

Do No Harm: Addressing Weight Stigma in Dietetics Practice

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Disclosures

None.

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Learning Objectives

- 1**
List pathways to poor health outcomes that stem from weight stigma.
- 2**
Describe how weight stigma may present in RD appointments.
- 3**
Identify modalities and strategies RDs can use within their SOP to help neutralize the effects of weight stigma.
- 4**
Explain how RDs in all areas of practice can avoid contributing to weight stigma.
- 5**
Relate patient-centered care to social justice.


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What is Weight Stigma?

An Overview




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Bias, Stigma, & Discrimination¹

- Weight bias: Negative, prejudiced attitudes towards and beliefs about weight
- Weight stigma: Directing that prejudice towards individuals based on their weight
- Weight discrimination: Overt behavioral manifestation of weight bias



World Health Organization, Regional Office for Europe. Weight bias and obesity stigma: Considerations for the WHO European Region.





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Weight Stigma

Labeling, stereotyping, ostracizing, status loss and discrimination that may be:

- **Embedded** in institutions, governments and the broader society (*structural/institutional*)
- **Perpetuated** by others, including friends, family, co-workers or strangers (*external*)
- **Internalized** and self-directed (*internal*), i.e., when someone accepts weight-based stereotypes about themselves



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Weight Stigma Prevalence

- Weight discrimination is one of the most common forms of **discrimination** reported by U.S. adults, especially women.²
- About 40% of the general population reports **experiencing some type of weight stigma**, ranging from teasing to outright discrimination.^{3,4}
- Among youth who are teased, bullied or victimized at school, weight is one of **the most common** reasons.^{5,6}

1. American Dietetic Association. (2019). *Position of the American Dietetic Association: Nutrition and Weight Management*. *Journal of the Academy of Nutrition and Dietetics*, 19(1), 1-10.
 2. Puhl, R. M., & Hebl, G. R. (2010). *Weight Stigma: A Review of the Empirical Literature*. *Current Directions in Psychological Science*, 19(6), 281-286.
 3. Puhl, R. M., & Hebl, G. R. (2010). *Weight Stigma: A Review of the Empirical Literature*. *Current Directions in Psychological Science*, 19(6), 281-286.
 4. Puhl, R. M., & Hebl, G. R. (2010). *Weight Stigma: A Review of the Empirical Literature*. *Current Directions in Psychological Science*, 19(6), 281-286.
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Why Weight Stigma is Different

- Internalization⁷
- Little **group** "protection"⁸
- **Social** acceptability^{9,9}
- **Exacerbated** by binge eating disorder (BED)⁹



7. Puhl, R. M., & Hebl, G. R. (2010). *Weight Stigma: A Review of the Empirical Literature*. *Current Directions in Psychological Science*, 19(6), 281-286.
 8. Puhl, R. M., & Hebl, G. R. (2010). *Weight Stigma: A Review of the Empirical Literature*. *Current Directions in Psychological Science*, 19(6), 281-286.
 9. Puhl, R. M., & Hebl, G. R. (2010). *Weight Stigma: A Review of the Empirical Literature*. *Current Directions in Psychological Science*, 19(6), 281-286.

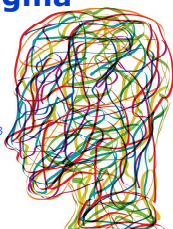
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Internalized Weight Stigma

- **Stronger** predictor of poor health^{7,10}
- Can lead to **unhealthy** eating behaviors¹¹
- Can contribute to **eating disorders**¹¹⁻¹³
- Worsened by **failed weight loss** attempts¹³
- **May not improve** with weight loss⁹




7. Puhl, R. M., & Hebl, G. R. (2010). *Weight Stigma: A Review of the Empirical Literature*. *Current Directions in Psychological Science*, 19(6), 281-286.
 8. Puhl, R. M., & Hebl, G. R. (2010). *Weight Stigma: A Review of the Empirical Literature*. *Current Directions in Psychological Science*, 19(6), 281-286.
 9. Puhl, R. M., & Hebl, G. R. (2010). *Weight Stigma: A Review of the Empirical Literature*. *Current Directions in Psychological Science*, 19(6), 281-286.
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 12. Puhl, R. M., & Hebl, G. R. (2010). *Weight Stigma: A Review of the Empirical Literature*. *Current Directions in Psychological Science*, 19(6), 281-286.
 13. Puhl, R. M., & Hebl, G. R. (2010). *Weight Stigma: A Review of the Empirical Literature*. *Current Directions in Psychological Science*, 19(6), 281-286.



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Weight Stigma Effects

Psychosocial and Physical Health





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Psychosocial Effects

- **Increased risk** of depression and anxiety^{14,15}
- **Poor body image** and lower self-esteem^{2, 8,14,18}
- **Increased stress**^{2,15}
- **Disordered eating behaviors**^{2,14}
- **Avoidance** of physical activity^{2,8,16,17}





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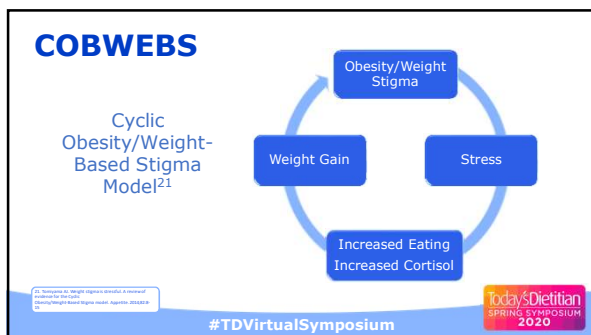
Dysregulated Eating

- More common in **marginalized** groups¹⁸
- Includes **"emotional"** eating and binge eating^{19,20}
- May explain why binge eating disorder treatment **fails**¹⁸



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Physical Effects

- Higher **cortisol** levels^{14,22-24}
- Greater **oxidative stress**^{14,22}
- Higher systemic **inflammation** and CRP levels^{14,22,25}
- **Visceral fat** accumulation²³
- **High-risk** health behaviors²⁶

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Where Does BMI Fit In?

- Even after adjusting for BMI and sociodemographic risk factors, weight stigma is associated with **multiple chronic medical conditions**²⁷⁻²⁹
- **Weight dissatisfaction** is a major driver of unhealthy dieting behaviors, which are associated with adverse health-related endpoints²⁷⁻²⁹
- Association between **weight stigma and poor psychosocial health outcomes** happen regardless of BMI, so it's unlikely that body weight itself is a cause⁸

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The Pressure of the Thin Ideal

- Weight stigma is **not** BMI-dependent³⁰
- **Fear** of weight gain¹¹
- Modified **labeling** theory^{19,31}
- **Vicarious** experiences of stigma¹⁸
- Social identity **threat**^{19,30}




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Weight, Stigma & Health

- Is stigma an **intermediary** between weight and poor health outcomes?
- Which health problems are due to **stigma**? Which are due to **weight**?
- This is why stigma studies **control for BMI**
- Stigma is a "**unique** contributing role to poor health"



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Stigma in Healthcare

Harming, Not Helping


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Healthcare Avoidance

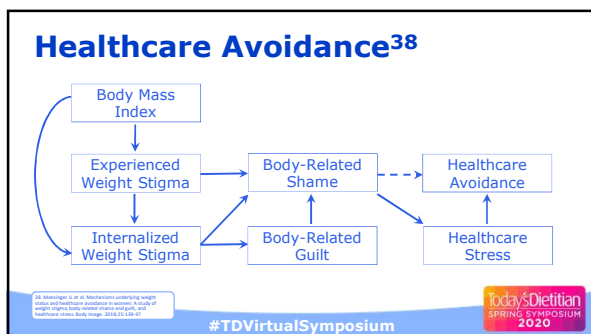
- **Weight bias** by healthcare providers leads to:
 - Canceled or delayed appointments³²⁻³⁴
 - Avoidance of preventive screening exams³⁵⁻³⁷
- This in turn leads to:
 - **Worse** health outcomes
 - **Higher** healthcare costs



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Stigma From Doctors

- One of the **biggest sources** of weight stigma³⁹
- Stereotypes → **lack** of patient trust^{33,40}
- Primary care guidelines recommend **automatic** weight loss intervention for BMI > 30, even for issues unrelated to body weight⁴¹
- Patients with higher weight bodies are **less likely** to receive evidence-based care^{34,42}



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Stigma From Dietitians

2015 Systematic Review:⁴³

- RDs and dietetic students tend to have **less-negative attitudes** than the public
- But...6 of 8 studies found **some degree of weight bias** against people with "obese" BMIs
- 4 studies found that RDs viewed **weight as a personal responsibility**




43. Long KF et al. *Overweight and Adiposity: Stigma in the Context of Obesity: A Systematic Review*. *PLoS One*. 2015;10(10):e0140276.

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Stigma in Society

A Social Justice Lens



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Media & Society

- Emphasis on **personal responsibility**^{43,44}
- Portrayal of larger bodies as **lazy** or **gluttonous**^{33,45}
- **Constant** "obesity epidemic" messages
- **Sensationalist** or miscommunicated research⁴⁶



43. Long KF et al. *Overweight and Adiposity: Stigma in the Context of Obesity: A Systematic Review*. *PLoS One*. 2015;10(10):e0140276.
44. Long KF et al. *The Role of Dietitians in Addressing Weight Stigma: A Systematic Review*. *PLoS One*. 2016;11(12):e0166000.
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Recent Examples

- Nike Mannequin
- Lizzo
- Taylor Swift
- Biggest Loser reboot



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Victim Blaming

- Lose weight to **avoid** stigma? How much weight?
- Few people maintain weight loss long-term, especially enough to **escape** external stigma^{47,48}
- Need to **reduce** stigma from ALL sources
- The approach to weight stigma needs to be **founded in social justice**^{47,49,50}



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Impact of the "War on Obesity"

Public health campaigns may have **opposite effect**:

- Stigmatizing **language**¹⁹
 - "Childhood obesity is child abuse"
 - "Chubby kids may not outlive their parents"
- Stereotypical and stigmatizing **imagery**^{51,52}
- **Feeding** both external and internalized stigma^{48,53}



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Framing Weight Stigma

Is weight stigma a problem because it creates a **barrier to weight loss?**

- **Obesity** research perspective
- **Weight stigma** research perspective



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Omissions in Obesity Research

- **Inferring** causality based on correlations
- **Failure** to address weight stigma as a confounder in studies on weight and health
- **Separation** of stigma research and obesity research
- Severe **underfunding** of stigma research




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In the RDs Office

How Weight Stigma Shows Up




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What Patients May Reveal

- **Disordered** eating
- Exercise **avoidance**
- Anxiety or mood **disorders**
- Social **isolation**
- **Poor** body image




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Case Study: Miri

- 65yo female
- Hx of **weight cycling**
- **Hysterectomy** for uterine cancer 18 mo prior to intake
- Hx of **parental neglect** in childhood with gaslighting
- Grew up in Hollywood, among the **thin ideal**
- **Poor** body image
- Self-described as being "**addicted**" to sugar



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Case Study: Miri

Pre-hysterectomy:

- Client was at **lowest** historically achievable weight (BMI 28)
- Following **Paleo diet, training** with a personal trainer, high PA level (loves exercise!)
- Final pre-op appt, expressed **concern** that her cancer would kill her
- Doctor responded: "Oh, your cancer won't kill you, but your **weight** will."



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Case Study: Miri

Post-hysterectomy:

- Client consumed with **guilt** that her weight caused her cancer
- Experienced significant **emotional eating**
- **Gained** significant amount of weight
- **Shame** over weight gain lead to:
 - **Avoiding** most forms of exercise
 - **Avoiding** follow-up cancer screenings
 - Social **isolation**




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Case Study: Miri

Initial plan:

- Introduced **intuitive** eating
- Focus on health-promoting **behaviors**, not weight
- **Advocated** for return to preventive medical care
- **Explored** ways client "hid" when her weight was up
- Helped client **reintroduce healthy pleasures** she was denying herself




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Case Study: Miri

Results to date:

- Has **lost** some weight (although this is not her focus)
- Resumed all forms of **exercise** (including some new ones)
- Is able to **wear** shorts/swimsuits/sleeveless shirts in summer
- Is able to **advocate** for herself with healthcare providers
- Recognizes "diet talk" and **no longer engages**
- **No longer** considers herself "addicted" to sugar



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Case Study: Miri

"I feel **really good** about myself, and I would not have felt that way about myself a few years ago when I was dieting."

"I feel like my doctor sees me as a 'model' patient because my weight is down. I wonder how they would be treating me if I **had not lost weight.**"

On a yoga retreat in Italy, regularly **received comments** about how fit/strong/active she was; feels that she would not have received these comments if she was in a thin body.

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What RDs Can Do

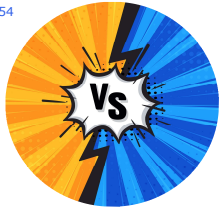
Avoiding Harm

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Implicit vs. Explicit Bias

- **Explicit** attitudes are conscious⁵⁴
- **Implicit** attitudes are unconscious (but still affect actions)⁵⁵
- Both types of bias **coexist**⁵⁴⁻⁵⁶
- **Project Implicit:** Implicit Associations Test⁵⁷



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Compassionate Introspection

- Examine your **personal** beliefs and biases
- Be prepared to be **uncomfortable** (it will be OK!)
- Pair newfound self-awareness with **non-judgment**
- Remember that **you are human**, and humans are **fallible**
- When you know better, **do better**



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Reading Obesity Research

Use a **nuanced and critical** eye:

- Do the authors **conflate** correlation and causation?
- Do they **factor in** cardiorespiratory fitness?
- Do they **assess for** internalized weight stigma?
- What are the health **endpoints**?
- What is the length of **follow-up**?





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Reconsider Weigh-Ins

- Is a weigh-in **medically** necessary?
- Consider the patient's **previous experiences**
- **Ask** permission (and present options)
- **Avoid** praising weight loss or dissecting weight gain
- **Don't assume** patient is seeking weight loss



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Perils of Person-First Language

- The word "obesity" is **stigmatizing** (it uses weight as a proxy for health without considering actual markers of health)⁵⁸⁻⁶¹
- Use **neutral terms**, like "weight" and "higher weight"
- Do you even need to discuss **size**?
- Ask your patient what words **they prefer!**

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What RDs Can Do

How to Be Part of the Solution

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First, Do No Harm

- Move towards weight **inclusivity**⁶²
- Educate yourself about the **effects** of weight stigma⁶³
- Offer **evidence-based** health interventions^{41,47}
- Help people get into their bodies, **out of their heads**⁶²
- Focus on **long-term** health and well-being⁴¹

START


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Respect & Build Patient Trust

- Be an **empathetic** listener
- **Assess** for experiences of weight stigma and history of weight cycling
- Assess for **history of trauma**
- Ask, "What will be **different** in your future, idealized body?"
- Offer to talk to patient's **other healthcare providers**
- Help patient set and develop **boundaries**



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Weight-Inclusive Tools

- Intuitive Eating
- Motivational interviewing
- Self-compassion
- Body image



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Questions?

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