

Obesity stigma: Prevalence and impact in healthcare

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Article points

1. Healthcare providers have been reported to have negative attitudes towards obese people, perceiving them to be lazy, non-compliant with treatment and unintelligent.
2. These stereotypes are not supported by evidence and can lead to suboptimal healthcare care provision from the practitioner and dissatisfaction, embarrassment and reduced motivation to seek medical help and make diet and lifestyle changes in patients.
3. Obesity stigma is reinforced early in a medical student's education, and it is at this stage that interventions to reduce stigma have been found to be successful.

Key words

- Obesity
- Stigma

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Obesity stigma is reported across population groups, impacting the wellbeing of obese people. Perhaps counterintuitively, healthcare professionals have stigmatising attitudes and, in some cases, fail to provide advice and treatment to obese patients. The reports summarised in this review suggest that intervention is required to improve treatment and to reduce adverse patient behaviours such as avoiding appointments and not reporting concerns to healthcare providers.

Obesity has emerged as a public health concern across the world. Over time, there has been a substantial increase in the prevalence of obesity and its associated health complications, such as diabetes and coronary heart disease (James, 2008). Obese children and adults often become withdrawn from society through experiences of rejection, stigma or stereotyping, which may have additional impacts on health and psychological wellbeing (Puhl and Brownell, 2006). The impacts of obesity stigma on the individual include depression, anxiety, low self-esteem, body image concerns, binge eating, avoidance of physical activity, self-harm and suicide (Faith et al, 2002; Puhl and Brownell, 2006; Vartanian and Shaprow, 2008; Puhl and Heuer, 2009).

A plethora of studies (e.g. Tillman et al, 2007; Puhl and Heuer, 2009) indicates that overweight and obese people are perceived negatively by others, which can result in a number of harmful psychological responses, such as lowered self-esteem and confidence. Rejection and stigmatisation are purported to be more likely in childhood and adolescence, the years of development in which socially adaptive relationships are formed more frequently (Pearce

et al, 2002). Obesity stigmatisation is reported in various populations; for instance, in jurors in their decisions of guilt and responsibility (Schvey et al, 2013) and obesity researchers (Flint and Reale, 2014), as well as settings including the home and school (Puhl and Latner, 2007), the workplace (Flint and Snooke, 2014) and exercise facilities (Robertson and Vohora, 2008).

Previous research examining obesity stigma has shown that obese people are stereotyped as lazy, gluttonous, unattractive, intellectually slow, socially inept and lacking in self-esteem (Crandall, 1994). These stereotypes are often without evidence but they are informed by a variety of sources, including the media and education. The foundations for stigmatising obese people is suggested to be a result of attributing the condition to controllable causes (i.e. energy intake vs. energy expenditure), and this is a constant message in a society that is bombarded with information suggesting that body fatness can be modified relatively easily, which has led to increased awareness of body shape and size. It has also been reported that healthcare professionals report a belief that obesity is controllable, which is linked to obesity stigma (Swift et al, 2013a). In fact, Latner et al (2008) suggest that obesity stigma

is likely to be stronger than other forms of stigma, and that this may be due to the differences in perceptions of personal responsibility.

It would be reasonable to expect healthcare professionals to be an influential source when forming perceptions about health conditions. However, an area of increasing interest is the potential impact of obesity stigma on medical treatment. Counterintuitively, obesity stigmatisation has been reported in healthcare professionals, including physicians, nurses, psychologists and dietitians. Healthcare professionals have a critical role in the management of obesity. Thus, assessing current practice and examining opportunities to improve healthcare provision is of high importance.

When evaluating obesity stigma, it has been proposed that measuring implicit attitudes (i.e. those that occur without conscious awareness and are formed involuntarily) is superior to measuring explicit attitudes (i.e. those that occur consciously and are deliberately formed), as this negates demand characteristics and response biases (Rudman, 2004). Demand characteristics occur when participants form an interpretation of the research aims and subsequently modify their behaviour. Response bias refers to inaccurate responses due to, for instance, the wording of a question, and this is commonly associated with survey research.

Whilst measurement of implicit attitudes can be employed using, for instance, the Implicit Association Test (Greenwald et al, 1998), which has occasionally been used to examine obesity stigma (Flint et al, 2013), research on the phenomenon in healthcare professionals has primarily involved measures such as the Attitudes Toward Obese Persons scale and the Beliefs About Obese Persons scale (Allison et al, 1991), or the F-Scale (Bacon et al, 2001). Notwithstanding these weaknesses, the research to date indicates the presence of stigmatising attitudes in healthcare professionals.

Teachman and Brownell (2001) report that healthcare professionals have negative attitudes towards both obesity as a condition and people who are obese. Healthcare providers perceive obese people to be lazy, non-compliant, poorly self-controlled, weak-willed, sloppy, dishonest, unsuccessful and unintelligent (Price et al, 1987;

Hebl and Xu, 2001; Foster et al, 2003; Ferrante et al, 2009; Puhl and Heuer, 2009; Huizinga et al, 2009).

Stigma among specific healthcare practitioners

Physicians

A cluster of studies have reported that physicians view obese patients as less self-disciplined, less compliant and more annoying than non-obese ones and that, as patients' BMI increases, physicians are likely to have less patience and desire to help them (Hebl and Xu, 2001; Huizinga et al, 2009). Additionally, physicians have reported that seeing obese people was a waste of their time and that they had less respect for these patients. For example, Kristeller and Hoerr (1997) sampled more than 1200 physicians, examining attitudes, intervention approaches and referral procedures for obesity. The physicians' responses were indicative of poor management. Despite an awareness of the associative health risks and despite acknowledging that many patients were overweight or obese, the physicians failed to intervene to the extent they should have in their role, appeared ambivalent in relation to the management of patients, and were unlikely to refer patients to weight management programmes. Moreover, the authors reported that only 18% of physicians would discuss weight management with overweight patients, while 42% would do so with mildly obese patients. Similarly, Price et al (1987) reported that 23% of physicians did not recommend treatment to obese patients, with 47% reporting that weight management counselling was inconvenient.

Nurses

Physicians are not the only healthcare providers who have been found to hold anti-fat attitudes and perceptions. Both registered and student nurses stereotype obese patients (Foster et al, 2003; Poon and Tarrant, 2009). For example, nurses were reported to view these patients as lazy, lacking in self-control and non-compliant to treatment (Ogden and Hoppe, 1998). Reports that nurses have stigmatising attitudes are concerning given that a concomitant increase in obesity-related clinical practice has been observed in line with the increased prevalence of the condition across

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1. While many studies into obesity stigma are limited by their use of measurements of explicit attitudes, there is a lot of evidence that healthcare professionals hold negative stereotypes of both obesity as a condition and obese people.
2. Physicians have been found to have less patience and respect for obese patients, and less desire to help them.
3. Despite knowing the associated health risks, less than half of physicians report discussing weight management with obese patients, feeling that it is a waste of their time.

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1. Stigma in healthcare professionals can be traced as far back as medical school, with the majority of healthcare students reporting stigmatising attitudes and the belief that obesity is controllable.
2. The effects of this stigma on patients include reluctance to raise concerns about their weight to their practitioner and avoiding contact with them.
3. In addition to healthcare providers' attitudes, their choice of language can affect the relationship with patients and can cause feelings of stigma and demotivation.

the world. For example, Brown et al (2007) reported that UK practice nurses often provide lifestyle advice and engage in other obesity-related activities. Nurses' anti-fat attitudes are particularly alarming given the potential implications on patients' quality of life (Kolotkin et al, 2001) and experiences of healthcare (Puhl and Brownell, 2001).

Healthcare students

A number of studies have evaluated the attitudes of students in training for a range of obesity-related occupations, including doctors, nurses, dietitians, psychologists and nutritionists. This research has demonstrated stereotypical attitudes towards obese patients, including beliefs that they have poor self-control and no willpower, and that they are sloppy, less likely to adhere to treatment, unsuccessful and responsible for their symptoms (Keane, 1991; Wigton and McGaghie, 2001; Persky and Eccleston, 2011; Swift et al, 2013a). It has also been reported that medical students' derogatory and cynical humour is directed at obese patients (Wear et al, 2006). Swift et al (2013a) examined weight bias in 1130 healthcare students in the UK. They demonstrated that the majority of the sample, and in particular those who were training to become nurses, reported fat stigmatisation and strong beliefs that obesity is controllable. Controllability beliefs are particularly important, as it is suggested that there is a positive correlation between beliefs that obesity is controllable and stigmatising attitudes towards obese people (Allison et al, 1991).

Patient impact

The importance of studying healthcare professionals' attitudes is also highlighted by the impact of stigmatising experiences on patients. Patients report feelings of disrespect, criticism and being dismissed by healthcare professionals, which has led to the perception that their weight-related concerns are not taken seriously and that professionals are reluctant to address them (Brown et al, 2006). For example, Brown et al (2007) report that obese patients are reluctant and, in some instances, ambivalent about raising concerns about their weight due to their experiences with the GP or practice nurse. This breakdown in

communication further exacerbates the poor patient–practitioner relationship, potentially leading to increased feelings of shame and embarrassment in reporting health concerns. Furthermore, these perceptions are suggested to lead to patients avoiding and cancelling appointments. There are also reports that parents of obese children believe they are criticised by healthcare professionals, which impacts the patient–practitioner relationship (Anderson and Wadden, 2004; Bertakis and Azari, 2005). Tackling obesity stigma in healthcare to avoid this detrimental impact on patients is warranted. Puhl and Heuer (2010) suggest that obesity stigma is a health threat, may cause health inequalities and can hinder efforts to intervene with obesity.

Terminology used by healthcare professionals

Beyond the attitudes of healthcare professionals, consideration of the language used in consultation has drawn some attention. Various terms are used to refer to overweight and obese people (Smith et al, 2007), and the impact of these terms has been highlighted over the last decade. Schwartz and Brownell (2004) suggest that the language used may have a number of implications that are particularly important in healthcare settings. The interchangeable terminology used to describe excess fatness and the impact of inappropriate language employed by healthcare professionals suggest that guidelines are warranted. Previous research has highlighted the detrimental impacts of inappropriate language on the patient–practitioner relationship (Tailor and Ogden, 2009; Dutton et al, 2010; Jochemsen-van der Leeuw et al, 2011).

Certain language used by healthcare professionals has been reported to stigmatise and impact motivation by giving the impression of blaming patients for their weight. Communicating effectively by not stigmatising patients, emphasising health improvement with change and identifying achievable behavioural goals rather than weight targets is recommended and may increase the effectiveness of healthcare provision. Terms such as fat, morbidly obese and chubby are reported to be the most stigmatising and least motivating, whilst other terms that should be used are weight,

unhealthy weight and overweight. Patients' reactions to stigmatising language include feeling upset and embarrassed, seeking new healthcare support, not talking to healthcare professionals about their obesity and experiences, and avoiding subsequent medical appointments (Amy et al, 2006; Taylor and Ogden, 2009; Puhl et al, 2011; 2013).

Interventions to reduce obesity stigmatisation

Anti-fat attitudes are reported to be robust and resilient to change, and there have been a number of unsuccessful intervention efforts (e.g. Flint et al, 2013). Interventions that have shown promise in studies of healthcare students are those that attempt to address beliefs about the controllability of obesity (O'Brien et al, 2010; Swift et al, 2013b). These interventions can reduce obesity stigma through education about the uncontrollable causes of obesity. This is in line with suggestions that the more controllable obesity is believed to be, the more likely a healthcare provider is to have stigmatising attitudes towards obese people.

Of the interventions for obesity stigmatisation, educational interventions appear to be the most successful (Daníelsdóttir et al, 2010). For example, Poustchi et al (2013) reported that a brief intervention in which medical students were exposed to a 17-minute video titled *Weight Bias in Health Care*, in addition to discussions about their experiences with obese patients, was effective in reducing obesity stereotypes and increasing their belief that uncontrollable factors such as genetics are a contributing cause of obesity. Likewise, Kuschner et al (2014) reported that an educational intervention consisting of interactions with an overweight or obese patient, targeted reading and a facilitated discussion was effective in reducing stereotyping and increasing empathy and confidence in counselling skills in a sample of first-year undergraduate medical students. However, despite the promising short-term findings in reducing such stereotypes, follow-up analysis 1 year later revealed that the reduction in stereotyping had reverted to baseline levels. Furthermore, to date, no evidence to demonstrate the long-term effectiveness of interventions to reduce obesity stigma has been published.

Conclusion

Given that the role of healthcare is preventive and curative, reports that healthcare professionals stigmatise obese patients and, in some cases, are not performing their job by providing advice and treatment are both concerning and unacceptable. Stigmatising attitudes and behaviours of healthcare professionals threaten efforts to address the prevalence of obesity. The extent and impact of stigmatising attitudes noted in extant literature suggests that intervention is warranted. Stigmatising attitudes towards obese people are reported in medical students, and it is at this stage of training where intervention appears to be most appropriate.

Reports that healthcare professionals and students stigmatise obesity would suggest that current training fails to address this issue. Recent reports demonstrate that educational interventions to modify beliefs about the controllability of obesity is effective in reducing obesity stigma during training; however, long-term interventions are warranted. ■

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Page points

1. Educational interventions that inform practitioners about the uncontrollable causes of obesity and allow discussion with obese people about their experiences have been shown to reduce stigma and stereotyping.
2. These interventions are most effective when delivered to healthcare students.
3. However, there is no evidence that these effects persist over the long term.

“Given that the role of healthcare is preventive and curative, reports that healthcare professionals stigmatise obese patients and, in some cases, are not performing their job by providing advice and treatment are both concerning and unacceptable.”

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