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Breaking WEIGHT BIAS

Promoting Health without harming through digital training tools

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2.2. Identifying potentially harmful practices

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2.2. Identifying potentially harmful practices

2.2.1. Verbal and non-verbal communication

Verbal communication

Language is an influential factor that can affect the access of people living in a large body to quality healthcare. The use of stigmatising language by healthcare professionals can exacerbate weight bias in healthcare settings (Kyle & Puhl, 2014). Such language is also demotivating for patients in large bodies and thus, it affects their engagement with healthcare services. Indeed, a study investigating the opinions and preferences of the public regarding the language used by healthcare professionals concerning weight found that if the patients' doctor made a stigmatising reference to their weight, 19% of them would most probably forgo future medical sessions, while 21% would seek a new doctor (Puhl et al., 2012).

When we describe somebody as "fat," "overweight" "obese," "big," "heavy," "voluptuous," or simply "higher-weight," these labels are reflecting certain **culturally constructed values**. It is important to take into consideration whether those words respect the dignity of humans and investigate whether they increase or impede their physical and mental health. If those phrases do not serve the overall well-being of people, that means they unintentionally reinforce weight stigma and thus, it is crucial to avoid using them. A positive first step could be to start using, in papers, research and healthcare settings, more neutral terms, such as "weight" and "higher weight" (Meadows & Daníelsdóttir, 2016).

As Puhl et al., says: *"Obese is an identity."*, whereas *"Obesity is a disease. By addressing the disease separately from the person—**and doing it consistently**—we can pursue this disease while fully respecting the people affected."*

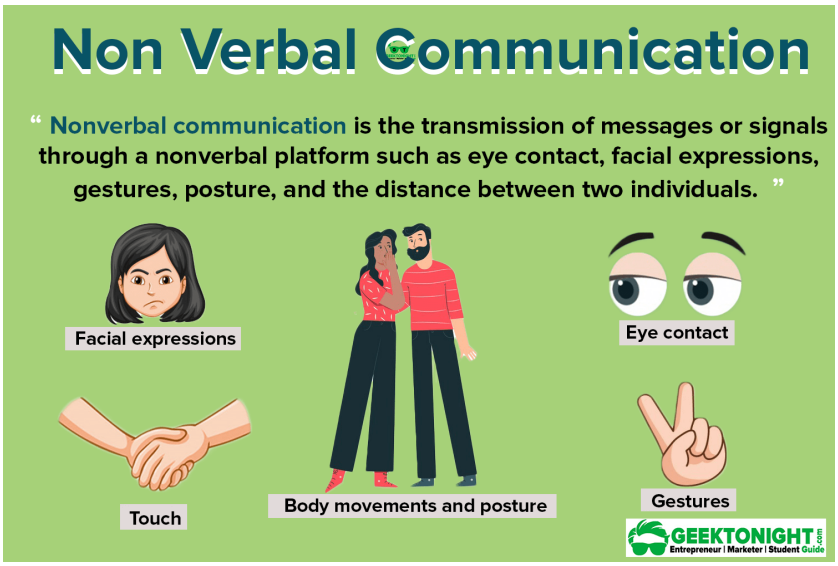
Since obesity is a medical condition, that means it is something that people can "have" rather than "be". Thus, the use of phrases such as "you are obese" implies that the recipient is defined by their medical condition, in this case by obesity, thus creating an inaccurate identity, while it amplifies the process of assigning the blame on them (Coltman-Patel, 2018).

In the context of addressing this issue, **"People-First Language"** has attracted a lot of attention. Even though this way of communication is being used for a great majority of chronic diseases, it is still not applied when it comes to obesity (Puhl et al., 2012).

According to the People-First Language approach, when calling a person "obese", they are being dehumanised (Obesity Action Coalition, 2021). Thus, **such labels should not be used when interacting with or describing people living with obesity**. According to Obesity Action Coalition (2021), examples of People-First Language can be:

1. “People who are affected by obesity very often encounter weight bias.” instead of “Obese people very often encounter weight bias.”
2. “People with obesity may need medical treatment.” instead of “Obese people may need medical treatment.”

Non-verbal communication



When interacting with others, people are constantly sending and receiving non-verbal signals through gestures, eye contact, tone of voice, and other behaviours, which can influence the feelings of the involved individuals (Segal et al., 2021).
Non-verbal communication is an equally important influential factor in patients’ outcomes. A study showed that patient satisfaction is associated with the physician's affirmative nonverbal behaviour, such as eye contact and closeness (Mast, 2007).
According to Segal et al. (2021), there are several types of non-verbal communication. Some examples are:

- Facial expressions:

The human face is incredibly expressive, capable of conveying a wide range of emotions without saying anything. Facial expressions - such as these for happiness, sorrow, anger, surprise, fear, and contempt - unlike certain other kinds of non-verbal communication, are universal.

- Body movement and posture:

The way people walk and carry themselves is quite informative. The posture, bearing, stance, and subtle motions are all examples of non-verbal communication.

- Gestures:

Gestures cover a huge part of people’s daily lives. People frequently, almost off-hand, use gestures instead of words when expressing themselves. In contrast with facial expressions, gestures are not universal. Thus, the meaning of certain gestures varies across cultures. For example, ”while the “OK” sign made with the hand, usually conveys a positive message in English-speaking countries, it’s considered offensive in countries such as Germany, Russia, and Brazil” (Segal et al., 2021).

- Eye contact:

Eye contact is a particularly essential kind of non-verbal communication, as many things may be communicated by the way one looks at someone else. These include interest, anger, or desire.

- Touch:

Touch is also a strong means of communication. Examples include “a weak handshake, a warm bear hug, a patronising pat on the head, or a controlling grip on the arm” (Segal et al., 2021).

- Space:

Physical space may be used to convey a variety of non-verbal messages, including signs of closeness and affection, hostility, and authority. For example, when one stands too close it may be interpreted by others as being authoritative. However, the need for physical space is dependent on the culture, situation and closeness between the involved individuals.

- Voice:

Speaking is not only a matter of what is spoken but also a matter of how this is spoken. Things that are also important in that context are:

  - timing
  - tempo
  - the volume of the voice
  - tone and inflection
  - sounds that convey understanding (e.g. “ahhh”, “uh-huh”)

In the context of weight bias, research has shown that weight stigma can also manifest itself in subtle ways. Thus, the person who stigmatises may not be aware of the fact that they express such behaviours. However, such manifestations of weight bias can still negatively impact the person who is stigmatised (Tomiyama et al., 2018). Examples of weight bias through non-verbal communication in healthcare settings can be that a physician may have more eye contact with a patient with an average BMI rather than with a patient living with obesity (Vartanian, Pinkus & Smyth, 2018 as cited in Tomiyama et al., 2018).

2.2.2. The application of “tough love”

A recent trending method that is applied by healthcare professionals in the context of motivating their patients to lose weight is that of “tough love”. “Tough love” has been defined by the Cambridge Dictionary as “*the fact of deliberately not showing too much kindness to a person who has a problem so that the person will start to solve their own problem”* (Cambridge Dictionary, n.d.). In that context, physicians seek to persuade patients by describing the illness progression caused by a lack of behavioural change. Providers highlight the implications of obesity, including forecasts of severe

complications and early death, to induce patients to modify their lifestyle practices (Sackett & Dajani, 2019).
The use of "tough love" has been perceived as being an appropriate strategy when applied for the right reasons. However, it might cause **fear and embarrassmen**t in certain people. Thus, the American Psychology Association (APA) declared that the effectiveness of such strategies is not guaranteed and can even be harmful (American Psychological Association Website, 2017 as cited in Sackett & Dajani, 2019).
Tough love, when applied to the case of obesity, refers to the use of weight stigma as an incentive for people with overweight to adopt healthier nutrition and exercise habits, acting as a social control mechanism. This is founded on the belief that stigmatised people will adjust their behaviours - thus, conforming to the social norms - in an effort to avoid stigmatisation. However, the effectiveness of this practice is quite controversial due to the absence of supporting evidence. Contrastingly, research has shown that weight stigma increases the risk of binge eating, and unhealthy weight control behaviours as well as it is associated with low levels of physical exercise thus, acting in support of obesity (Puhl & Heuer, 2010), rather than preventing it.

2.2.3. Attribution of all health issues exclusively to weight

It has been documented that people living in large bodies feel that they are not really being listened to by healthcare professionals, because of the latters' tendency to attribute all of their symptoms to weight, without taking into consideration any other aspects of health (Alberga A.S. et al., 2019). Attribution of all health conditions to weight can discourage people living in large bodies from expressing their concerns about a health issue or even from revealing to their general practitioner what symptoms they may be experiencing (Brown I. et al., 2006). Indeed, weight-related reasons can be one of the most important barriers to proper healthcare utilisation, since patients believe that they should wait until they lose weight before going to an appointment. Avoiding or delaying medical appointments because of the fear of having to step on the scale and feeling judged about their weight can have detrimental effects on the treatment of people with obesity (Drury, CA. & Louis, M., 2002). Moreover, it is worth mentioning that over-attributing symptoms to obesity may result in mistreating health issues that need different therapeutic approaches. Giving unsolicited advice for "weight-loss" can hinder patients from undertaking further diagnostic testing to receive the right treatment for their health condition (Phelan S.M. et al., 2015).

2.2.4. Assumptions & low trust

Negative weight-based assumptions
Negative weight-based assumptions constitute another manifestation of weight bias in healthcare settings. Research indicates that medical decision-making does not only result from rational prescriptive models, but also from non-medical factors, such as the

patients' physical appearance, the healthcare professionals' clinical experience and the healthcare setting (McKinlay et al., 1996). Thus, implicit bias can result in inaccurate assumptions and poor outcomes, which in the context of healthcare provision can be even dangerous (Bedford, n.d.).

Making false assumptions about patients with obesity is a harmful practice of healthcare professionals that has been reported by patients living with obesity (Alberga et al., 2019). Healthcare professionals often hold thoughts, beliefs, and opinions regarding how their patient has gained weight, which most probably may be the result of stereotypical thinking. Some examples of negative weight-based assumptions that often occur in healthcare settings are:

- Healthcare professionals being judgmental on their patients with obesity about eating unhealthy food or not exercising enough without asking their patients about their reality and even when they do ask, they do not believe them (Alberga et al., 2019);
- Healthcare professionals consider patients with overweight as not being willing to lose weight (McHale et al., 2020);
- Healthcare professionals consider patients with overweight being less compliant with healthcare instructions (Ferrante et al., 2006 as cited in Lee & Pausé, 2016).

Such assumptions not only can negatively affect the patients' outcomes as they oversimplify the causes of obesity and thus, overlook the complex nature of human metabolism, but also contribute to further spreading the misconception of weight loss as being a straightforward process (Phelan et al., 2015).

Low trust

Lower trust in healthcare professionals has been widely reported to be a consequence of experiencing weight bias in healthcare settings. According to Gudzune et al., (2014), patients with overweight who felt being stigmatised due to their weight by healthcare professionals were much less likely to trust them. Although an exploratory study revealed a minor relationship of trust with health behaviours, quality of life, and symptom severity, a strong link was detected between patient satisfaction and trust. Overall, though, this study concluded that in the cases where patients had increased trust in their healthcare provider, there was increased satisfaction with treatment, beneficial health behaviours, quality of life and fewer symptoms (Birkhäuer et al., 2017).

Trust is generally perceived to be **one of the most crucial elements in the context of healthcare relationships between professionals and patients**. This is founded mainly on the perception that trust strongly influences the communication between healthcare professionals and patients as well as the latters' decision to remain with their physician (Johnson, 2019). According to Johnson (2019), some examples of manifestations of trust in the context of interactions between healthcare professionals and patients include:

- physicians' willingness to listen to patients;
- patients' believing that physicians value patient autonomy and ability to make informed decisions;
- patients feeling comfortable enough to express and engage in dialogue related to their health concerns.

"….'patients must be able to trust doctors with their lives and health,' and maintaining trust is one core guidance for physicians…"

(Birkhäuer et al, 2017, as cited in Johnson, 2019)

2.2.5 Diet prescription

Dieting and other weight-loss practices are frequently perceived to be and promoted as a solution to the "issue" of obesity not only in the medical practice but also from a public health policy perspective (Bacon & Aphramor, 2011). This has been based on claims supporting that the use of stigma and social pressure as an incentive for people with obesity to lose weight positively impacts population health (Tomiyama et al., 2018). A study found that when conducting obesity counselling, healthcare professionals are more likely to discuss "exercise", "diet" and "obesity" rather than "physical activity", "eating habits" and "unhealthy weight" respectively (Petrin et al., 2017).

However, it is still important to remember that using determined words can have a different influence on patients, due to their internalisation of a certain language. Every patient can internalise words differently due to their subjectiveness. That is why each healthcare provider needs to take into consideration every patient's feelings differently.

According to Bacon & Aphramor (2011), **the so-called weight-focused paradigm is founded upon certain assumptions**. These are:

- Adiposity poses significant mortality risk;
- Adiposity poses significant morbidity risk;
- Weight loss will prolong life;
- Anyone who is determined can lose weight and keep it off through appropriate diet and exercise;
- The pursuit of weight loss is a practical and positive goal;
- the only way for people with overweight and obesity to improve health is to lose weight,
- Obesity-related costs place a large burden on the economy, and this can be corrected by a weight-centred attention on obesity treatment and prevention, based on personal responsibility.

However, research has failed to prove these assumptions right (Bacon & Aphramor, 2011). On the contrary, it suggests that weight stigma can impair the patients' metabolic health and weight growth by causing psychological and behavioural changes, such as avoidance of exercise (Tomiyama et al., 2018). Moreover, consequences have also been detected on the patients' biological health including increased eating, decreased self-regulation, and higher cortisol levels (Tomiyama et al., 2018).

Thus, Bacon & Aphramor (2011) suggest that "body weight is a poor target for public health intervention" (p.9) and that existing data are adequate so that a shift away from conventional weight loss to be supported.

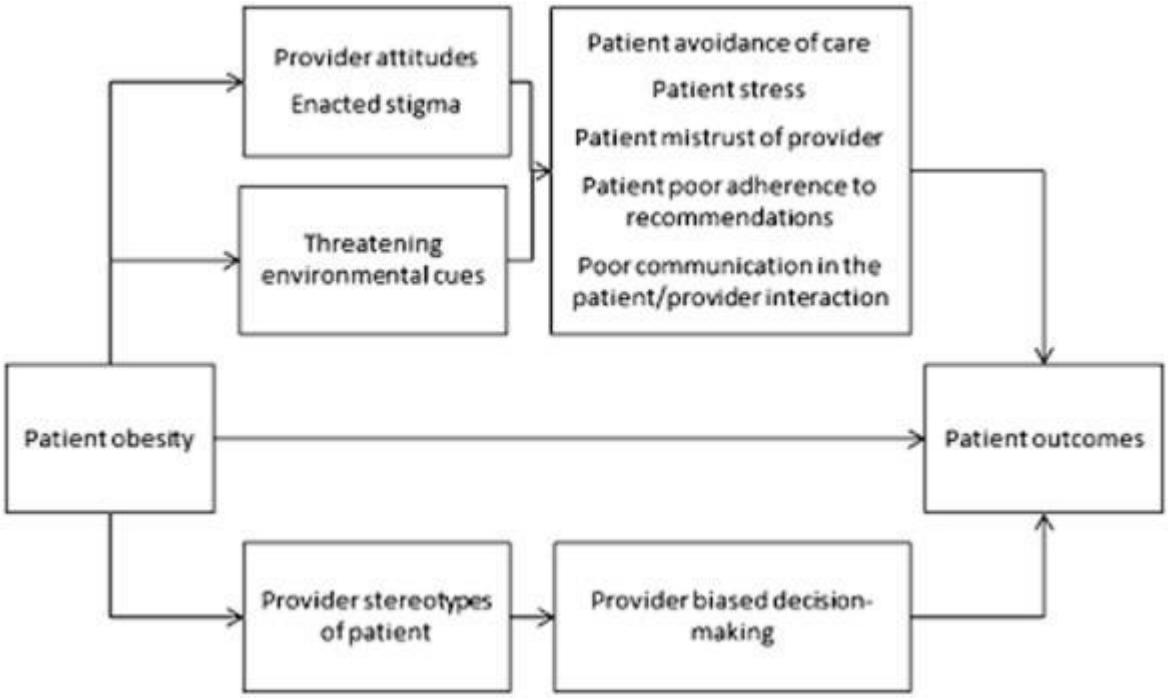


Figure 2.2. Conceptual model of hypothesised pathways explaining possible associations between obesity and health outcomes that are partially mediated by healthcare providers' attitudes and behaviours about people with obesity and the patients' response to feeling stigmatised (Phelan, SM. et al., 2015).

EXTERNAL RESOURCES

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