mal subjects. However, it may be difficult to diagnose epididymal torsion compared with TT using pulse oximetry, as the epididymis is relatively difficult to locate owing to its small size. This shortcoming may be overcome with subsequent improvements in oximetry techniques.

Conclusions | In conclusion, pulse oximetry can be used for monitoring hemodynamic changes of the affected testis attributed to its small apparatus design, noninvasiveness, and general availability. In comparison, the estimate of the cost of pulse oximetry is around $600, which is 1.2% of the cost of Doppler US. Therefore, it can be useful in resource-constrained settings in which there is no access to US. However, future studies are warranted to evaluate the test characteristics of pulse oximetry for detecting TT based on using US and surgical findings as the gold standards and, nonetheless, to reliably differentiate among the various conditions of acute scrotum such as torsed appendage and epididymo-orchitis.

Weight Labeling and Obesity: A Longitudinal Study of Girls Aged 10 to 19 Years

Anti-obesity efforts that rely on stigmatizing weight (eg, using harsh language or stereotypical portrayals of overweight individuals) may impede health promotion efforts, as weight stigma is often negatively related to behavior change and thus seems unlikely to result in weight loss.1 Indeed, considerate research underscores the detrimental effects of weight stigma on the physical health and well-being of children and adolescents,2 and nationally representative, longitudinal data show weight-based discrimination is associated with weight gain among older individuals.3 Although the childhood weight stigma literature frequently examines overt and often malicious behaviors (eg, bullying), stigma processes can begin when an individual experiences weight labeling.4 By labeling someone as overweight, the negative stereotypes, status loss, and mistreatment associated with this label may now be applicable to the individual. Recent research suggests that the negative psychological effects of weight stigma can begin when one is simply labeled as “too fat” by others.5 However, the relationship between weight labeling and weight gain remains unknown. Thus, we examined if weight labeling during childhood was related to the likelihood of having an obese body mass index (BMI) nearly a decade later.

Results | Participants without BMI data at age 19 years (n = 317) were excluded from analyses. These participants did not differ in baseline BMI, weight labeling, or race but had slightly lower levels of household income and parental education. At baseline, 57.9% (n = 1188) of participants reported being labeled “too fat” followed by a list that included father, mother, brother, sister, best girlfriend, boy you like best, any other girl, any other boy, and teacher. Participants reporting “yes” to any item were considered labeled.

Methods | Sample. The National Heart, Lung, and Blood Institute Growth and Health Study followed up girls who self-identified as black (n = 1213) or white (n = 1166) from age 10 years until age 19 years. Extensive study information is available at https://biolincc.nhlbi.nih.gov/static/studies/nghs/Protocol.pdf. The National Heart, Lung, and Blood Institute Growth and Health Study protocol was approved by institutional review boards at all 3 sites (University of California, Berkeley; University of Cincinnati; and Westat/Group Health Association, Rockville, Maryland). The University of California, Los Angeles Institutional Review Board provided human subjects approval for the current study. The child provided written assent and a parent/guardian provided written informed consent until the child became 18 years old, at which point she provided written informed consent.

Measures. A parent or guardian provided income and education information at baseline. Certified staff conducted anthropometry and collected information on pubertal timing and weight labeling. Weight labeling was assessed by asking participants, “Have any of these people told you that you were too fat?” followed by a list that included father, mother, brother, sister, best girlfriend, boy you like best, any other girl, any other boy, and teacher. Participants reporting “yes” to any item were considered labeled.
the source of labeling and 1.40 when nonfamily members were the source. These effects were not modulated by race.

Discussion | Being labeled “too fat” in childhood was associated with higher odds of having an obese BMI nearly a decade later. Importantly, this relationship was independent of initial BMI and thus not attributable simply to participants’ objective weight at baseline. These data provide novel evidence that the relationship between weight stigma and weight gain may begin early in life; these findings also demonstrate that this relationship can emerge even for a seemingly innocuous facet of stigma (ie, labeling). Weight stigma may contribute to weight gain by increasing obesogenic stress processes and triggering weight-promoting coping behaviors like overeating; future research should examine these potential mechanisms.

Conclusions | Given our findings, and the broader literature suggesting weight stigma adversely affects the well-being of overweight children,2 advocating for weight stigma as public health policy seems unproductive.6 Researchers, public health officials, and clinicians should consider nonstigmatizing approaches to improving the health and well-being of overweight children.

Jeffrey M. Hunger, MA
A. Janet Tomiyama, PhD

Author Affiliations: University of California, Santa Barbara (Hunger); University of California, Los Angeles (Tomiyama).

Corresponding Author: A. Janet Tomiyama, PhD, Department of Psychology, University of California, Los Angeles, 1285 Franz Hall, Los Angeles, CA 90095 (tomiyama@psych.ucla.edu).


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COMMENT & RESPONSE

Understanding Sexual Violence Perpetration

To the Editor | It seems unlikely that the 9% of adolescents reported by Ybarra and Mitchell1 to have coerced sex, or to have attempted or completed rape, made a conscious decision to commit a felony. It is more likely that they made excuses for their behavior because they had not fully understood the lesson that any penetration of the body of a girl (or boy) without free consent is rape—consent being valid only if she or he is capable of giving consent. Somehow, they convinced themselves that the rules did not apply to them.

This ignorance is not surprising because study after study has found that most people define rape using a stereotypical script in which a sober girl is injured resisting a stranger.2 Scenarios that deviate from this script are often thought to be legal—although perhaps not good—behavior. Even victims doubt that rape occurred if the event deviated from the societal script.3 As soon as a perpetrator knows the victim, or if the victim has used alcohol or drugs, society’s script is less critical of behavior that can still legally be considered rape.

Fortunately, it is possible to get adolescents to rethink their scripts for acceptable behavior. In Canada, an educational program for high school freshmen was associated with reduced dating violence (sexual assault was not assessed separately).4 In California, a coach-led program for high school athletes was associated with reduced sexually aggressive behavior.5 More important, after the program, student athletes engaged in less negative bystander behavior such as laughing, going along with abusive behavior, or saying nothing. Bystander behavior is important because, as shown by a Facebook posting in Steubenville, Ohio, one motivation for rape is to exhibit one’s prowess to bystanders. And changing bystander behavior brings us back to the importance of societal scripts.

We do not typically think of our daily lives as bystander activity that helps shape the societal script for rape. However, common jokes, different types of entertainment, and casual conversations frequently reinforce myths that undermine the seriousness of rape. We should apply the lessons learned from high school students to rethink the actions that we as the adults in society call rape. This is not a negative action leading to censorship but rather an affirmative action to rethink our collective script so that everyone is aware that forced or coerced sex is never acceptable—even between friends who have been drinking.

William H. Goodson III, MD

Table. Results of Logistic Regression Analyses Predicting Obesity Status at Age 19 Years From Baseline Weight Labelinga

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Source of Labeling, OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Model 1: Anyone</td>
</tr>
<tr>
<td>Baseline BMI</td>
<td>1.70 (1.61-1.80)</td>
</tr>
<tr>
<td>Race</td>
<td>1.31 (0.93-1.84)</td>
</tr>
<tr>
<td>Parental education</td>
<td>0.73 (0.58-0.93)</td>
</tr>
<tr>
<td>Household income</td>
<td>0.76 (0.64-0.89)</td>
</tr>
<tr>
<td>Age at menarche</td>
<td>1.01 (0.91-1.12)</td>
</tr>
<tr>
<td>Baseline labeling</td>
<td>1.66 (1.20-2.30)</td>
</tr>
</tbody>
</table>

Abbreviations: BMI, body mass index; OR, odds ratio.

a The pattern of results was the same when modeling both weight labeling and BMI as continuous variables; these full results are available from the authors.