

Obesity Stigma in Sexual Relationships

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Abstract

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Objective: Obese children are stigmatized in same-sex relationships. This study examines whether, in adulthood, obesity stigma exists in adults when they are asked to rank order preferences for a sexual partner.

Research Methods and Procedures: Following the methods of Richardson et al. (Richardson SA, Goodman N, Hastorf AH, Dornbusch SM. Cultural uniformity in reaction to physical disabilities. *Am Sociol Rev.* 1961;26:241–247) and Latner and Stunkard (Latner J, Stunkard AJ, Wilson GT. Age, ethnic and gender differences in stigmatization of obesity. Orlando, FL: International Conference on Eating Disorders; 2004), 449 college students were asked to rank order six drawings of potential sexual partners. The drawings included an obese partner, partners with various other disabilities, and a healthy partner.

Results: The least-preferred partners were obese. Men, compared with women, provided significantly lower ranks for obese partners ($U = 20,180.00$, $z = -2.84$, $p = 0.01$).

Discussion: Despite the fact that the majority of adults in the U.S. are overweight, discrimination on the basis of weight occurs in making a choice of a sexual partner. Males particularly make choices of partner based on their weight. Obesity stigma may specifically affect women in sexual relationships. Weight-related stigma needs to be addressed in the treatment of binge eating disorder or weight management. Finding ways to change attitudes and behavior toward the overweight is a goal for future research in the area.

Key words: discrimination, interpersonal relationships, stigma, weight, sex

Introduction

The prevalence of individuals who are overweight (BMI = 25 to 30) or obese (BMI >30) has reached epidemic proportions in the U.S. Currently, approximately 65% of adult Americans are overweight or obese (1). The overall prevalence of obesity in adults has more than doubled from 1962 (13.4%) to 2000 (30.9%) (2). The prevalence of overweight in U.S. children 6 to 11 years old appears to have tripled from 4% in 1963 to 1965 to 15% in 1999 to 2000 (3). Men are more likely to be overweight than women (67.2% vs. 61.9%, respectively), whereas women (33.4%) have a higher prevalence of obesity than men (27.5%) (2).

Regardless of these high and increasing rates, obesity is associated with considerable social costs and stigma. Overweight children, adolescents, and adults face considerable negative consequences as a result of discrimination (4). In adolescence, overweight high school girls compared with boys report significantly more weight-related teasing from both peers and family and also report significantly more distress about this (5). Obese children and adults are ascribed negative attributes such as being lazy, undisciplined, and less competent by employers (6), health professionals (7,8), and peers and teachers (9). Obese people are underrepresented and stereotypically portrayed in the media (10). For instance, overweight people, particularly females, are portrayed as objects of humor and are less likely to be portrayed in romantic relationships, unlike their thinner counterparts.

Obese people are less likely to be promoted, have lower wages, and are less likely to be hired than thin people with equivalent qualifications (11,12). In educational settings, obese young adults are less likely to be accepted to college (13) and are more likely to be dismissed wrongfully than their thinner peers (14). Obese young adults, particularly women, are given less financial support for college than their thinner counterparts (15,16).

Obesity stigma or discrimination appears to affect the emotional well-being of overweight people. For instance, obesity is associated with the increased likelihood of depression, suicidal thoughts, and suicide attempts (17).

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Women seem to be particularly affected (18). Older women (50 to 86 years old), unlike men, are more likely to be depressed if overweight. The experience of stigma accounts for this differential relationship between weight and depression between men and women (19). There is also the suggestion that binge eating disorder (BED),¹ which affects a minority of overweight people, is predicted by experiences of obesity stigma or discrimination (20,21).

Obese people are less favored as friends by adults than non-obese people and individuals with physical disabilities (22). This seems to particularly affect women, with overweight and obese women being less likely to be married than obese men (23). Men are more likely to select from newspaper advertisements a romantic partner recovering from drug dependency than an obese woman (24).

The purpose of the present study was to examine obesity stigma in adults by looking at the relationship between obesity stigma and adults' preferences for sexual partners as opposed to friendships. In their seminal study, Richardson et al. (25) asked elementary school boys and girls 10 to 11 years old to rank six drawings of same-sex children with various physical disabilities as to which child they liked the most. The drawings were of boys and girls missing the left hand, using a crutch, using a wheelchair, obese, or having a facial disfigurement, and one classified as healthy. The drawing of the obese child was most likely to be ranked "least liked." Given research on racial stereotypes (26), increased contact with obese individuals would be expected to be associated with reduced stigma; however, a recent study showed that obese children are significantly more stigmatized now than in 1961 when obesity was less common (27).

Following the methodology of Richardson et al. (25) and Latner et al. (22), college students were shown drawings of various types of people (obese, disabled, disfigured, etc.) and asked to rank order the drawings based on the physical characteristics that they would prefer a sexual partner to have. In contrast with other studies, we replaced the drawing of the facially disfigured person with drawings of a person described as having a history of sexually transmitted diseases (STDs) and a person with mental illness because these may be other less overt criteria that may be important in the choice of sexual partner. This study also examined sex and weight as a potential moderator of the effects of picture type on sexual partner preferences.

Research Methods and Procedures

Participants

Participants were recruited as part of a mass screening of undergraduate psychology students at the University of

Washington. As part of a Psychology course, students were approached to participate in mass testing. Participation was based on informed consent.

Measures

For the questionnaire about sexual partner preferences, following Latner et al. (22), participants were given a questionnaire that included six line drawings of men and women (each drawing approximately 3 × 2 cm high). Each category of the questionnaire included a drawing of one man and one woman, allowing participants to complete the questionnaire based on the preferred gender of their sexual partners. The drawings were identical with the exception of the physical characteristic they were assigned. Below each drawing a written description was given, stating the following: he/she is healthy (healthy), he/she is missing their left arm (armless), he/she is in a wheelchair (wheelchair), he/she is obese (~100 lbs. overweight) (obese), he/she has a history of suicide attempts and self-harm (mental illness), and he/she has a history of curable STDs and currently practices safe sex with all partners (STDs). The drawings used for the STD, healthy, and mental illness categories were all identical because these categories have no visible characteristics. Participants were asked to rank order these drawings from 1 to 6 based on the characteristics they would most prefer and least prefer for a sexual partner to have, with 1 being most preferred and 6 being the least preferred, using each rank only once.

The questionnaire also asked demographic information, such as sex, age, ethnicity, weight, and height, history of STDs, and condom use at last instance of sexual intercourse. Participants completed the questionnaire regardless of sexual orientation. Sexual orientation was not examined in the current study.

Data Analysis

A Friedman Rank Test was used to find whether there were differences among the rankings of the categories of drawings (healthy, armless etc.). Post hoc sign tests were used to measure differences in specific categories (e.g., obese vs. wheelchair). Gender differences in the ranking of categories (healthy, armless, etc.) were measured using a Mann-Whitney *U* test. A Mann-Whitney *U* test was also used to compare the ranking of categories by subjects with BMI > 25 or BMI < 25. The alpha rate for significance was taken to be $p < 0.05$.

Results

Participants included 449 students (mean age = 19.21, standard deviation (SD) = 1.53, range 18 to 35 years). Of the 449 participants, 276 were women (61.5%) and 173 were men (38.5%). The ethnic distribution of the sample was: white (62.4%), Asian American (26.7%), Hispanic

¹ Nonstandard abbreviations: BED, binge eating disorder; STD, sexually transmitted disease; SD, standard deviation.

Table 1. Mean ranks and SDs for categories of drawings by gender, BMI*, and the total sample

Category	Men (<i>n</i> = 173)	Women (<i>n</i> = 276)	BMI < 25 (<i>n</i> = 355)	BMI > 25 (<i>n</i> = 91)	Total (<i>n</i> = 449)
Healthy	1.27 (1.12)	1.27 (1.14)	1.30 (1.18)	1.18 (0.81)	1.27 (1.13)
Armless	3.47 (1.16)	3.43 (1.37)	3.46 (1.16)	3.35 (1.20)	3.45 (1.17)
Wheelchair	4.41 (1.31)	4.32 (1.32)	4.36 (1.31)	4.31 (1.31)	4.35 (1.31)
Mental illness	3.88 (1.46)	4.09 (1.48)	4.01 (1.47)	4.01(1.51)	4.01 (1.48)
Obese	4.66 (1.26)	4.28 (1.36)	4.45 (1.35)	4.34 (1.31)	4.43 (1.34)
STDs	3.32 (1.49)	3.59 (1.58)	3.40 (1.53)	3.81 (1.59)	3.49 (1.55)

* The BMI data of three subjects were missing, so their data were not included.

(1.3%), native African American (0.7%), Alaskan Native/Native American (0.4%), and other (7.1%). Mean BMI was 22.85 (SD = 3.72, range = 14.88 to 42.60). Of the sample, 79.6% were in the healthy range (BMI < 25), and 20.4% were in the overweight and obese range (BMI > 25) (28).

See Table 1 for the mean sexual preference rank and the SD for each category of drawing (i.e., healthy, armless, wheelchair, mentally ill, etc.) for all subjects, for male and female subjects, and for subjects with BMI < 25 or BMI > 25.

The most preferred category, healthy, had an average rank of 1.27, and the least preferred category, obese, was ranked 4.43 on average. The Friedman Rank test showed that there was a significant difference in the ranks of healthy and obese [$\chi^2(5) = 875.57, p = 0.001$]. Given the means and SDs found, three post hoc tests were run, showing that the difference between ranks on the two least preferred categories, obese and wheelchair, was not significant ($z = -1.23, p = 0.22$). There was a significant difference between rankings on obese and mental illness ($z = -3.40, p = 0.00$) and on wheelchair and mental illness ($z = -2.08, p = 0.04$).

The Mann-Whitney *U* test used to compare sex differences in ranks revealed a significant sex difference only in ranks for the obese category. Compared with women, men provided significantly lower ranks for obese partners ($U = 20,180.00, z = -2.84, p = 0.01$). There was a trend for women to rank the STD partner lower than men ($U = 21,519.50, z = -1.83, p = 0.07$).

The Mann-Whitney *U* test used to compare weight differences in ranks showed that people with higher weights (BMI > 25) provided significantly lower ranks for the STD partner, compared with people with lower weights (BMI < 25) ($U = 13,698.50, z = -2.33, p = 0.02$). However, there was no significant difference in how participants in each BMI category ranked the obese drawing.

Discussion

This study supports previous research on the stigmatization of people who are overweight. Raters least preferred the

obese sexual partner and the partner in the wheelchair. This finding occurred despite the fact that the majority of the population in the U.S. is overweight (1,2).

The most compelling finding was the gender difference in obesity stigma. Both men and women ranked the obese partner as least liked. However, in comparing mean rankings between genders, we found that men ranked the obese partner as significantly less preferred than women did. Men are more likely to choose sexual partners on the basis of weight than women are. If it is assumed that the majority of the sample had heterosexual preferences, the current study adds to the growing evidence that obesity stigma particularly affects women across the lifespan in both opposite- and same-sex relationships (22,25,27).

From a treatment perspective, whether in weight management or treatment for BED, the implications are that weight-related stigma with regard to dating needs to be addressed in the treatment of both women and men. It may be that learning skills to cope with rejection, e.g., to counter weight-biased attitudes without invalidating the self, may be particularly important for overweight clients.

On a broader sociocultural perspective, attitudes toward the overweight and obese have to change. This may involve treating obesity stigma like racism or sexism, perhaps, as a start, by making it illegal to discriminate against people on the basis of weight in employment situations and in educational situations. Other avenues of changing attitudes toward weight-related stigma have been outlined by Puhl and Brownell (4).

The strength of the current study is that it is, to our knowledge, the only study that compares the sexes with regard to weight-related stigma in a large college-aged sample. It also used a strong test of a person's choices by forcing people to rank order each category of potential sexual partner.

The findings of the present study were limited in a variety of ways that can be explored in future studies. The current study did not examine the myriad of sexual relationships. Future studies need to examine whether obese people are

particularly discriminated against in short-term, casual sexual relationships as opposed to longer term sexual relationships. Future studies also need to ask subjects what their sexual orientation is and address what part sexual orientation has to play in this stigma.

We did not explore exactly how weight-related discrimination in partnership choice occurs. This would require the experimental examination of behavior rather than assessment of attitudes because there may be a discrepancy between the two. For instance, one study found that just the physical proximity of a man to an overweight woman was enough to lead to stigmatization against the man (29). In the future, studies may be done to examine how social reinforcement affects making partnership choices.

Future research should examine the relationship between mental health (i.e., self-esteem, depression, binge-eating) and weight-related stigma. Subsequent studies need to explore to what degree the self-esteem and mood of overweight people are affected by weight-related stigma in relationships (19,30). Studies can also examine what coping strategies may be effective in dealing with this. This study did not explore how overweight and obese people cope with discrimination, and these results suggest that future work may examine how making downward comparisons, i.e., comparing oneself with other groups who are worse off, may be protective of self-esteem (31). Future research should examine how weight-related stigma with regard to interpersonal relationships can maintain or start the cycle of binge eating and, importantly, then, how best to target this in treatment of BED.

As described above, the results of the current study have opened up many avenues for research. Our findings are an important foundation for subsequent research on obesity stigma in sexual relationships.

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