinkston (2017)

used data from the National Longitudinal Survey of Youth from 1997 to 2009 to study the impact of weight on salary income and found that both participants' past BMI and current BMI had an impact on salary, and that this impact was constantly changing. Obese women were more discriminated against at work, with less career achievement and income than women of normal weight under the same conditions (Fikkan & Rothblum, 2012).

The medical field has been an important direction of weight stigma research, mainly manifested in the negative evaluation, attitude and even discrimination shown by doctors, nurses, health experts, etc. Discrimination and bias based on weight are widespread in the medical field, with an incidence rate close to 69% (Ferrante, Piasecki, Oman-Strickland, & Crabtree, 2009). Forhan and Salas (2013), based on the literature of the past 20 years, pointed out that obese patients face persistent discrimination and bias from medical staff in the process of seeking treatment. Attitudes towards obese patients need to change, stigmatizing views that obese patients lack wisdom and perseverance need to change (Johnston, 2012), weight bias in the medical environment leads to shorter visit times and reduced medical services for obese patients (Forhan & Salas, 2013).

Overweight and obese students will experience being ridiculed, teased, bullied, and having a lower evaluation of their academic, social, and self-management aspects than students of normal weight, which will affect their access to academic resources (Swami et al., 2025). Burmeister, Kiefner, Carels, and Musher-Eizenman (2013) found that the higher the BMI of obese students after completing an interview, the less likely they were to receive a graduate admission offer in psychology. After controlling for variables such as gender, age, personal social skills, and grade, the study analysis concluded that overweight and obese primary school students received less peer acceptance and friends and were more susceptible to school bullying (Krukowski et al., 2009). Weight stigma exists not only in the workplace, healthcare, education and other fields, but also in interpersonal communication, news media and other fields. These discriminations and prejudices appear in all aspects of social life but are accepted and recognised by society and become reasonable social phenomena.

3.3 Assessment tools for weight stigma

Based on the above definition of weight stigma, the measurement of weight stigma is mainly in two directions, namely the public (non-obese group) and the obese group. The Anti-Fat Attitudes Test (AFAT) is the most frequently used questionnaire, developed by American scholars Lewis, Cash, Jacobi, and Bubb-Lewis (1997). The main survey was about the public's attitude towards obesity. It includes three factors: social/role disregard (personal emotional response to obese people), body shape/romantic lack of charm (perception of the personality and physical attractiveness of obese people), and weight control/blame (eating habits and factors influencing weight). In addition, the Antifat Attitudes Questionnaire (AAQ) (Crandall) 1994) The Attitudes Toward Obese Persons Scales (ATOP) The Beliefs About Obese Persons scales BAOP (Dedeli, Bursalioglu, & Deveci, 2014) is also widely used. These scales have good internal consistency, reliability and validity, and can reflect the public's explicit attitudes and views to a large extent.

In addition to public bias, overweight and obese groups can also be biased against themselves. For this reason, the academic community has designed Internalization stigmatization questionnaires for self-assessment by obese and overweight groups, such as the Weight Bias Internalization Scale (WBIS) (Hilbert et al., 2014). The questionnaire has good reliability and validity and can well measure how overweight and obese people perceive themselves. No matter which measurement tool it is, weight stigma is conceptualized as negative attitudes, biases, and discrimination.

In some situations, people hide their negative attitude, which they rationally consider unreasonable, and this latent state is called Implicit stigma (Wang et al., 2025). Weight stigma is an anti-obesity attitude that an individual cannot precisely identify. To accurately identify this attitude, the Implicit Association Test (IAT) was developed and gradually gained recognition. The implicit association test, first proposed by Greenwald in 1998, has been used to measure implicit mental illness stigma, etc. (Ruggs, King, Hebl, & Fitzsimmons, 2010). It is a measurement design that is developed according to the needs of different studies. While implicit association tests are more accurate in reflecting the public's attitude towards obesity, they take more time than questionnaires. More crucially, studies have shown no significant difference between public implicit and explicit stigma (Ruggs et al., 2010). Phelan, Burgess, and Puhl et al. (2015) investigated the implicit and explicit stigma of obesity among 1,795 medical students using IAT to measure their perceptions of obese individuals and those with normal weight, and found that both implicit and explicit stigma were present. But the degree of implicit stigma was higher. Therefore, most studies can use questionnaires, supplemented by associative tests, to examine whether there is a significant difference between implicit and explicit stigma. In addition, researchers can also draw on the measurement methods of other stigma studies. Generally, it is best to use a more recognized specialised questionnaire, based on which the conclusions are

more widespread. In addition, as research progresses, a new, reliable tool, the Weight Stigma Exposure Inventory (WeSEI), has been developed to comprehensively measure all the common occasions and sources where weight stigma can be seen in a person's life (Ruckwongpatr et al., 2025)

4. The impact of weight stigma on an individual

Existing studies have used rigorous empirical methods to analyse the negative effects of weight stigma. Self-reported experiences of weight stigma are associated with poorer physical and mental health (Hunger & Major, 2015). Some scholars have summarized the effects of weight stigma in specific domains, such as Phelan, Burgess, and Yeazel et al. (2015), which systematically reviewed the impact of weight stigma in the medical field on healthcare workers, obese patients, and the medical environment. Most empirical studies have not yet classified obese groups, but scholars unanimously agree on the adverse effects of weight stigma on the physical and mental health of individuals. Puhl and Suh (2015) found that weight stigma leads to binge eating behaviour, reduced physical exercise frequency, and directly endangers physical health; Vartanian and Porter (2016) clarified the relevant empirical studies in recent years, mainly organizing the harm of weight stigma to eating behaviour based on the characteristics of the selected sample populations and research methods. We believe that the impact of weight stigma on individuals is generally reflected in three aspects: mental health, health behaviour, and physical health.

4.1 Negative effects on mental health

Overweight and obese people often encounter public eye criticism, verbal abuse from strangers and negative judgments from society, which can lead to individual depression, frustration, a sense of insecurity, and doubts about their own abilities and image (Blackstone, 2016). The existing research argues from two perspectives. One is that weight stigma reduces positive psychological indicators such as self-esteem, self-identity, self-efficacy, and well-being. Schafer and Ferraro (2011) found that perceived weight discrimination reduces self-identity. Major, Eliezer and Rieck (2012) inferred through theoretical models that situations of weight stigma anxiety led to a body identity crisis, which in turn increases stress and reduces self-control. Graham and Edwards (2013) selected 108 obese patients with a BMI of 40 or above as samples to explore whether self-esteem is associated with anti-obesity attitudes among medical staff and analysed that self-stigma is a key predictor of self-esteem. African American obese young patients have lower self-esteem. Another analysis based on national survey data proved that perceived weight stigma was associated with well-being, with overweight and obese students having less social support and stronger feelings of loneliness compared to their peers (Phelan, Burgess, Puhl et al., 2015).

Second, weight stigma leads to an increase in negative emotional states. Durso, Latner and White et al. (2012) demonstrated through empirical research that internalizing weight bias increases depression in obese patients. Likewise, an analysis in Italy found that BMI was associated with depressive symptoms in overweight and obese patients, and perceived healthcare discrimination was an important moderating factor (Innamorati et al., 2017). Preiss, Brennan, and Clarke (2013) searched 46 empirical studies with different analytical methods, different regions, and different age groups, all of which demonstrated a positive correlation between weight stigma and depression. Major et al. (2012) found that women with a high BMI perceived more stress in the context of weight stigma compared to those with a normal BMI. A study in Guatemala demonstrated that weight stigma is a significant source of stress in low-income developing countries and may exacerbate depressive symptoms in obese women (Hackman, Maupin, & Brewis, 2016). Himmelstein, Incollingo Belsky, and Tomiyama (2015) compared the two groups through experimental manipulation and found that weight stigma increases corticosteroid, a major indicator of the physiological response to stress.

4.2 Negative effects on health behaviour

The impact of weight stigma on health behaviour is mainly reflected in two aspects: increased binge eating behaviour and reduced physical activity. Almeida, Savoy, and Boxer (2011) found that weight stigma plays a unique role in binge eating behaviour in obese individuals and college students compared to factors such as environmental stress, psychological function, and negative coping. The higher the level of stigma, the higher the frequency of binge eating and the greater the likelihood of developing binge eating disorder (Ashmore, Friedman, Reichmann, & Musante, 2008). Experiences of being ridiculed for weight are associated with weight control behaviour and the frequency of binge eating among female adolescents, and the higher the frequency of being ridiculed, the stronger the association (Olvera, Dempsey, Gonzalez, & Abrahamson, 2013; Wang et al., 2025). Another correlation analysis using online

surveys, including both male and female samples, indicated a significant association between weight discrimination and binge eating behaviour (Durso, Latner, & Hayashi, 2012). Other studies have also shown that childhood weight mockery is associated with later life binge eating, eating problems, compensatory behaviour, eating disorders, etc. (Quick, McWilliams, & Byrd-Bredbenner, 2013).

A growing number of studies have begun to explore the impact of weight discrimination on physical activity, especially on young people. Ridicule for weight is a common experience for obese students in school physical education activities (Puhl & Suh, 2015). Qualitative and quantitative studies of decision-making and behaviour have shown that people who are examined for their body shape have less enthusiasm for physical activity and make decisions to avoid exercising in public places such as schools and swimming pools (Vartanian & Smyth, 2013). Weight stigma is linked to exercise avoidance among overweight/obese college students/adults, and internalizing weight stigma moderates this relationship (Vartanian & Novak, 2011). Other studies have found this effect in children and adolescents as well (Vartanian & Smyth, 2013). Weight teasing at school or in physical activity undoubtedly undermines the physical activity enthusiasm of teenagers. An experimental study of 140 overweight teenagers showed that students in the experimental group assigned to stereotype threats performed worse in sports play activities than those in the control group (Li, Lwin, & Jung, 2014).

4.3 Negative effects on physical health

The negative effects of weight stigma on physical health can be reflected in several physiological indicators. Studies targeting groups with a BMI over 25 have shown that weight discrimination regulates the relationship between BMI and C-response, an important indicator of health. In addition, perceived weight discrimination also increases the likelihood of systemic inflammation in individuals (Sutin, Stephan, Luchetti, & Terracciano, 2014).

Given the harmful effects of weight stigma on healthy behaviour, studies have begun to view obesity as a potential outcome of the stigma. A longitudinal study of adults has shown a clear link between weight discrimination and obesity (Jackson, Beeken, & Wardle, 2014) and weight gain (Hansson & Rasmussen, 2014). Farrow and Tarrant (2009) found that internalizing the impression of obesity did not lead to weight loss in overweight and obese individuals, but rather increased BMI. Among young people, weight discrimination increases the risk of overweight and obesity in women by 64% to 66% (Haines, Kleinman, Rifas-Shiman, Field, & Austin, 2010; Quick, Wall, Larson, Haines, & Neumark-Sztainer, 2013). Weight discrimination leads to an increase in BMI and waist circumference index (Jackson et al., 2014), according to longitudinal data analysis from the National Survey on Aging in the UK.

4.4 Associations with the negative effects of weight stigma

In recent years, there has been an increasing number of studies exploring the outcome mechanism of weight stigma. The negative effects of weight stigma on the body and mind are interwoven, and there is a progressive relationship among the effects. Puhl and Heuer (2010) argued that weight stigma damps exercise enthusiasm, increases binge eating behaviour, and leads to weight gain, which is widely recognized. Another psychological mechanism theory suggests that stigmatizing experiences increase physical stress, and stress leads to weight gain. The COBWEBS (Cyclic Obesity/ weight-based Stigma Model) proposed by Tomiyama (2014) explains that Weight stigma is not a static structure but a vicious cycle system. This cycle is manifested in the fact that stigma causes an increase in stress, followed by an increase in food intake, which eventually leads to weight gain. This theory was confirmed in a longitudinal study in Australia, where high levels of stress predicted a 0.2 kg/m² increase in BMI over five years (Harding et al., 2014). A recent study by Hunger, Major, Blodorn and Miller (2015) further deepens the mechanism by suggesting that weight stigma is a social identity threat factor that leads to increased stress in individuals, enhanced stigma avoidance motivation and reduced self-control ability. This affects individuals' health-related behaviours and ultimately their physical and mental health levels.

5. Intervention strategies for weight stigmatization

A systematic theory of weight stigma intervention has not yet been developed either domestically or internationally, and research on this issue mainly focuses on three directions. How to reduce weight stigma has always been a difficult point in the field of stigma research; How to effectively help overweight and obese individuals lose weight is seen as the fundamental solution to the problem; But recent research has shifted to how to establish effective positive intervention strategies to enhance an individual's ability to cope with the stigma of weight.

5.1 Reduce public stigma

Reducing public prejudice and discrimination is a key point that stigma research has always focused on and explored. The traditional approach to dealing with weight stigma mainly involves education and raising individual awareness, reinforcing public awareness of the complexity of causes of obesity, which may include genetic, metabolic and social factors (Williams, Mesidor, Winters, Dubbert, & Wyatt, 2015). O'Brien, Puhl, Latner, Mir, and Hunter (2010) provided a set of information about the causes of obesity to members of the experimental group and emphasized the uncontrollability of body weight. The results showed that participants who received the information reduced their bias against the obese group. Swift et al. (2013) showed healthcare workers the medical discrimination and negative consequences faced by overweight and obese individuals through educational films. After the intervention, the explicit discrimination against obesity among healthcare workers improved, but there was no significant change in the implicit anti-obesity attitude. These interventions are difficult to achieve results in the short term and are hard to promote. The negative perception of overweight and obese individuals is deeply rooted, and it is difficult to change the stable cognitive structure in the short term. Therefore, using short-term intervention strategies to reduce public stigma cannot produce immediate results.

5.2 Losing weight

For a long time, there has been a certain bias in the perception of obesity and weight stigma. The public believes that dissatisfaction with weight will strengthen an individual's willingness to control their body weight, and the experience of weight stigma will dampen the appetite of obese people and at the same time prompt them to exercise hard to lose weight (Heinberg, Thompson, & Matzon, 2001). Health experts have designed specialized weight loss programs and believe that people will be subject to less bifidum and bias after losing weight, which has been verified in some empirical studies. Puhl and Brownell (2001) found that obese workers, by reducing their weight, showed a healthier lifestyle to their employers, indicating a greater willingness to invest in human capital, which implies an expected improvement in future work productivity. Brown et al. (2015) carried out the Nutrition and Exercise for Wellness and Recovery (NEW-R) training program, and after an 8-week intervention, participants lost an average of 3 pounds of weight. The average weight loss was 10 pounds after 6 months. However, Crawford, Jeffery, and French (2000) analysed data from a community weight prevention program and found that more than half (53.7%) of the participants regained the weight they had lost within 12 months of the intervention. 24.5% of the participants avoided gaining weight over three years, while only 4.6% were successful in losing and maintaining their weight.

5.3 Active Intervention

Positive Psychology is a new field of study emerging in the American psychology community, mainly focusing on positive emotions and experiences, positive personality traits, and positive mental processes (Sheldon & King, 2001). A Positive Psychology Intervention is an intervention paradigm based on the theory of positive psychology, a therapeutic approach or purposeful activity aimed at promoting positive feelings, behaviours, or cognition. However, it is worth noting that programs, interventions, or treatments aimed at repairing, remedying, or treating pathological/defective problems rather than building advantages do not fit the definition of positive psychological intervention. Positive psychological interventions include gratitude training, optimism therapy, positive thinking exercises, mindfulness, relaxation, and other interventions within that can promote positive feelings, behaviours, and cognition in individuals (Sin & Lyubomirsky, 2009).

Positive psychological intervention has achieved good results in different groups such as cancer patients and those with depression, and it is also feasible to apply it to obese people. For example, using acceptance and commitment therapy to improve the quality of life of obese people, the theory suggests that reducing avoidance behaviour and increasing resilience will reduce the psychological unhappiness of stigmatized people, thereby enhancing their tolerance and coping ability to negative evaluations and improving their quality of life (Lillis, Hayes, Bunting, & Masuda, 2009). Furthermore, Lattimore et al. (2017) used mindfulness therapy for women with eating disorders and found that the intervention could alleviate psychological symptoms and eating disorders in women to some extent. Johnson, Burke, Brinkman, and Wade (2016) also confirmed that school-based mindfulness interventions can prevent depression in obese adolescents and reduce their stress and binge eating behaviours. At present, studies at home and abroad have paid less attention to intervention strategies, although data show that the number of obese people is on the rise and the rate of weight stigmatization is increasing. But there are few studies on how to carry out effective interventions to curb this phenomenon in a timely manner, and few studies have focused on how to improve the physical and mental health status of the stigmatized group.

6. Deficiencies and Prospects of weight stigmatization research

With the increasing number of obese people, weight stigma has gradually become a research hotspot, and its research is of great practical significance. Although some achievements have been made, there are still some problems in the field that need to be explored.

First, the research content needs to be further deepened and expanded. In recent years, research on weight stigma has shifted from describing phenomena to exploring results, delving deeper into the mechanisms behind the results. However, the research on these mechanisms has mainly remained at a superficial level, lacking precision and depth. Why does being ridiculed and bullied for obesity lead to binge eating among teenagers? Why does weight stigma suppress the enthusiasm for exercise and physical activity? Does weight stigma necessarily lead to negative responses in individuals (Puhl & Suh, 2015)? Which group is most vulnerable to weight stigma, or which group is more vulnerable to weight stigma based on age, gender, race, or other factors? Are there any factors modulating the association between weight stigma and negative effects (Vartanian & Porter, 2016)? Many previous studies have pointed out that psychological misfortunes such as stress resulting from weight stigma can lead to improper eating behaviour in overweight individuals. Does this mean that a reduction in negative emotions leads to weight loss? Such questions have not been properly explained, and the link between weight stigma and mental health has not been thoroughly studied. Only by accurately grasping these mechanisms of influence can scholars build on them for further research. Of course, there are also studies that have made useful explorations in this regard, such as the currently more widely accepted theory of social identity threat to explain the negative effects of weight stigma (Hunger et al., 2015), which will need to be supplemented and verified with data in the future.

Secondly, there is a large amount of literature documenting the manifestations and effects of weight stigma in various fields, while there is a relative lack of research exploring psychological strategies to mitigate stigma. Theoretically, the best way to eliminate weight stigma is to lose weight; In fact, obesity cannot be simply attributed to diet and lifestyle; some obesity is uncontrollable. For most obese people, losing weight is not a consistently effective approach, and the weight lost through extreme means will rebound after a few years. Therefore, some experts suggest that the quality of life and the stigma that leads to unhappiness should be the focus of obesity treatment (Brownell, Puhl, Schwartz, & Rudd, 2005). There are still few studies on interventions for weight stigma, and it is impossible to infer which intervention strategies are most effective and which specific strategies or combinations make certain methods more effective for certain special groups (O'Brien et al., 2010). In addition to continuing to explore how to reduce public stereotypes, biases, and discriminatory attitudes towards obese people, there should be an increase and emphasis on intervention studies and empirical research in the future to explore which intervention methods can alleviate the negative experiences brought about by weight stigma. Professional mental health workers should also turn their attention to this large but neglected group, reduce the negative impact of stigma on their physical and mental health, and establish reasonable interventions to deal with the stigma to help them return to a normal life.

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