



# Implicit Weight bias in Healthcare: How can RD/RDNs Minimize its Effect?



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


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## Objectives

By the end of this presentation, participants will be able to:

1. Define and identify at least three consequences of weight bias.
1. Identify three ways RD/RDNs may implicitly perpetuate weight bias.
1. Analyze their words, behaviors, and omissions to formulated at least two action steps to minimize weight bias in their practice.



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## Weight-Bias

“negative weight-related attitudes and beliefs that are manifested by stereotypes, rejection and prejudice towards individuals because they are overweight or obese”


(Puhl, Moss-Racusin, Schwartz, & Brownell, 2008, p. 347)




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## Types of Weight Bias



<h3 style="text-align: center;">Explicit Bias</h3> <ul style="list-style-type: none"> <li>• <b>Definition</b> - Consciously expressing a bias that one knows they have</li> <li>• <b>Examples</b> -             <ul style="list-style-type: none"> <li>- Verbal Teasing</li> <li>- Physical Aggression</li> <li>- Relational Victimization</li> </ul> </li> </ul>	<h3 style="text-align: center;">Implicit Bias</h3> <ul style="list-style-type: none"> <li>• <b>Definition</b> - Unconsciously held beliefs about the characteristics of a person or group of people</li> <li>• <b>Associations with weight:</b> <ul style="list-style-type: none"> <li>- Laziness</li> <li>- Unmotivated</li> <li>- Unhappy</li> <li>- Uneducated</li> </ul> </li> </ul>
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
## Prevalence

**Spotlight Action: End Weight Bias in Healthcare**

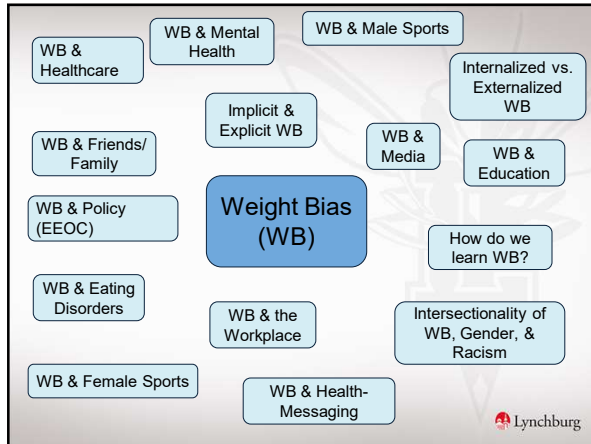
 <b>69%</b> of patients report that physicians are a source of weight bias	<b>52%</b> of patients report that they have been stigmatized on multiple visits	<b>2<sup>nd</sup></b> Physicians are the second highest source of weight bias
 <b>31%</b> of nurses would prefer not to treat patients with obesity	<b>24%</b> of nurses agreed that patients with obesity "repulsed them"	<b>12%</b> of nurses would prefer "not to touch" patients with obesity

<https://www.obesityaction.org>

“Weight bias is still considered a socially acceptable form of prejudice today and is rarely changed”  
(Obesity Action Coalition, 2012).



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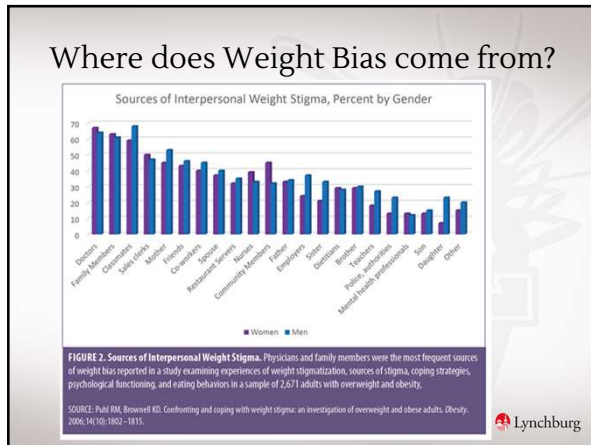


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## How does bias develop?

- Construct of Bias - evolves from the formation of memory and attitudes (Banaji, 2001)
- Attribution Theory -Fritz Heider (Malle, 2011; McLeod, 2012; Pearl, 2018; Sikorski et al., 2011)
  - Cause and effect leads to assumptions about groups
  - Positive memories cause us to associate positive attitudes/beliefs towards a target.
  - Negative memories cause us to attribute negative attitudes/beliefs towards a target.

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## What does Weight-Bias look like?

*“I have always had to make a good second impression because my weight makes the first.”*  
 Brendon - attendee at the “Weight of Living” Conference (Canadian Obesity Network Summit, 2017)

- Microaggression - *“She has such a pretty face”*
- Unsolicited advice
- Inappropriate comments
- Assumptions about the character of the individual

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## Weight Bias and Personal Responsibility Ideology

- Overweight/obesity is within an individual person’s control, weight bias increases
- Overweight/obesity is attributed to primarily biology or genetic influence, weight bias is weaker

(Alberga et al., 2016; Ata, Thompson, Boepple, Marek, & Heinberg, 2017; Ebnetter, Latner, & O’Brien, 2011; Foster et al., 2003; McClure, Puhl, & Heuer, 2011; Puhl & Brownell, 2001)

Well-intentioned health messages portrayal of weight as within one’s personal control and responsibility, perpetuate weight bias.

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## Health Disparity Linked to Weight Bias

- Reduced or eliminate interactions with a health care provider resulting in underutilization of preventive care (Aldrich & Hackley, 2010; Blanton et al., 2016; DeBarr & Pettit, 2016)
- Increase in canceled appointments or delay seeking medical attention when needed (Amy et al., 2006; Friedman, Hemler, Rosetti, Clemow, & Ferrante, 2012)
- Reduced health care follow up after experiencing weight discrimination (Phelan et al., 2015; Waller et al., 2012)

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## Health Consequences of Weight Bias

- Continued weight gain (Hunger, Major, Blodorn, & Miller, 2015)
- Linked with negative mental health outcomes including depression, anxiety, and poor self-esteem (Alberga et al., 2016; Hayward, Vartanian, & Pinksus, 2018; Puhl & Heuer, 2010)
- Initiation or perpetuation of an eating disorder (Alberga et al., 2016)
- Avoid exercise due to fear of public shaming (Alberga et al., 2016; Amy et al., 2006; Vartanian & Novak, 2011)

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## Health consequences resulting from experiences of weight stigma

(Puhl, Phelan, Nadgrowski, & Kyle, 2016)

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## Weight Bias and Substandard Health Care

- Distant interactions, less eye-contact and rapport building (Gudzun, Beach, Roter, & Cooper, 2012; Persky & Eccleston, 2011)
- Assume overweight/obese patients are less likely to follow health care-related directives and therefore reduced efforts to educate patients related to health behaviors (Bertakis & Azari, 2005; Persky & Eccleston, 2011)
- Overweight patient pain reports are more likely to be attributed to attempts to avoid undesirable activity as opposed to truthful reporting of pain (Boyle, Janicke, Robinson, & Wandner, 2018)

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## Stigma Experienced by Children and Adolescents with Obesity

The American Academy of Pediatrics Section on Obesity and The Obesity Society offers the following recommendations for pediatricians to address weight stigma in different settings.

- Improving Clinical Practice:**
  - Be a role model - share best practices for nonjudgmental behaviors.
  - Pay attention to language.
  - Use an empathetic approach for clinical documentation.
  - Use patient-centered empowering counseling techniques.
  - Create a supportive clinical environment.
  - Perform behavioral health screening.
- Advocate Against Weight Stigma:**
  - Schools: Promote inclusive policies to protect vulnerable students.
  - Youth-Targeted Media: Partner with youth with obesity awareness and advocacy.
  - Provider Training: Address ongoing professional learning and education for medical students, residents, and practicing physicians.
  - Improve facilities and policies to manage and address weight-related health issues in schools, communities, and homes.

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## How do we measure implicit bias?

Project Implicit®

**Implicit Associations Test**

- Race IAT:** Asian American (Asian - European American) IAT. This IAT requires the ability to recognize White and Asian-American faces, and images of places that are either American or foreign in origin.
- Gender-Career IAT:** Gender - Career. This IAT often reveals a relative link between family and females and between career and males.
- Gender-Science IAT:** Gender - Science. This IAT often reveals a relative link between liberal arts and females and between science and males.
- Height (T or - Thin) IAT:** Height (T or - Thin) IAT. This IAT requires the ability to distinguish faces of people who are obese and people who are thin. It often reveals an automatic preference for thin people relative to fat people.
- Arab-Muslim (Arab-Muslim - Other People) IAT:** Arab-Muslim (Arab-Muslim - Other People) IAT. This IAT requires the ability to distinguish names that are likely to belong to Arab-Muslims versus people of other nationalities or religions.
- Skin-tone (Light Skin - Dark Skin) IAT:** Skin-tone (Light Skin - Dark Skin) IAT. This IAT requires the ability to recognize light and dark-skinned faces. It often reveals an automatic preference for light skin relative to dark skin.
- Sexuality (Gay - Straight) IAT:** Sexuality (Gay - Straight) IAT. This IAT requires the ability to distinguish words and symbols representing gay and straight people. It often reveals an automatic preference for straight relative to gay people.
- Presidents (Presidential Popularity) IAT:** Presidents (Presidential Popularity) IAT. This IAT requires the ability to recognize photos of Donald Trump and one or more previous presidents.
- Disability (Disabled - Able) IAT:** Disability (Disabled - Able) IAT. This IAT requires the ability to recognize symbols representing able and disabled individuals.
- Religion (Religious - Nonreligious) IAT:** Religion (Religious - Nonreligious) IAT. This IAT requires voice familiarity with religious terms from various world religions.
- Race IAT:** Native American (Native - White American) IAT. This IAT requires the ability to recognize White and Native American faces to reflect classes of modern times, and the names of places that are either American or foreign in origin.
- Religion (Religious - Nonreligious) IAT:** Religion (Religious - Nonreligious) IAT. This IAT requires the ability to recognize White and Black faces, and images of religious or harmful objects.
- Age IAT:** Age (Young - Old) IAT. This IAT requires the ability to distinguish old from young faces. This test often indicates that Americans have an automatic preference for young over old.
- Race IAT:** Race (Black - White) IAT. This IAT requires the ability to distinguish faces of European and African origin. It indicates that most Americans have an automatic preference for white over black.

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## How do RD/RDNs unknowingly perpetuate weight bias?

- Language
- Treatment options
- Before and after pictures (Geier, Schwartz, & Brownell, 2003)
- Shock-tactics (Puhl, 2014)
- Excessive focus on the word "obesity" (Puhl, 2014)

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## Develop Your Action Plan

Step 1: Learn about ALL the causes of obesity

- Lack of physical activity
- Excessive food/beverage consumption
- Genetics
- Side Effects of medications
- Poverty
- Poor role modeling by caregivers
- Synthetic and metabolic disrupting chemicals
- Obesogenic environments (Zorbas et al., 2018)

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## Develop Your Action Plan

Step 2: Look within and identify our own biases

- Become aware and alert to how we treat others differently related to size
- Look for the positive in other persons
- Become more relational
- Have the hard conversations about weight bias

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## Develop Your Action Plan

Step 3: Watch your words

- Avoid “fat talk”
  - “I feel so fat in this outfit”
  - “I can’t have one, I am on a diet”
- Use “People-First” language
  - “There are many obese and overweight people”
  - “There are many people affected by obesity”

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## Develop Your Action Plan

Step 4: Celebrate what a person's body can do as opposed to what it can't do

- Offer options for activities so that each person feels like they can succeed
- Change the message from weight, size, and fat/obese to striving for a goal of health

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## Develop Your Action Plan

Step 5: Change the focus to health, not weight

- Include images of larger persons portrayed in a positive light in educational materials
- Positive reinforcement of pro-health behaviors
- Emphasize strength and health-not appearance (Engeln, Shavlik, & Daly, 2018)

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## Develop Your Action Plan

Step 6: Advocate on behalf of those dealing with weight bias

- Speak up when you see/hear weight bias comments
- Seek permission - Respect personal autonomy

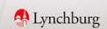


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## The Story of Ellen Maud Bennett



<https://www.cbc.ca/news/canada/newfoundland-labrador/fat-shaming-medical-1.4766676>



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## Shifts in the Research

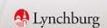
- Shifts in the Research
  - Less on demonstrating that weight bias occurs in students
  - More on evaluating weight bias in active practitioners
  - More on testing training and interventional practices to reduce weight bias
- Shifts in Policy
  - Federal Policy change - Weight bias is an accepted form of prejudice without federal law to stop its perpetuation.
  - State Policy change - Michigan ([https://www.michigan.gov/mdcr/0,4613,7-138-4954\\_4997-16288--,00.html](https://www.michigan.gov/mdcr/0,4613,7-138-4954_4997-16288--,00.html))



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## Resources to Address Weight Bias

- Rudd Center for Food Policy & Obesity: <http://www.uconnruddcenter.org/>
- Implicit Project - Harvard University: <https://implicit.harvard.edu>
- Obesity Action Coalition <https://www.obesityaction.org/>
- [Weight Bias in Healthcare: A Guide for Healthcare Providers Working with Individuals Affected by Obesity](#)



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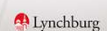
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
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
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## Thank You

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