

## JAN Article November 2017 | Weight Bias

*Weight bias refers to negative weight-related attitudes and preconceptions, predominately towards people larger in size. Nadia Craddock discusses the detrimental and wide-reaching impacts of weight bias and what can be done to avoid weight bias in healthcare practice.*

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Imagine four prospective patients. Each fall within a different weight category: underweight, normal weight, overweight, and obese based on their body mass index (BMI). Who is the smartest? The most sedentary? The kindest? The funniest? The healthiest?

Maybe there's not enough information to judge. Try now, knowing each patient is female, 35 years old, and Caucasian. They all have professional jobs in the city. Try rank-ordering each prospective patient on each adjective: smart, sedentary, kind, funny, healthy.

Which adjective was the easiest to identify? Which was the most difficult?

Of course, this is an illustration of how weight bias can arise, a phenomenon common among healthcare professionals (Phelan et al., 2015). Clearly, there isn't enough information in this example to make a call on any of different adjectives. We don't, for example, have their IQ scores. Similarly, we can't make judgement on health as we don't know what their diet is like, what their activity levels are, nor do you know their blood pressure, cholesterol, muscle mass, whether they are on any medication etc.

### **Defining Weight Bias**

The term weight bias (or weight stigma) refers to negative weight-related attitudes, assumptions, judgments and beliefs towards individuals who are larger in size (Puhl, Andreyeva, & Brownell 2008). Like other forms of bias (e.g., gender, race, age), weight bias is manifested by negative stereotypes, prejudice, and discrimination (Puhl et al., 2008). Common weight bias stereotypes include the idea that larger people are 'lazy', 'undisciplined', 'less intelligent', 'gluttonous' and 'unclean' compared to their smaller counterparts (Puhl & Heuer, 2009).

### **Where Does Weight Bias Come From?**

It is important to remember, we cannot accurately make negative judgments on character and behaviour based upon weight alone. Yet, these negative stereotypes of larger people are widely perpetrated in society, especially by the media, which glorifies thinness as aspirational and

synonymous with success while portraying fatness as undesirable (Ata & Thompson, 2010). Often, media images of larger people are dehumanised, e.g., with the camera zooming in on a person's stomach (McClure, Puhl, & Heuer, 2011). Further, although the root-causes of weight bias are not conclusively understood, a major contributing yet fallible assumption is that our weight is highly controllable, and subject to personal choice and discipline (Alberga et al., 2016). However, individual responsibility is frequently over simplified and overstated (Alberga et al., 2016; Kahan & Puhl, 2017). Public health experts point to the change in our environment such as pervasive unhealthy food availability (particularly in low-income neighbourhoods) and a diminished necessity for physical activity as the primary factors behind growing national obesity rates (Bray & Champagne, 2005; Poston & Foreyt, 1999).

### **Weight Bias Can Lead to Weight-based Discrimination**

Significantly, negative stereotypes of people who are larger in size, compounded with weight bias prejudice (i.e., the negative sentiment towards fat people), can lead to weight-based discrimination (i.e., the unequal, unfair treatment based on a person's size and weight). Research has found evidence of weight-based discrimination in multiple settings, including the workplace, educational institutions and health care (Puhl & Heuer, 2009). In the workplace, for example, research shows that a larger person is more likely to be penalised when it comes to recruitment, job promotion, and salary. Indeed, one study found that, after controlling for age, education, marital status, and a range of other related factors, overweight and obese adults earned significantly less than average-weight adults (Judge & Cable, 2011). Notably, weight-based discrimination is the most socially accepted form of societal discrimination (Pomeranz, 2008) and is not protected by law (Hervey & Rostant, 2016).

### **Who's Affected Most by Weight-Based Discrimination**

In line with the growing average weight of the population in many Western countries, research has shown a parallel increase in the prevalence of weight-based discrimination, rising by 65% between 1995-2005 (Andreyeva, Puhl, & Brownell, 2008). Perhaps unsurprisingly, a person's chances of being discriminated against because of weight become higher as their body weight increases (Puhl et al., 2008). Importantly, women experience weight discrimination at lower BMIs compared to men and more frequently (Fikkan & Rothblum, 2012; Puhl et al., 2008). For example, one study has found that larger women experience weight discrimination at a similar rate to race-based discrimination (Puhl et al., 2008). There is also some evidence to support the intersection of race and weight, whereby

people of colour with a higher BMI are more likely to experience discrimination than their white counterparts, supporting a 'double-disadvantage' hypothesis (Grollman, 2014).

### **Negative Health Outcomes Associated with Weight Bias**

In addition to the social and economic consequences associated with weight-based discrimination, weight bias predicts multiple negative health outcomes (Puhl & Heuer, 2009). These can be psychological, whereby people reporting experiences of weight bias also report higher levels of depression, anxiety, poor body image, and low self-esteem (Freidman et al., 2005; Harriger & Thompson, 2012). Furthermore, weight bias has negative implications for healthful behaviours, for example, experiencing weight bias is associated with more unhealthy eating behaviours such as binge eating, extreme dieting and other unhealthy weight control practices (Almeida, Savoy & Boxer, 2011; Durso, Latner & Hayashi, 2012). Furthermore, it leads to the avoidance of physical activity, for fear of being shamed for their weight (Vartanian & Novak, 2011; Pearl, Puhl, & Dovidio, 2015). Importantly, research shows that these adverse health outcomes associated with weight bias may be particularly potent if individuals have internalised the stigma and discriminatory treatment they experience as a result of their size with negative implications on both physical and mental health (O'Brien et al., 2016). Taken together, it's clear that weight bias and shaming individuals because of their size does not inspire positive, healthful behaviour change.

### **Weight Bias in Healthcare**

Evidence of weight bias in healthcare professions is pervasive. Studies from the UK, US, Australia and Europe report high levels of weight bias in doctors, nurses, psychologists, obesity specialists, maternity care providers and pre-service health students (Mulherin et al. 2013; Phelan et al., 2015; Sabin, Marini & Nosek, 2012; Swift et al., 2013). Significantly, evidence shows that even health care professionals specializing in obesity are not immune to weight bias (Schwartz et al., 2003). Undoubtedly, strong negative attitudes and stereotypes about people with obesity may impact the care health professionals provide. This may be particularly relevant when it comes to the patient-provider relationship (Mold & Forbes, 2013) with research finding that weight bias can impair patient-centred communication (Gudzune et al., 2013). This can then lead to an increased risk of patient non-adherence, mistrust, and limited recovery (Phelan et al., 2015).

### **How to Avoid Weight Bias to Improve Patient Care**

Two key evidence-based ways of reducing weight bias as a means for health professionals to improving patient care have been identified in the literature. The first pertains to raising awareness of weight bias and the limited control people in fact have over their weight. For example, a brief, education-based anti-weight bias intervention successfully reduced weight bias among pre-service health students (Diedrichs & Barlow, 2011). The second relates to translating this knowledge into action in order to build patient trust and ultimately foster healthful behaviours and so is centred on empathy and shifting the conversation away from weight, weight loss, and the health consequences associated with obesity (Phelan et al., 2015). Evidence shows that focusing on the benefits of physical activity and healthy eating increases the likelihood of behaviour change and maintenance (Lewis et al., 2010). More advice for healthcare providers to improve the care they offer by reducing weight bias can be found at <http://biastoolkit.uconnruddcenter.org> - a freely available online toolkit designed by leading experts at the Rudd Centre for Food Policy and Obesity (USA).

### **Key Points**

1. Weight bias or stigma refers to negative attitudes, assumptions, judgments and beliefs towards individuals who are larger in size.
2. Weight-based discrimination affects women at a lower BMI and more frequently than men.
3. People experiencing weight bias are more likely to engage in disordered eating behaviours such as binge eating or fasting, and are more likely to report depression, anxiety, and stress.
4. Evidence of weight bias is pervasive among healthcare professionals.
5. More understanding around weight bias stands to improve patient care.

### **Key Words**

Weight Bias | Weight Stigma | Obesity | Discrimination

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