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Weight Bias: A Hidden Stigma

Interviewee

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What prompted your interest in weight bias, stigma and discrimination?

Early on in my training as a graduate student, I was offered an opportunity to do some research on weight stigma. This was an issue that I knew little about, but I became immersed in the topic as I learned how widespread weight bias is in our society, and that it was essentially unchallenged and ignored. At that time I was also providing psychological and behavioural weight loss treatment to patients with obesity. I was struck by how often patients talked about their experiences of weight bias, and how frequently these experiences caused emotional distress and created significant barriers in treatment. The more I learned about weight bias, the more I wanted to do research on this issue to try to help improve the quality of life of those who are affected.

Is weight bias a problem In healthcare?

Several decades of research show that weight bias exists in the healthcare setting. In fact, our research found that women with obesity report that doctors are one of the most common sources of weight bias in their lives – 69% of women reported these experiences with doctors. Negative weightrelated attitudes and stereotypes toward patients with obesity have been documented among physicians, nurses, medical students, dietitians, psychologists, and even health professionals who specialise in obesity. Stereotypes include assumptions that patients with obesity are non-compliant with treatment, lazy, and lack willpower and motivation to improve their health. Recent studies have examined weight biases among large samples of medical students and physicians, and found that levels of weight bias in these groups were no different than the extent of weight bias present in the general population. Weight bias remains considerably common in our society, and health providers are not immune to adopting these biases.

What effect does it have on patients?

Weight biases by health providers can affect the quality and content of the care that they provide to patients. These biases are related to disparities in the quality of communication and decision-making by providers, how much time they spend with patients, the likelihood of discussing weight-related health, and can contribute to avoidance of healthcare and low ratings of care by patients. In addition, research shows that health providers have less respect for patients as their BMI increases, well as more frustration, less patience, less rapport, and less desire to help patients with obesity compared to thinner patients.

What should healthcare providers do to address weight bias?

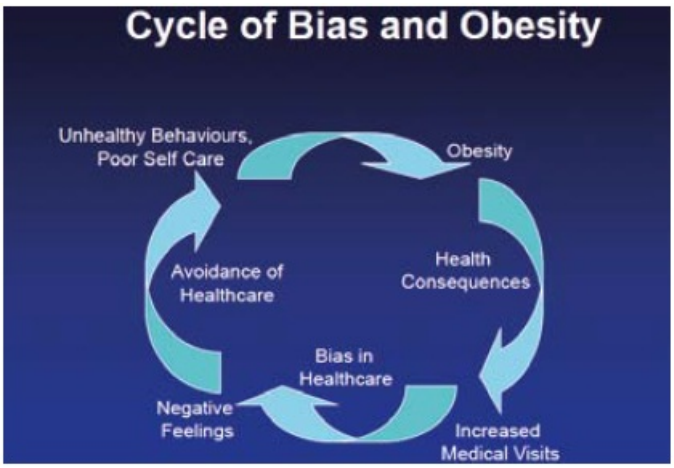
Healthcare providers can implement a number of strategies in their clinical practice to reduce and avoid weight bias. As a first step, it is helpful to become aware of one's personal assumptions and attitudes about body weight, and to challenge weight-based stereotypes. In addition to increasing self-awareness, it is important to give careful consideration to the language you use to discuss body weight with patients and colleagues. Our research has found that when patients feel that a doctor has used stigmatising language to describe their excess body weight, many patients report feeling ashamed and intend to avoid future healthcare appointments. Using people-first language, motivational interviewing techniques, and language that avoids blaming or judging patients about their weight can help providers to more effectively support their patients with obesity. We often suggest that providers begin a conversation about weight with patients by asking patients how they feel about their current weight, and what preferred language or terminology to describe excess body weight patients would feel most comfortable with.

In addition to promoting positive and productive discussions about weightrelated health, providers need to look carefully at the medical office setting to see where there might be unintentional messages or situations that promote weight bias. For example, the reading materials provided in the medical office waiting room offer an opportunity to provide patients with important health messages related to nutrition, eating and physical activity. But it's important to ensure that these reading materials or magazines have no stigmatising messages or emphasise the importance of weight loss for the purpose of physical appearance rather than improved health. Other aspects of the medical setting can also create experiences of shame or embarrassment for patients with larger bodies. To avoid this, be sure that medical equipment is large enough to accommodate patients with larger bodies, whether it be examination tables, blood pressure cuffs, scales, patient gowns, or waiting room chairs. Organisations like the U.S. National Institutes of Health have developed guidelines for strategies to promote a medical setting that accommodates patients of diverse body sizes.

Should obesity be viewed as a disability with attendant legal and civil rights? There is a test case before the european court of human rights on this issue. What is the position in the United States?

There are different views about whether or not obesity should be considered a disability. In our national polling studies, we have found that Americans express substantial support for legal measures to prohibit weight discrimination toward people with obesity (especially in the context of weight discrimination in employment), but less so for laws that would extend disability protections to persons with obesity. Still, in our most recent study which tracked public attitudes for laws that would extend disability benefits to individuals with obesity, we found increasingly favourable public attitudes between 2011-2013. The increased support for this type of law was primarily observed in 2013, and it's possible that this was partially attributed to the announcement by the American Medical Association (and resulting national media attention) classifying obesity as an official disease. This announcement and media coverage occurred shortly before our 2013 data collection.

At the same time, some people have argued that labelling obesity as a disability may instead promote additional societal stigma. There are many individuals with obesity who are not disabled by their weight, and who do not want to be perceived as having a disability. This is certainly a complex issue, and one that warrants additional discussion and research attention.



Do women who are overweight or obese experience more discrimination than men? does this mean, for example, That they are less likely to present for mammographic screening?

The research on this topic is somewhat mixed. Certainly both women and men are vulnerable to weight bias and discrimination. Some of our studies, using national samples, have found that women are more vulnerable to weight discrimination, and at lower levels of overweight, compared to men. For example, we have found that women with a BMI of 27 are already reporting considerable weight discrimination, but that

comparable levels of weight discrimination among men don't seem to occur until higher levels of obesity. It appears that for women, if they deviate (even slightly) from expected societal ideals of thinness and physical attractiveness, they are at risk for experiencing weight bias.

We also see in studies that women with obesity are more likely to delay preventative health screenings, and that weight bias may be a contributor. In one study by Amy and colleagues, women with obesity attributed their decision to avoid and cancel medical appointments to the fact that they had experienced weight bias from providers in the past, felt ashamed and embarrassed of being weighed, and felt that the medical equipment was too small to be functional for their body size. The percentage of women who reported these barriers increased with their BMI. So there are certainly important implications of weight bias for utilisation of healthcare.

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