Reducing Weight Bias and Stigma in British Columbia’s Health Care System

Findings from a Critical Review of the Literature and Environmental Scan

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Executive Summary

Introduction and background

In western society, body size is one of the few personal characteristics still considered to be an acceptable target of prejudice. Accordingly, weight-related bias (i.e., negative attitudes, beliefs, assumptions and judgments toward people deemed over or underweight), and weight-related stigma (i.e., the process by which a socially devalued characteristic (e.g., excess weight) interferes with individuals’ identity and causes them to be socially discredited) are prevalent across a variety of settings, including homes/families, schools, workplaces, and health care. The harms associated with weight bias and stigma are well documented, and include: poor body image, low self-esteem, low self-confidence, loneliness, sense of self-worthlessness, depression, anxiety and other psychological disorders, suicidal thoughts and acts, maladaptive eating patterns and eating disorders, avoidance of physical activity, and stress-induced pathophysiology. Weight-related discrimination (i.e., unfair treatment because of weight) has also been shown to result in socioeconomic disadvantages, such as social exclusion and lower levels of educational attainment and income, which can further compromise health and wellbeing.¹

The health care system can contribute to harm related to weight bias and stigma in three ways:
1. Patients may directly experience weight bias and stigma in their encounters with the health care system, resulting in harm to their health and well-being as described above;
2. Having experienced, or fearing bias and stigma in the health care system, people who are heavier may be reluctant to seek help from health professionals, which in turn can contribute to poor health; and,
3. Messaging about the obesity epidemic from public health professionals, and the dominant emphasis on individual behaviour change as the solution can contribute to and perpetuate the social acceptability of weight-related bias and discrimination.

The development and implementation of effective strategies for decreasing the bias and discrimination experienced by people in, and influenced by, the health care system is a huge priority, given the moral imperative of health professionals to do no harm.

British Columbia Mental Health and Addiction Services (BCMHAS) has committed to the development of a resource to reduce weight-related bias and stigma in the health care system. The first step in development of this resource was to conduct a review of current evidence regarding strategies for weight bias and discrimination reduction, particularly in the health care system. To this end, we conducted a critical review of the literature and an environmental scan that included in-depth interviews with 22 local, national and international key informants. These key informants included researchers working in the field, health professionals involved in integrating weight bias and stigma reduction into their work, and individuals who provided a patient experience perspective.


The quest here is to gain insight about effective ways of helping well-intentioned health care professionals to look beyond the weight and the labels – the bias and discrimination - and see the real, feeling, intelligent, authentic human being who, with the labels removed, is just like any other person.
Reducing weight-related bias, stigma and discrimination: Findings from the literature review

The critical review of the literature illuminated a number of key issues:

1. Implicit anti-fat attitudes are commonly found among multiple groups and also amongst health care professionals; they are robust and durable despite various interventions to change them.

2. Our understanding of weight-related bias, stigma and discrimination, and ways to reduce it, is in very early stages; much more needs to be learned.

3. What works for other stigmatized conditions (e.g., HIV/AIDS, race, age, mental illness) may not necessarily work for weight-related bias.

4. Many of the studies conducted to date suffer from methodological issues.

5. Four broad approaches to decreasing bias and stigma were found in the literature:
   - Those that emphasize intellectual understanding by providing information on the complex relationship between health and weight, and the impact of weight bias and stigma on health and well-being. This approach captures peoples’ minds.
   - Those that emphasize understanding and empathizing with the lived experience of people who are larger in body size. This approach targets peoples’ emotions – their hearts.
   - Those that emphasize self-awareness through self-reflection and gaining an understanding of one’s own attitudes and biases.
   - Those that emphasize the influence of respected and trusted leaders or peers as opinion leaders who can “sway” people to think one way or another.

6. Ultimately, there are two broad principles underlying stigma reduction:
   - Any approach must be multi-faceted and multi-level in order to address the many mechanisms that can lead to harm.
   - Any approach to creating change must address the fundamental causes of stigma – that is, it must address the deeply held attitudes and beliefs of powerful groups that lead to stereotyping, setting apart, devaluing and discrimination, or it must change the circumstances so as to limit the power of such groups to make their views the dominant ones.

In addition to the limitations in the literature articulated above (see points 1-4), we identified three major gaps in the literature: 1) the lack of research into the understanding and reduction of weight bias and stigma in the context of the uniqueness and diversity of the health care setting; 2) moving beyond information provision and awareness raising to skill or competency building for reducing weight bias and discrimination in the health care setting; and, 3) the absence of literature regarding weight bias and stigma against those who are underweight.
Moving from theory to practice: Findings from the environmental scan

Acknowledging the limitations, gaps and resulting lack of clear answers in the research literature on weight bias and stigma reduction, we recognized the importance of turning our attention to ‘promising practices’. Key informants, in describing the approaches they take to reducing weight bias and stigma among health professionals, drew upon many of the theoretical approaches to weight-related bias reduction that are outlined in the literature. A key finding here is that once health professionals are aware of weight-related bias and its significance, they want to develop new skills and competencies to address bias and to conduct their practice in ways that do not perpetuate discrimination. To provide only information, then, without also helping health professionals to change their practice accordingly may only generate anxiety and frustration.

The three patient key informants described experiences of weight bias and stigma in the health care system that occurred in two disparate but equally damaging ways. The first was having health professionals focus on weight as the problem when they were seeking help for another health issue; and the second was health professionals’ reluctance to talk about weight and provide support when the patient asked for help. Patients wanted to be able to get help with other health issues, like a “normal patient” (i.e., without their weight being the sole focus). When their weight was negatively affecting their health and well-being, they wanted to be able to turn to health professionals for help and support. They highly valued the positive relationships, characterized by mutual respect and trust, that they had been able to develop with some health professionals, often their family physician.

Key informants described a range of resources available and initiatives underway provincially, nationally and internationally. Several urged that the objective should be to leverage and align with these in a way that optimizes the development and delivery of this resource. Promising practices and resources to align with, build upon and leverage include those developed by: the Yale-Rudd Center for Food Policy and Obesity; Health at Every Size (HAES); the Canadian Obesity Network; the Leveraging Equitable Non-Stigmatizing health promotion delivery (LENS) project; Project Invisibility (a Nova Scotia research project); and a variety of initiatives in British Columbia (e.g., presentation on weight bias and stigma at the Fraser Health Forum; a weight bias and stigma workshop developed for public health nurses; Health Compass; Indigenous Cultural Competency training).

Many of the people we spoke with emphasized the importance of moving beyond a simple focus on changing the attitudes and behaviours of individual health professionals. They noted the importance of also targeting organizational structures, processes and culture. The bottom line here is that health professionals care about and want to help people, so it’s important that the emphasis is on creating a health care system that enables them to do so.
Bringing it all together: Potential components of a resource for reducing weight-related bias, stigma and discrimination in health care

Based on the findings from both the literature review and key informant interviews, we have developed a list of five key components for potential inclusion in a weight-related bias reduction resource that is targeted at health professionals.

1. **Myth Busters - Providing evidence about weight, weight bias and health**
   In this first component the emphasis is on providing information about the complex relationship between weight and health, contributing factors to weight gain and the controllability of weight, the prevalence of weight-related bias, and its effects on health and well-being. The information presented is based on the most recent evidence on the subject (i.e., weight science).

2. **Self-awareness - Self-reflection & understanding of one’s own biases & attitudes**
   This second component focuses specifically on personal and professional reflection on one’s own biases and assumptions about weight, and the extent to which they are manifested in, and impact the care that one provides to patients with weight-related issues. It’s important that this be done in a safe and compassionate manner.

3. **Exposure to overweight people and the experience of being heavy**
   The third component focuses on fostering empathy for people who are subject to weight-related bias, stigma and discrimination. Having patients share their experiences through narratives is one strategy for enhancing understanding of what it’s like for a heavy person accessing health care and living in a society that values thinness.

4. **Influence of opinion leaders in the professions and/or society**
   The fourth component draws from practical experience of key informants and social influence theories that emphasize the importance of using respected opinion leaders to denounce weight bias and promote acceptance of people with weight issues.

5. **Competency development**
   This fifth component is the development of competencies for fostering effective working relationships with people who are experiencing health (mental and physical) concerns because of their weight, and is drawn primarily from the key informant interviews. This involves adopting a philosophy of patient-centred care, and a shift from a focus on weight to a focus on overall health and well-being.

For any resource to be effective, it’s critical that we move beyond the resource content and also consider what is known about adult learning principles, the creation of a safe learning environment, and how to translate learning into practice. Adult learning is most effective if it emphasizes experiential learning (i.e., bringing in learners’ work and life experiences, and embedding learning into practice) and provides opportunities for transformational learning (i.e., learning as making meaning, with critical reflection as the central dynamic).
Concluding remarks

We have designed an acute care system that is ill-equipped to address chronic illness and health issues, and so have a tendency to reduce everything to a simple cause and effect model. This reductionist nature of our health care system is a major contributing factor to weight bias and stigma in health care, and indeed in our society more broadly. One final and significant caveat, then, is that any weight bias and stigma reduction resource developed will inevitably be only one piece of the “solution” for weight-related bias amongst health professionals. Broader interventions will also be needed, including those that focus on changes in organizational culture and the inclusion of instrumental organizational supports that facilitate the translation of new knowledge into practice.

One area of critical importance is to continue to develop a health care culture that supports the fundamental relationships between patients and health care professionals, a culture that promotes and supports patient-centred care and relationship practice. Before diagnosis and treatment comes basic respect and regard for each individual, no matter their stature in society, nor their shape, form, or health concern. To find the time to understand and get to know “the patient” as a unique person, and to listen, to give credence to his or her history (his/her “experiential expertise”), concerns and strengths is the crux of care and compassion which lies at the heart of health care. If we could do one thing to address weight-related bias in the health care system, it would be to ensure that this philosophy was manifested in every health care encounter, particularly with those at risk of weight-related bias and discrimination.

Health professionals also have considerable power to positively contribute to reducing weight-related bias and stigma at a societal level. It may be that western society is at a tipping point, where health professional contribution could make a big difference. There is an increasing understanding of the multiple contributing factors to weight gain, the complex relationship between weight and health, the failure of traditional approaches to weight management, and the clear harm to health and well-being created by weight bias and stigma.

Finally, it is our hope that the promising initiatives and resources identified through this review can be built upon and woven together, creating a strong tapestry of approaches that will mark the end of weight-related bias, stigma and discrimination. Herein lies both the promise and the challenge of the development of a weight bias and stigma resource. The promise is the development of this resource as a glimmering thread in this tapestry; the challenge is finding ways to connect this work with other activities and strategies and in so doing, to maximize its contribution to the bigger movement.

“In my early professional years I was asking the question: How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth?”
Carl Rogers
1.0 Introduction and Project Purpose

It is well documented in the academic and grey literatures that people who live with overweight or obesity are often treated in stigmatizing ways in the health care system (Puhl & Heuer, 2009; Fabricatore, Wadden & Foster, 2005; Schwartz et al., 2003). Two key consequences of this are that people who carry excess weight are often reluctant to seek help from health professionals, and if they do seek help, their mental health and well-being can be negatively affected (Fikkan & Rothblum, 2011; Puhl & Heuer, 2009). Given the growing number of people in Canada who live with overweight or obesity, and the ethical imperative that health care professionals should do no harm, the development and implementation of effective strategies for decreasing the weight bias and discrimination experienced by people in the health care system is a priority.

This project was commissioned by British Columbia Mental Health and Addiction Services (BCMHAS). Its purpose is to conduct a review of the research evidence and an environmental scan of promising practices to inform the development of a weight bias reduction resource for use with health professionals in British Columbia (BC). This work is in follow-up to a literature review on weight bias and stigma commissioned by the Provincial Health Services Authority (PHSA) of BC that identified how common it is for health professionals to treat people who are living with overweight and obesity in a stigmatizing way.

Please note that the intent of this paper is to review current thinking and practice regarding the amelioration of weight-related bias and discrimination. It is not to review research relating to the effects of weight-related bias and discrimination. Readers seeking more content about the nature and impacts of weight-related bias, stigma and discrimination are referred to the literature review noted above, which was recently released by the BC Provincial Health Services Authority (2013). Finally, this report is not meant to be the content for this weight bias and stigma resource that is being developed, rather it pulls together existing knowledge from research, practice and life to inform its development.

The report is organized in seven main sections. Section 2.0 below provides some basic background information. Methods used to develop this paper are described in Section 3.0, and this is followed by a presentation of key findings in Section 4.0. Based on these findings, an overview of potential components of a weight-related bias reduction resource for use with health care professionals is presented in Section 5.0, along with key resource materials to support each of these components. In Section 6.0 questions for BCMHAS to consider in developing the resource are posed. The paper concludes with some final thoughts from the writers.

2.0 Background

In Western society, body size is one of the few personal characteristics still considered to be an acceptable target of prejudice (Watts & Cranney, 2009). In the United States, for example, weight bias is the third most common type of discrimination amongst women (on par with racial discrimination in some settings) and the fourth most prevalent form of discrimination reported by all adults (Puhl, Andreyeva & Brownell, 2008, pg. 7). Almost every person with overweight or obesity has encountered bias in one setting or another (Puhl & Heuer,
Indeed, weight bias is prevalent across many parts of society including families, schools, workplaces, the general public, and health care settings (Puhl, Andreyeva & Brownell, 2008).

The pervasiveness of weight-related bias is not surprising given the power of social norms to shape individual attitudes and behaviours, even from an early age, and the daily bombardment of messages about beauty and thinness to which we are all subjected. The dominant cultural idea seems to be that “thin is in” and extra weight is socially unacceptable – even to those people who, themselves, carry extra weight.

Weight bias is not innocuous; to the contrary it can have significant, even life-threatening impacts on mental and physical health and can translate into inequities in employment, education, health care and social circumstances (Puhl & Heuer, 2009). In short, the effects of weight bias on health can be just as damaging, if not more damaging, than the impacts of excess weight on health (Vartanian & Novak, 2011; Puhl & Heuer, 2009; Meunnig, 2008).

Much of this weight-related bias and discrimination takes place within the health care system. Indeed, there is strong evidence to show that health care professionals are not immune to societal bias against people who carry excess weight. Rather, into their work as professionals, they often bring the same biases and prejudices that are prevalent in society. Health care professionals have been found to endorse stereotypes and negative attitudes toward people with excess weight, and this bias can negatively affect their advice about weight management (Puhl & Heuer, 2009).

But more compelling than facts and statistics is to have an understanding of how patients experience weight-related bias in the health care system that is supposed to provide “care” and support. Brownell (2005, pg. 2) asks:

“Why care about individuals and their lives? Health professionals ply their trade to prevent and reduce human suffering, but physical suffering is only one target. Psychological torment and social discrimination are important in their own right, but may also affect health. [People living with obesity] suffer, plain and clear. They exist in a socially constructed world that determines what is right and wrong, what is pleasing and disgusting, how blame is assessed and who deserves some version of a scarlet letter.”

We could say then, that excess weight is a modern-day scarlet letter, borne by larger people as they move through society and the health care system. The quest in this paper is to gain insight about effective ways of helping well-intentioned health care professionals to look beyond the weight and the labels – the bias and discrimination – and see the real, feeling, intelligent, authentic human being who, with the labels removed, is just like any other person.
3.0 Methods

A mixed methods approach was used to obtain evidence to inform the development of a weight bias and stigma reduction resource. Outlined in Table 1 is a list of the key questions that were addressed through this review of the evidence, and the data collection strategies used to address each question. These questions were addressed by conducting a critical review of the academic literature and an environmental scan, which included both a scan of pertinent grey literature and key informant interviews.

Table 1: Key questions and data sources

<table>
<thead>
<tr>
<th>Question</th>
<th>Data source</th>
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<tbody>
<tr>
<td>1. What are evidence-informed practices (i.e., based on evidence) for decreasing weight bias and stigma amongst health professionals?</td>
<td>Academic literature, grey literature, key informant interviews with weight bias and stigma experts</td>
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<tr>
<td>2. What are evidence-informed practices for decreasing health professional bias and stigma toward clients/patients, which might be adapted for weight bias and stigma? *</td>
<td>Academic literature, grey literature, key informant interviews with bias and stigma experts</td>
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<tr>
<td>3. What are evidence-informed practices for decreasing weight bias and stigma in other target audiences, which could be adapted for use with BC health professionals? *</td>
<td>Academic literature, grey literature, key informant interviews with weight bias and stigma experts</td>
</tr>
<tr>
<td>4. Are their promising weight bias and stigma reduction projects, initiatives, and resources targeted at health professionals being actively used in other contexts that could be adapted for use in BC?</td>
<td>Grey literature, interviews with national and international key informants actively involved in the development and/or delivery of weight bias &amp; stigma initiatives</td>
</tr>
<tr>
<td>5. What (if anything) is currently happening in BC to address weight bias and discrimination?</td>
<td>Grey literature, key informant interviews with local key informants</td>
</tr>
<tr>
<td>6. What is the gap between what’s currently happening in BC, and what is known about promising practices based on evidence?</td>
<td>All data sources outlined above</td>
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<tr>
<td>7. Are there existing health professional development resources in BC that a resource on weight bias and stigma reduction could be integrated into?</td>
<td>Grey literature, key informant interviews with local key informants</td>
</tr>
<tr>
<td>8. What resource format would work well for BC health professionals, in which contexts and why?</td>
<td>Grey literature, key informant interviews with members of the target audience for the resource</td>
</tr>
<tr>
<td>9. What is the patient experience with weight bias and stigma in the BC health care system?</td>
<td>Key informant interviews with patients and other key informants</td>
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* Note: These broader questions were included in case there was not enough research and/or experiential evidence-based promising practices on weight bias and stigma reduction specifically targeted at health professionals.
3.1 Critical review of the literature

**Search strategy**
A search of the peer-reviewed literature was conducted to locate published literature related to evidence-informed practices for decreasing weight bias and stigma amongst health professionals. The search strategy was developed and executed in MEDLINE then adapted as required to match the thesauri of six other databases: PubMed, CINAHL, PsycINFO, SocINDEX, Social Services Abstracts and Social Work Abstracts. A combination of keywords was utilized across four main themes: health care professionals and health care delivery; obesity/overweight; stigma/bias and evidence-based practices to reduce stigma/bias. The search was limited to English language only literature from 2002 to 2012. Comments, editorials and letters were excluded.

Please see Appendix 1 for a comprehensive outline of the search strategy used in this critical review of the literature.

**Selection and critical appraisal of the articles**
Searches of electronic databases captured 2,440 citations in total, post duplication deletion. A preliminary review of titles and abstracts narrowed this list down to 249 citations for further review. These 249 abstracts were screened for relevance, and 35 full text articles and book chapters were identified for review and potential inclusion in this report. Additional articles were identified by searching the reference lists of these articles, and through the key informant interviews. A critical appraisal of these articles yielded key themes pertaining to what is known to date about the origins of bias, stigma and discrimination, and potential strategies for reducing weight bias, stigma and discrimination.

3.2 Environmental Scan

**Key informant interviews**
The BC Mental Health and Addiction Services team leading this project developed a list of local, national and international key informants to be invited to participate in an interview. As the interviews progressed, additional people working or doing research in this field were identified by people we talked to. We spoke with a mix of people (see Appendix 2), including:

- People involved in developing weight bias and stigma resources, and/or weight management resources that include a component on weight bias, stigma and discrimination;
- Citizens who are heavy, and volunteered to provide a patient perspective on their experience with the health care system; and,
- Researchers actively working in the areas of critical obesity, weight bias and discrimination, and body image.

Two interview guides were developed: one for researchers and people working in this area (Appendix 3); and another for the citizens bringing the patient perspective (Appendix 4). A series of open-ended questions were used to guide the conversations with these key informants.
A total of 22 interviews were conducted, either by telephone or via Skype, in December 2012 and January 2013; they ranged in length from 45 minutes to 80 minutes. All interviews were audiotaped and detailed notes taken. Two interviews that contained particularly rich information were also transcribed.

**Scan of grey literature**
A scan of the grey literature was also conducted, focusing primarily on local, national and international websites and materials recommended by our key informants. We were looking for promising practices in weight bias and stigma reduction, and related materials that might be built on or incorporated into a BC resource for health professionals.

**Data analysis**
The key informants interview notes and transcripts were critically reviewed with the goal of identifying key themes that emerged in response to the questions outlined in Table 1. Throughout the data analysis process, the emphasis was on identifying themes that would inform the development of a BC resource for weight bias and stigma reduction. The information obtained through the grey literature reviewed was used to augment what was learned from the people we spoke with.

**Strengths and limitations**
The strengths of this work are the systematic approach taken to our critical review of the peer-reviewed literature, and the number and variety of people we were able to speak with through the key informant interviews. The 22 people we had the privilege to speak with, including three citizens bringing a patient perspective, had acquired considerable wisdom through their years of study, work and life. They shared with us openly and honestly what they had learned through the years, and their ideas about the future. The opportunity to discuss the emerging findings with the Steering Committee and then the Promoting Healthy Weights Working Group, improved the quality of this report.

There are of course limitations to this work. The timeline constrained the depth of our analysis of all the data we collected, and it was challenging to try and synthesize this volume of data in this timeframe. Although we did take a systematic approach to our review of the peer-reviewed literature, we focused narrowly on understanding bias, stigma and discrimination and how to reduce it. There was no opportunity to review the literature on adult learning, knowledge exchange, implementation, patient experience with weight stigma, eating disorders; nor the critical obesity literature. Finally, all of the articles we reviewed on weight bias and stigma focused on bias and stigma against people who are perceived to be overweight and/or obese and not people who are too thin.

**4.0 Findings**
Our findings from the literature review and environmental scan are reported in this section. These findings are generally organized according to the key questions identified in Table 1. We begin with key findings from the literature review, which include exploration of theories and approaches to reducing bias, stigma and discrimination generally, and how these theories have been applied specifically to the issue of weight bias, and
with what level of success. Then in section 4.2 we describe what we learned through the 22 key informant interviews, organizing these under headings corresponding to the key themes we identified. Our focus has been on organizing these findings in a way that can inform the next steps in the planning and development of the resource, and serve as a reference as this work progresses.

4.1 Overview of the literature: Defining, understanding and reducing weight-related bias, stigma, prejudice and discrimination

In presenting our findings from the literature review, we begin with a general overview of bias, stigma and discrimination from a general perspective and then move to a synopsis of the literature reviewed that is specific to weight-related bias, stigma and discrimination. This is not a comprehensive review; rather, the intent is to provide an orientation to current thinking about the roots of stigma, bias and discrimination in general and of weight-related bias, stigma and discrimination in particular. The intent is to capture main ideas that can be used to inform the development of a weight bias resource for health care professionals. The information provided in this section is also relevant to remarks made by some of our key informants.

4.1.1 An introduction to stigma, bias, prejudice and discrimination

In the English language, “stigma” implies a “mark of disgrace or infamy; a sign of severe censure or condemnation, a brand” (Oxford Dictionary, Online) and “bias” is a word used to describe an “inclination or prejudice for or against one person or group, especially in a way considered to be unfair” (Oxford Dictionary, Online). “Prejudice” is defined as “a preconceived opinion not based on reason or actual experience... unreasoned dislike, hostility or antagonism against a race, sex or other class of people” (Oxford English Dictionary, Online). Finally, “discrimination” is typically conceived as actions taken based upon bias or prejudice and is defined in the Oxford Dictionary (Online) as, “the unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age, or sex.”

These attitudes and actions have preoccupied sociologists and social psychologists for decades. Goffman (1963) defined stigma as, “an undesirable or discrediting attribute that an individual possesses, thus reducing that individual’s status in the eyes of society” (Brown, et al., 2003, pg. 50) and reducing the bearer from a “whole and usual person to a tainted, discounted one” (Link & Phelan, 2001, pg. 364). Goffman perceived stigma as a dynamic process arising from the perception that a particular set of shared attitudes, beliefs and values has been violated. The group or individual becomes labeled by society as different or deviant and this stigmatization can result in prejudicial thoughts, behaviours and actions by any number of people and institutions such as governments, employers, friends and families (Brown, et al. 2003).

Consistent with Goffman, Link and Phelan (2001, pg. 367) have more recently argued that stigma exists when four interrelated components converge. These components are:

- People distinguish and label human differences
- Dominant cultural beliefs link labeled persons to undesirable characteristics (negative stereotypes)
- Labeled persons are placed in distinct categories so as to accomplish some degree of separation between “us” and “them” and;
Labeled persons experience status loss and discrimination that lead to unequal outcomes.

Further, and importantly, the production and perpetuation of stigma is entirely reliant upon forms of power (social, economic, political) that enable the social expression of these components. That is, power is required: i) to define particular differences as socially important; ii) to successfully assign negative stereotypes to those who are “different”; iii) for the separation of those who are labeled as “different” into distinct categories (“us” and “them”) and; iv) for the expression of disapproval, rejection, exclusion and discrimination of the labeled group.

Consequences of stigma, bias and discrimination

Link and Phelan (2001, pg. 370-373) outline some of the key consequences of stigma for labeled groups and persons, including:

- **Downward displacement of the person or group on the social hierarchy.** Stigmatized groups are disadvantaged when it comes to factors that impact life chances such as income, education, psychological well-being, housing status, medical treatment and health.

- **Additional discrimination due to loss of social status.** Lower placement in the status hierarchy can, in and of itself, affect a person’s life chances and have a “cascade of negative effects on all manner of opportunities” (pg. 373). An example cited by Link and Phelan is that a person of low status may be less attractive to socialize with, to involve in community activities, or to include in a business venture – exclusion from these kinds of activities can lead to social exclusion and isolation and loss of opportunities important to the achievement and sustenance of good health and well-being.

- In extreme situations, the stigmatized person can be conceived as being so different that s/he is not perceived as being “human”, setting up the potential for all forms of “horrific” treatment (pg. 370).

Broad principles for stigma reduction

Finally, Link and Phelan (2001, pg. 381) present two broad principles for reducing stigma:

1. **Any approach must be multi-faceted and multi-level** in order to address the many mechanisms that can lead to disadvantaged outcomes for labeled individuals and groups.

2. **Any approach to change must address the fundamental causes of stigma** – that is, it must change the deeply held attitudes and beliefs of powerful groups that lead to stereotyping, setting apart, devaluing and discrimination, or it must change the circumstances so as to limit the power of such groups to make their cognitions the dominant ones.

In the sections below, our attention turns specifically to weight-related stigma, bias and discrimination, beginning with an overview that includes definitions, prevalence, and consequences of weight bias. Following this, we describe the most common approaches currently being employed to reduce stigma, and specifically weight-related bias, stigma and discrimination.

4.1.2 Understanding weight-related bias, stigma, discrimination and bullying

A brief history of weight-related bias and stigma is provided by Brownell (2005, pg. 7-8) who notes that weight bias has been traced as far back as medieval times but science about this bias wasn’t fully launched until 1961 when Richardson and colleagues conducted a study in which children were asked to rate line drawings of an overweight child and a disabled child. They found that the overweight child was rated as least likeable. Other studies with children and adults followed, with similar findings. At the same time, obesity research began to take
off, and feminists started writing about the negative impacts of dieting caused by fears of obesity. Advocacy movements, such as the National Association to Aid Fat Americans (NAAFA – changed later to the National Association to Advance Fat Acceptance), also emerged. It wasn’t until the 1990s, however, that social psychology research on weight stigma began in earnest. A key event was the establishment of the Rudd Center for Food Policy and Obesity in 1998, which is dedicated to studying and ameliorating obesity stigma and bias. Thus, the study of weight-related bias and discrimination, particularly their reduction, is still in early stages.

Although research regarding weight bias is new, it has already been shown that this bias is “powerful, pervasive and difficult to change” (Puhl & Brownell, 2001, pg. 213). The terms “overweight” and “obesity” are defined in the medical literature based on body mass index (BMI), with overweight defined as a BMI between 25 and 29.9 and obesity as a BMI over 30. There is evidence that the higher one’s weight, particularly for women, the greater the likelihood of experiencing weight-related discrimination (Fikkan & Rothblum, 2011; Puhl, Andreyeva & Brownell, 2008; Puhl, n.d.).

Although all of the literature reviewed for this paper focused on bias related to overweight, the Steering Committee for this project has advised that bias directed toward individuals who are underweight is also problematic and should be considered in development of the BCMHAS resource. Hence, we use the term weight-related bias, stigma, and discrimination (often simply referred to as “weight bias” for the sake of brevity) in this document.

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2 As defined by the Public Health Agency of Canada (2011)
Definitions of weight-related stigma, bias, discrimination and bullying are presented in the box below³.

<table>
<thead>
<tr>
<th>Definitions of Weight-Related Stigma, Bias, Discrimination and Bullying</th>
</tr>
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<tbody>
<tr>
<td><strong>Weight stigma</strong> – the possession of some attribute or characteristic - such as excess weight or being underweight - that is devalued in a particular social context (adapted from Puhl &amp; Brownell, 2003, pg. 213). It is a “social sign that is carried by a person who is a victim of prejudice and weight bias” (Washington, 2011, pg. 1).</td>
</tr>
<tr>
<td><strong>Stigmatization</strong> – is “the process by which the reaction of others interferes with individuals’ normal identity and causes them to be socially discredited” (Goffman, 1963, cited in Brewis, 2011, pg. 116).</td>
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<tr>
<td><strong>Weight bias</strong> - negative weight-related attitudes, beliefs, assumptions and judgments toward individuals who are overweight and obese (Puhl, 2011; Ciao &amp; Latner, 2011). These attitudes are often manifested by false and negative stereotypes which cast overweight and/or obese individuals as being physically unattractive, incompetent, lazy, unmotivated, less competent, non-compliant, lacking self-discipline, and sloppy (Puhl &amp; Heuer, 2009; Rukavina &amp; Li, 2008).</td>
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<tr>
<td><strong>Weight discrimination</strong> – “unequal, or unfair treatment of people because of their weight” (Puhl, n.d., pg.1). Thus, discrimination extends beyond beliefs and attitudes to unjust or unfair actions and behaviours toward people who are overweight or obese (Ciao &amp; Latner 2011). Discrimination can take many forms, from verbal comments and derogatory remarks to excluding, avoiding, ignoring or rejecting, to cyber-bullying, physical aggression and victimization (Puhl, 2011).</td>
</tr>
<tr>
<td><strong>Weight-related bullying victimization</strong> – refers to an individual being repeatedly exposed to the negative actions of others with the intention to hurt. This victimization can be overt (physical – e.g., hitting), verbal (e.g., name calling) or relational (e.g., social exclusion) (Griffiths &amp; Page, 2008, pg.539).</td>
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*Prevalence and impacts of weight-related bias*

It has been said that people with obesity are one of the last socially acceptable targets of discrimination in Western society (Puhl & Brownell, 2001, pg. 788). Current research suggests that almost all overweight or obese people face stigma of some sort (Puhl & Heuer, 2009) and ironically, as rates of overweight and obesity have climbed in Western society, so have rates of weight-related bias, stigma and discrimination. Between 1995 and 2006 in the United States, for example, weight discrimination increased by an estimated 66 per cent, in some cases, bringing it to par with rates of racial discrimination (Puhl, Andreyeva & Brownell, 2008). This discrimination affects children and adults alike and can significantly impact physical and mental health. People living with excess weight may internalize this bias and apply negative stereotypes to themselves (Puhl & Brownell, 2003).

³ For a comprehensive overview of weight-related bias, stigma, discrimination and bullying, see, Provincial Health Services Authority (2013). *Technical report: From Weight to Well-Being: Time for a shift in paradigms?*
Research generated in the past five decades has yielded an extensive body of evidence that demonstrates the significant impact of weight bias on mental and physical health, independent of weight. That is, bias in and of itself causes harm to health. These impacts are outlined in detail elsewhere (see Puhl & Heuer, 2009; Provincial Health Services Authority, 2013) but include: poor body image and body dissatisfaction, low self-esteem, low self-confidence, loneliness, sense of self worthlessness, depression, anxiety and other psychological disorders, suicidal thoughts and acts, maladaptive eating patterns and eating disorders, avoidance of physical activity, and stress-induced pathophysiology which can lead to cardiovascular disease.

Particularly important in this paper is that patients who experience weight-related bias and discrimination in health care settings may delay or forego essential preventative care. Several studies show that people with obesity are less likely to undergo age-appropriate screenings for breast, cervical and colorectal cancer. This avoidance of care has been traced to weight-related barriers (e.g., equipment being too small) and weight bias, disrespectful treatment and negative attitudes from providers, embarrassment about being weighed, and receiving unsolicited advice about losing weight (Puhl & Heuer, 2009). The avoidance of medical care can pose significant risks to health, including the failure to diagnose and treat potentially life-threatening illnesses such as cancer.

In addition, weight-related discrimination has been shown to result in socioeconomic disadvantages such as social exclusion and lower levels of educational attainment and income (Puhl 2011; Gortmaker et al., 1993) which can further compromise mental and physical health and quality of life. Studies have shown that women are particularly disadvantaged by weight bias, experiencing greater levels of discrimination than men of equal weight, and “faring worse” than women of “normal” weight in multiple domains, including education, employment, romantic relationships, health care, mental health care and the media (Fikkan & Rothblum, 2011, pg. 1).

Of significance to the current BCMHAS project that this paper seeks to inform is the prevalence of weight-related bias in the health care system and amongst health care professionals. A recent systematic review of weight bias found strong evidence that health care professionals endorse stereotypes and negative attitudes about obese patients. A summary of this evidence is presented in the box below.

<table>
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<tr>
<td>• There is strong evidence that health care professionals endorse stereotypes and negative attitudes about obese patients.</td>
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<tr>
<td>• Several studies from different countries have shown that 30-50% of physicians view obesity largely as a behavioural problem caused by physical inactivity and overeating; that they perceive obese people to have reduced self-esteem, sexual attractiveness and health; that they are lazier and more self-indulgent than normal weight people; and that they lack motivation. Similar findings were reported in studies of medical students.</td>
</tr>
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- In other studies, physicians have reported that seeing obese patients was a greater waste of their time and that heavier patients were more annoying than patients with lower body weights.
- Physicians have been found to be ill-equipped to engage in weight management treatment practices.
- A 2006 review of nurses’ attitudes toward adult overweight and obese patients reported that nurses consistently expressed biased attitudes and common stereotypes (e.g., that obese patients are lazy, lacking in self-control and non-compliant).
- Student dietitians have been found to harbour similar biases and stereotypes – that obese people have poor self control, lack endurance, and suffer from low self-esteem.
- Patient views of biased treatment – In a study of 2400 patients, 53% reported receiving inappropriate comments about their weight and doctors were reported as the second most common source of stigma among a list of over 20 possible sources.

4.1.3 Why does weight-related bias exist and how can it be addressed?

It is interesting that the majority of human differences (e.g., eye colour) are socially irrelevant and ignored, but a handful of particular characteristics, such as race, gender, sexual orientation, and weight are not. Thus, a critical sociological question is how culturally constructed categories emerge and are sustained (Link & Phelan, 2001). There is much discussion in the literature about the origins of stigma, bias and discrimination. In this section, we summarize some of the key theories and approaches being applied to reduce or eliminate these social phenomena. Some of these approaches focus on changing individual attitudes and behaviours; others emphasize social dynamics as the genesis of bias and the avenue for its reduction. In describing these approaches, we begin with a general overview of the theory and approach and then describe its application to weight bias, including where possible the level of evidence/support for the approach based on research to date. Wherever applicable, findings specific to weight bias reduction with health professionals are presented.

Approaches directed toward individuals

A number of approaches can be classified by their focus on changing individual attitudes, beliefs and behaviours. These approaches include providing information and education about the controllability of the stigmatized characteristic (attribution theory); inducing cognitive dissonance between personal values and biases; evoking empathy for the stigmatized person or group; consciousness-raising; and challenging widely held stereotypes.

A Note about Implicit and Explicit Attitudes

Before reviewing these approaches, it is helpful to note that often discussed in the weight bias literature is a differentiation between implicit and explicit assumptions and attitudes regarding obesity and labels applied to people who are overweight or obese. Implicit attitudes refer to “automatic affective reactions” that occur when a relevant stimulus automatically activates a particular memory association. They do not require conscious thought or an intention to evaluate in order to be brought to mind. Importantly, because they are automatic,
they may be incongruent with a person’s expressed belief system (Watts & Cranney, 2009). In contrast, explicit attitudes are “evaluative judgments that are dependent upon effortful processes involving reflection and conscious assessment of the accuracy or inaccuracy of the evaluation of an object – they are therefore conceptualized as personal beliefs that are endorsed as true” (Watts & Cranney, 2009, pg. 111).

Measures of implicit attitudes – most commonly via timed reaction time tests – are often used to test changes in attitudes in interventional studies to reduce weight-related bias. Several key informants also described the use of implicit assumption tests to help health care professionals identify whether or not they may hold implicit, negative attitudes toward people with overweight or obesity. This “consciousness raising” is thought by some to be the first step in changing deep-seated, unconscious beliefs (Rukavina et al., 2010).

Teachman et al. (2003) and Watts and Cranney (2009) found that implicit anti-fat attitudes are widely held and relatively universal among many groups including university students, members of the general public, health professionals, and those who themselves are overweight or obese. These anti-fat attitudes have been found to be robust and durable despite various interventions to change them (Teachman et al., 2003). A key issue then is determining whether it is possible to change implicit attitudes, and how, or whether it is easier and acceptable to make people aware of their implicit biases so that they can monitor and change their behaviours to avoid displays of bias and discriminatory practices.

1) Attribution Theory

To date, attribution theory has received the most extensive empirical attention in the area of weight-related bias. As its name implies, the theory focuses on attributions or causal explanations about the social world. Attributions are grounded in the kind of information available to people about the causes of a particular characteristic or behaviour (Crandall & Reser, 2005). For example, if a person is acting aggressively, many explanations of this behaviour are possible: the person may be angry, or drunk, or have a brain tumour, for example. Or if a person has obesity, one explanation may be that the person is lazy; another may be that s/he is genetically predisposed to have a larger body. Each explanation will yield a different evaluation of that person, some of which will be sympathetic, and others not.

Attribution theory is inspired by findings that people are more likely to help or be sympathetic with a person whose distress originates from an uncontrollable cause rather than a controllable cause (Hegarty & Golden, 2008, pg. 1024). This effect is mediated by emotion: uncontrollable causes of distress elicit pity and sympathy, while controllable causes elicit anger and hostility. Thus, attributions of controllability are thought to affect the degree to which stigmatized individuals are blamed for their own fate. The more that people are deemed responsible for their negative outcomes, the more negative affect is expressed toward them (Crandall & Reser, 2005). Interventions based on this theory therefore attempt to inform and change beliefs about the controllability of a stigmatized trait, typically through instruction and the provision of information.

In the case of weight bias, the more that people believe weight is a function of personal control and willpower, the more negative will be their attitude toward those who carry excess weight. In other words, a strong predictor of weight-related prejudice is the view that people with overweight or obesity are responsible for their
weight (Crandall & Reser, 2005). As Cahnman (1968, pg. 294, cited in Crandall & Reser, 2005, pg. 85) bluntly stated:

“Contrary to those that are blind, one-legged, paraplegic, or dark-pigmented, the obese are presumed to hold their fate in their own hands; if they were only less greedy or lazy or yielding to impulse or obliviousness of advice, they would restrict excessive food intake, resort to strenuous exercise, and as a consequence of such deliberate action, they would reduce….While blindness is considered a misfortune, obesity is branded as a defect.”

**But, where do the attributions come from?**

Consistent with Link and Phelan’s (2001) principle of getting at the root causes of stigma, Crandall and colleagues have argued that attributions come from a connected set of convictions, beliefs and values that form a belief system or ideology. Many different values and beliefs are correlated with weight bias, including right-wing authoritarianism, the Protestant work ethic (strong emphasis on self control, and the view that hard work and determination yield success), and conservative political ideology, for example. All of these have in common the notion that people are responsible for what happens and that they deserve what they get (Crandall & Reser, 2005). This emphasis on personal responsibility is the foundation of Western individualism, which gets to the core of weight bias. Several researchers have pointed out that people who are overweight or obese in western society “contravene certain moral, ideological values (e.g., self-discipline, self-determination and the Protestant work ethic)” (Danielsdottir, et al., 2010, pg. 52). As Watts and Cranney (2009, pg. 120) observe:

“In Western society, the cultural norm for female beauty and attractiveness includes extreme slenderness, and from an early age, children are aware of the negative connotations of being overweight. It is likely, therefore, that by the time individuals reach adulthood, they have developed well-rehearsed and complex associative networks in memory between the concepts, “fatness” and “thinness” and negative and positive affective modes, respectively.”

Some researchers have named these attributions as “justification ideologies”: untested beliefs that promote and justify stigma while also reducing feelings of guilt for holding biased attitudes and behaving in discriminatory ways. An example is the argument used by health care professionals that weight bias is an incentive for people to lose weight. Individuals who are committed to these beliefs will stand up for them and reject those who challenge them. Thus, these attributions provide a way for people to stigmatize others with less guilt. This may help explain why weight bias is so widespread (Puhl & Brownell, 2003, pg. 216).

Another contributing but relatively underexplored factor may be the medicalization of overweight and obesity in Western society – that is, the “labeling of all fat people with the medical labels of “overweight” and “obesity” and presuming that all people falling within these categories are inherently unhealthy” (personal communication, C. O’Reilly, February, 2013). In this line of thinking, if people with overweight or obesity need to be cured, then something is wrong with them. Or, as Beausoleil and Ward (2009) observe, “The association of fat with poor health has translated into a fear of fat within the population and subsequent disdain for those who are different, who do not fit the desired norm” (p1). This process may indeed be one in which a powerful group (medicine/health) in society plays a role in determining who is “different” and thus subject to discrimination. Whether or not this is the case, it does speak to the value of having health professionals examine not only their
attitudes and behaviours but also, more broadly, their privileged position in society to distinguish “normal” and “healthy” from “abnormal” and “unhealthy.” We come back to this point in section 4.10.

**Bias reduction interventions based on attribution theory**

As noted above, interventions based on attribution theory assume that attributions can be changed, primarily through educational interventions aimed at changing beliefs and understanding about the controllability of the stigmatized characteristic. Puhl and Brownell (2003, pg. 223) reported that some of this research has shown success with improved attitudes toward obese people by educating participants about biological, genetic and uncontrollable reasons for obesity and helping individuals realize how their world views and attributional tendencies lead to bias” (Puhl & Brownell, 2003, pg. 223). Others have found no impact from attempts to change attributional beliefs (e.g., Hegarty & Golden, 2008). More recently, Danielsdottir, O’Brien and Ciao (2010) reviewed this research and concluded that, “studies manipulating attributions and beliefs about the causes and controllability of obesity provide less than encouraging evidence regarding their ability to reduce anti-fat prejudice” (p53).

The discussion above demonstrates that while attributions may be held within individuals, the origins of these attributions lie within the social fabric. From a very early age, members of society are aware that being overweight or obese is, in general, socially unacceptable. This implies that changing beliefs about controllability of weight is likely insufficient because that doesn’t change the underlying, dominant ideology in Western society. This may be part of the reason why educational interventions that attempt to change peoples’ beliefs about the controllability of weight have only yielded mixed results.

Thus, while attributions are important, as is sharing information about the uncontrollability of obesity, these approaches are in and of themselves insufficient to change weight-related bias, stigma and discrimination. Link and Phelan (2001) would likely argue that true change requires a change in social norms about weight. Whether that should begin with individuals or broader social approaches, or both, is a question worth considering.

**Attribution theory-based bias reduction strategies with health care professionals**

Some studies with health professionals, particularly students, have found success in reducing stigmatizing attitudes. For example, Diedrichs and Barlow (2011) conducted an intervention study with undergraduate psychology students and found that participants who received a lecture about the multiple determinants of weight were less likely to hold negative attitudes toward people with overweight and obesity or to rate them as unattractive. These findings supported those of other studies (Crandall, 1994; Hague & White, 2005; Puhl et al., 2005) which have shown that brief educational interventions show some success in challenging weight controllability beliefs and reducing weight bias in pre-service health students (Diedrichs & Barlow, 2011, pg.857). A study of medical students conducted by Persky and Eccleston (2011) similarly found that having students read materials highlighting the genetic contributions to obesity led to some reduction in stigma-related attitudes. It also resulted in greater avoidance of discussions with patients about health behaviours such as diet and exercise.
O’Brien et al. (2010) compared changes in explicit and implicit anti-fat prejudice amongst pre-service health students. One group received education about the uncontrollable causes of obesity; another received information about the controllable causes. Decreases in implicit anti-fat prejudice were found amongst the “uncontrollable causes” group while increases in implicit anti-fat prejudice were found amongst the “controllable causes” group. They concluded that “anti-fat prejudice can be reduced or exacerbated, depending on the causal information provided about obesity” (p1) and that, “health educators should ensure that information on genetic, social and environmental causes of obesity, and their interactions, is delivered in a convincing manner alongside traditional information on causes and treatments of obesity, such as diet and exercise” (p6).

2) Cognitive Dissonance Theory - Targeting Value Consistency and Self Worth
Somewhat in contrast to the self-justification described above, cognitive dissonance theory posits that inconsistencies within a person’s beliefs, attitudes or actions can cause psychological discomfort and that people will attempt to eliminate the inconsistency by changing their beliefs, attitudes, and actions (Ciao and Latner, 2011, pg. 1769). Creating a discrepancy between attitudes, beliefs or behaviours has been commonly used as a means to create changes in negative or resilient attitudes including internalization of the thin ideal, a construct related to weight stigma. For example, if a person believes himself to be a kind and caring person, pointing out that his bias against people of larger body size can create psychological distress, provides motivation to change his belief about people with weight issues.

In a study comparing interventions based on cognitive dissonance theory and social consensus theory (described below), Ciao and Latner (2011) found that a cognitive dissonance intervention successfully reduced negative attitudes about the appearance and attractiveness of obese individuals. The researchers proposed that the effect is because people are disappointed with themselves when they learn that their bias is inconsistent with their values (e.g., being kind to people and treating them equally) and provides motivation to change their stigmatizing attitude. If this is truly the case, then the use of implicit assumption tests with health care providers to surface an implicit weight bias may provide an “aha” moment that could spur them to change their attitudes and behaviours. For health professionals, if you’re a caring professional you don’t want to cause harm.

3) The Contact Hypothesis
The contact hypothesis originated in the work of Allport (1954) who asserted that “contact with a member of a stereotyped group can decrease stigma by providing counter-stereotypical information” – that is, the repeated presentation of associations that are counter to the stereotype (Gapinski et al., 2006, pg. 20). For example, having contact with a person who has obesity but happens to be energetic and productive (in contrast to the stereotype of being lazy) may help to reduce implicit bias.

Key qualifiers of this approach are that in order to decrease stigma, the contact needs to occur, “under optimal conditions of equal status, shared goals, authority sanction and the absence of competition” (Paluck & Green, 2009, p346). Under these circumstances, contact theory suggests that interaction between two groups should lead to reduced prejudice.

Studies by Cook in the 1960s showed support for the contact hypothesis in the case of racial stigma and prejudice. In these studies, white workers worked alongside black co-workers for an extended period of time.
Before and after this contact, the attitudes of white workers toward their black co-workers were measured. After extended contact, attitudes of white workers had changed – they were less prejudiced against their black co-workers and rated them highly in attractiveness, likeability and competence.

Couture and Penn (2003, pg. 303) reviewed the literature regarding contact as a strategy for reducing stigma associated with mental illness and concluded that “contact is important for reducing stigmatizing attitudes about mental illness and that this effect seems robust across Western and non-Western cultures.” However, what is unclear are the conditions and factors that are necessary for contact to be effective, what mechanisms underlie contact and what personal characteristics are important in the process. Alexander and Link (2003) similarly found that in the case of mental illness, contact can reduce stigmatizing attitudes. They noted, however, that any one intervention was unlikely to reduce these attitudes; rather, a combination of personal contact, education, and cooperative contact interventions is preferable.

Use of contact for weight bias reduction, however, was not prominent in the literature reviewed. One key informant suggested this might be because of the prevalence of overweight and obesity in society. Contact with people who have overweight or obesity is a daily occurrence for most Canadians. Further, this contact may highlight the difficulties associated with having excess weight that can exacerbate rather than ameliorate bias. Gapinski et al. (2006) observed that contact seems to work by providing counter-stereotypical information but that because social norms around obesity are so strongly negative that it is hard to generalize the positive traits of particular individuals who carry excess weight but who are successful and smart, to the general population of people with overweight and obesity.

That said, there is some evidence that longitudinal contact may result in changed attitudes toward people with obesity. Roberts et al. (2011) paired third-year medical students with people who were undergoing bariatric surgery. The participating students “established [long-term] relationships with individual obesity patients, learned about obesity and its management through an interdisciplinary chronic disease model, and were able to appreciate the powerful social, environmental, biological and economic forces that influence patients’ body weight and body image” (p6). The students kept a reflections journal throughout the program. The results of the program, in which only four students participated, were intriguing and mixed. A general conclusion was that sustained interaction with patients led to generally more positive attitudes toward obesity. There was also more pessimism, however, about the ability of people to lose weight. Interestingly, students’ journals and self-reflection essays were “powerful tools to consolidate their learning...they indicated that the students identified their own previously held stereotypes about obesity and that many of these judgments were negated as a result of extended interactions with an individual patient” (p78).

4) Evoking Empathy
Evoking empathy – similar to sympathy but “with a stronger component of being able to relate to another person or take another’s perspective” (p4) has shown to be effective in reducing prejudice against HIV/AIDS sufferers, homeless people, convicted murderers and African-Americans (Gapinski, Schwartz & Brownell, 2006). A typical approach is the use of videos of people talking about the discrimination they have suffered. Written materials and role-playing have also been used.
Accordingly, researchers have attempted to apply the same strategy in the case of weight bias by making “appeals to the more compassionate, social and accepting side of human nature” (Danielsdottir, et al., 2010, pg. 53). However, several studies have shown little or no effects. In some cases study participants reported greater understanding of the challenges of being overweight, but there was no change in their level of fat prejudice after the intervention. Danielsdottir et al. (2010, pg. 54) concluded that the evidence, based on the few studies conducted to date, suggests that “increasing empathy, acceptance and liking may not be an effective strategy for reducing anti-fat prejudice”. One reason why this approach may not be as effective for weight bias is that evoking empathy for people living with obesity may have the unintended effect of emphasizing the negative side of being overweight and reinforcing negative attributions associated with people who carry excess weight. Danielsdottir et al. suggest that it may be more effective to invoke feelings of acceptance, equality and respect for people with obesity, rather than empathy or pity. This observation has relevance to attribution theory and its aim to elicit feelings of sympathy and pity for those whose “condition” is a result of uncontrollable factors.

**Using empathy to reduce weight-related bias with health care professionals**

We found one study that is resonant with evoking empathy amongst dietetics and health promotion students. Cotugna and Mallick (2010) sought to reduce fat phobia amongst these students by putting them on a calorie-restricted diet (1200 calories for women; 1500 for men) for one week. Throughout this experience, students documented their thoughts and reflections in journal entries. After one week, reductions in fat phobia were significant. They concluded that, “from their journal entries, it was apparent that students had a newfound appreciation for people who are overweight or obese and are struggling to lose weight” (p323). Students reported the exercise would help them relate to their clients more empathetically and had provided new insights about how to help clients transition into exploring healthful foods in ways that were compatible with their lifestyles.

**Approaches directed toward groups**

Social influence has been shown to be a powerful but under-examined tool in altering prejudice-related attitudes. These approaches emphasize the social production of attitudes, beliefs and behaviours, often through group socialization and categorization processes (Paluck & Green, 2009). Research using these approaches to address weight-related bias and discrimination is in its infancy. There was discussion in the literature about two related approaches – one based on the clarity of social norms, and the other focused on social consensus. The approaches are similar in nature.

1) **Social Influence and Clarity of Social Norms**

A body of work in social psychology has shown that prejudicial attitudes and behaviours can be powerfully influenced by social norms (Paluck & Green, 2009, pg. 347). From this perspective, the **clarity** of the social norm is particularly important.

> When social norms are unclear; that is, when people don’t know how to react to something, they look to other people, observe how they behave and mimic that behaviour (Zitek & Hebl, 2006).

If norms are ambiguous and it is not clear how people should behave when faced with someone who is “different,” then the attitudes of others can be very powerful in determining whether one acts and behaves in a
prejudiced way. In these situations, even hearing one person condemn or condone discrimination can influence another person to do the same. Results of some interventions have shown that very brief encounters/situations can impact peoples’ views over time. Indeed, a single brief encounter was found in one study that included obesity as a target of discrimination, to have an effect up to one month later (Zitek & Hebl, 2006). This research speaks to the power of opinion leaders and expert opinion, particularly in cases where social norms are somewhat ambiguous.

2) Social Consensus Theory

Social consensus theory is based on the notion that individual attitudes and beliefs and behaviours are significantly influenced by perceptions of the attitudes, beliefs and others that we care about (Sechrist & Stangor, 2005). In short, prejudice is viewed as a social norm; we become prejudiced if we think other respected peers are, too. Prejudice, therefore is understood to develop as a result of group socialization processes.

In the processes of group formation and ongoing maintenance, group members learn appropriate attitudes and behaviours from each other and they expect each other to conform to these norms while rejecting, ignoring or punishing those who deviate from group values. Grounded in various social psychology theories, the assumptions here are that people have a need to evaluate and compare their opinions in order to establish a sense of validity, and the knowledge that other people hold similar beliefs provides that social validation. Social consensus information offers individuals and opportunity to evaluate and validate their beliefs. Internalization of group norms also provides the opportunity for social acceptance and approval. In this way, individuals are attracted to others who have similar beliefs (Sechrist & Stangor, 2005, pg. 98).

Several studies have supported this theory, showing that the beliefs of in-group members influence group attitudes and behaviours. These studies suggest that simply overhearing information about the beliefs of one other inter-group member can substantially change racial beliefs (Sechrist & Stangor, 2005). Specifically, hearing another student condemn racism increased anti-racist opinions and hearing someone condone racism produced anti-racist expression.

Social consensus theory has not yet been applied widely in the arena of weight bias. However, a small number of studies have shown promising results. These studies have manipulated peoples’ beliefs about the beliefs of their peers. Consensus feedback indicating peers’ positive views of people with obesity resulted in study participants having more positive beliefs as well, and vice versa.

Danielsdottir et al. (2010, pg. 55) concluded that the evidence so far suggests that social consensus (and social norm) approaches are a “promising strategy for reducing anti-fat prejudice” and that further research is warranted, particularly in naturalistic settings. Part of their endorsement is based on the strength of social norms in shaping attitudes and behaviours in many other domains (e.g., drinking attitudes and behaviours).
Using social consensus to reduce weight-related bias with health care professionals

Puhl, Schwartz and Brownell (2005) conducted three experiments with undergraduate psychology students to test the effect of perceived social consensus on their attitudes toward people with obesity. The experiments involved various manipulations of social feedback about the attitudes of others. Findings supported the hypothesis that “attitudes toward obese people are influenced by peoples’ perceptions of the consistency of their attitudes with others” (pg. 523). Information coming from in-groups was found to be more influential than if it came from an out-group, thus “supporting the proposal that people acquire information from those who they value and identify with, and that consensus can generate a sustained shift in reported attitudes” (pg. 523). Finally, positive or favourable consensus information was found to significantly increase positive views and decrease negative ones.

The promise of using multiple approaches

Not surprisingly, the literature points to the value of adopting multiple approaches to address bias, stigma and discrimination. Indeed, this is a key principle put forward by Link and Phelan (2001). We read a small number of review papers that had examined reduction of bias associated with mental illness and HIV/AIDS. In every case, approaches for these issues are multi-pronged. For example, Arboleda-Florez and Stuart (2012) outline six key strategies for tacking stigma associated with mental illness including: protest, education, contact, legislative reform, advocacy and self-stigma management. Similarly, Brown, Macintyre and Trujillo (2003) identify multiple approaches for addressing stigma associated with HIV/AIDS. These include: information-based approaches (videos, media ads, peer education, guided group discussion, written, classroom type presentations); skills building; counseling approaches; and contact.

A number of studies we reviewed did include more than one approach; however, the degree of success of combining approaches did not seem to be consistent. Danielsdottir et al. (2010) reviewed four studies that employed multiple approaches to address weight bias and concluded that, “the evidence for the efficacy of combined or multiple strategies is encouraging but modest” (p56).

Finally, an overview of approaches to weight bias, stigma and discrimination, based on the key studies we reviewed, is provided in Table 2.

Table 2: Approaches to Reduction of Weight Bias, Stigma & Discrimination – An Overview

<table>
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<tr>
<th>Approach</th>
<th>Brief description</th>
<th>Evidence</th>
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<td>Individual oriented approaches</td>
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<tr>
<td>1) Provision of information about the controllability of weight</td>
<td>Based on Attribution Theory – involves the provision of information about the multiple, uncontrollable contributing factors to overweight and obesity, and the actual connections between obesity and health in order to change</td>
<td>Mixed results. Some studies have shown improved attitudes after receiving information about controllability of weight; others have shown no change; one evidence review concluded the studies show “less than encouraging” evidence regarding</td>
<td>Danielsdottir, O’Brien, Ciao, 2010; Persky &amp; Eccelston, 2011; Puhl &amp; Brownell 2003</td>
</tr>
<tr>
<td><strong>Approach</strong></td>
<td><strong>Brief description</strong></td>
<td><strong>Evidence</strong></td>
<td><strong>Authors</strong></td>
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<td>-------------</td>
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<tr>
<td>2) Cognitive Dissonance Theory - Targeting value consistency and self-worth</td>
<td>Inconsistencies in a person’s belief system can cause psychological discomfort and motivation to change beliefs in order to resolve the discomfort</td>
<td>One study has shown that a cognitive dissonance intervention successfully reduced negative attitudes about the appearance and attractiveness of people with obesity.</td>
<td>Ciao &amp; Latner 2011</td>
</tr>
<tr>
<td>3) Contact and counter-conditioning</td>
<td>Based on the assumption that if repeatedly paired concepts develop and maintain stereotypes (e.g., obese people are lazy and unmotivated), some researchers have used counter-conditioning to reduce implicit bias – the repeated presentation of associations that are counter to the stereotype (e.g., obese people are smart, productive and nice).</td>
<td>Has been shown to be successful for racial bias and mental illness, but limited evidence of use for weight bias, perhaps because of the high prevalence of overweight and obesity in the population which means people have frequent contact with people who carry excess weight. However, one study has shown that longitudinal contact with bariatric surgery patients led to more positive attitudes.</td>
<td>Gapinski et al, 2006; Roberts et al., 2011</td>
</tr>
<tr>
<td>4) Evoking empathy, acceptance &amp; liking, and /or enhancing personal appreciation of the experience of heavier individuals</td>
<td>Research with other stigmatized groups has shown that the experience of empathy can reduce bias against stigmatized groups, including people who have obesity.</td>
<td>However, interventions for obesity have yielded inconsistent results. In some studies, the intervention had no effect and in others, has been associated with an increase in anti-fat bias.</td>
<td>Danielsdottir, O’Brien, &amp;Ciao, 2010; Gapinski, et al., 2006; Cotugna &amp; Mallick, 2010</td>
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</table>

**Social/group-oriented approaches**

| **1) Clarity of social norms** | Some research has shown that when social norms are unclear – when people don’t know how to react to something – they observe how others behave and mimic that behaviour. | One study has shown that even hearing one person condemn or condone discrimination can influence another person to do the same. Speaks to the power of opinion leaders, especially when social norms are unclear. | Zitek & Hebl, 2006 |
| **2) Social consensus and clarity of social norms** | Social consensus theory proposes that changing group attitudes is more effective than changing individual attitudes. Assumption is that people have a need to evaluate and compare | Puhl et al. (2005) found support for social consensus theory via experimental studies with undergraduate psychology students. They found that attitudes toward people with | Danielsdottir, O’Brien, Ciao, 2010; Puhl et al. 2005 |
their opinions in order to evaluate their validity. The knowledge that other people hold similar beliefs provides that social validation. Internalization of group norms provides social acceptance and social approval.

obesity are influenced by the attitudes of others; that information coming from in-groups was more influential than from out-groups; and, positive or favourable consensus information significantly increased positive views about people with obesity and decreased negative ones.

4.1.4 Discussion and conclusion

Our review of the literature illuminated a number of key issues. First, implicit anti-fat attitudes are commonly found among multiple groups and also amongst health care professionals; they are robust and durable despite various interventions to change them (Watts & Cranney, 2009; Teachman et al., 2001).

Second, our understanding of weight-related bias, stigma and discrimination, and ways to reduce it, is in very early stages; much more needs to be learned. In short, there is no clearly-defined theory of weight-related bias, nor is there a clearly-defined approach to reduce weight-related bias. There are even fewer studies about weight bias reduction amongst health care professionals. The vast majority of the studies that have been conducted are with students, particularly medical, nutrition, and health promotion students. There is a strong argument to be made for the value of pre-service education since students are still learning and forming attitudes. They are also a relatively captive audience and have time to participate in various bias reduction endeavours, whether this is instructional time, or long-term contact with patients. However, this does little to inform the development of a resource for health care professionals with busy work lives.

Third, what works for other stigmatized conditions (e.g., HIV/AIDs, race, age, mental illness) may not necessarily work for weight-related bias. Unlike mental illness or HIV/AIDS, weight is highly visible; it is also highly prevalent in society. Also unlike HIV/AIDs in which stigma is associated with fear of illness, contagion or even death, obesity is not contagious. Some studies have found that, unlike other conditions, contact with people living with obesity can reinforce bias, possibly because it reinforces the difficulties that these people face living in our current society. Finally, and most difficult, is that it is socially acceptable to be biased against people who have overweight or obesity and there are multiple socio-cultural reinforcements of this bias.

Fourth, many of the studies suffer from methodological issues, some of which include:

- They are often conducted in laboratory settings, which yield limited ability to apply in complex natural settings;
- Many different outcome variables are assessed in intervention studies which limits comparability across approaches;
- The long-term effects of interventions are seldom assessed; and,
There is insufficient attention to the potential effects of context or situation on weight bias (King et al., 2005).

Danielsdotter et al. (2010) in their review of the anti-fat prejudice literature, for example, conclude:

“(M)ost notable was the lack of research on interventions for reducing anti-fat prejudice. Methodological problems that limit the interpretability of results were identified in the majority of studies found. Interventions employing more rigorous experimental designs provided at best mixed evidence for effectiveness. Although several studies reported changes in beliefs and knowledge about the causes of obesity, reductions in anti-fat prejudice did not typically accompany these changes” (p45).

While understanding the academic importance of designing studies that are able to determine cause and effect, from a practical perspective there appears to be many overlaps or at least strong inter-relationships amongst possible contributing factors to weight bias reduction (e.g., contact and counter-conditioning, evoking empathy, cognitive dissonance, and the influence of respected peers). In the practice setting it is very possible that all of these factors are simultaneously in play; meaning it’s much messier in real life than in the laboratory.

Fifth, as we reviewed the literature we came to realize that there are four broad types of approaches:

1) Those that emphasize intellectual understanding of weight, overweight, obesity and weight-related bias, stigma and discrimination. This approach captures peoples’ minds and provides basic, necessary information, especially for health professionals.
2) Those that emphasize understanding and empathizing with the lived experience of people who are larger in body size. This approach targets peoples’ emotions – their hearts.
3) Those that emphasize self-awareness through self-reflection and gaining an understanding of one’s own attitudes and biases.
4) Those that emphasize the influence of respected and trusted leaders or peers as opinion leaders who can “sway” people to think one way or another.

Some studies that have tested these approaches have succeeded; others have failed. It seems there are bits of truth in each theoretical perspective, but each, in and of itself, is insufficient to reduce weight-related bias and discrimination. These approaches were also discussed by many of the key informants we interviewed, so we pick this up again in the next section of the report.

Finally, in our opinion what’s largely missing in the literature is looking at weight bias and stigma reduction in the context of the uniqueness and diversity of professional and health care cultures. The health care culture(s) is well described in the medical sociology and anthropology literatures. Typically, there is a divide between professional and patient, with the professional being the expert and the patient being subordinate. Not knowing how to deal with issues of overweight and obesity thus represents a conundrum for many health professionals who feel they should have all the answers. This can lead to avoidance behaviours and perhaps the adoption of negative attitudes and biases toward patients with weight-related issues. These attitudes can influence others, such as students, in the health care environment. Roberts et al. (2011) discuss the “hidden curriculum” in clinical training: “the unrecognized transmission of attitudes and beliefs relating to patient care and professional values” (p2) which can influence how medical students perceive obesity. In addition, different professions are grounded
in different philosophical models (e.g., a biomedical model for physicians, a more socio-environmental model for nurses). Thus, interventions for one group may not be effective for another.

One way out of the expert model conundrum is the development of a health care system and culture that supports patient and family-centred care; where the relationship between patients and health professionals is based on mutual trust and respect, and the respective knowledge and expertise that each brings into this partnership is equally valued. The health professional comes with their expertise in whatever medical or health care field they have chosen to study, and the patient comes with their expertise in their own body, health and experience living with a chronic condition. The key informants we had the privilege to speak with provided many insights relevant to this approach as one of great value in both reducing weight bias amongst health professionals, and in increasing health professional competency in working with patients in a way that is truly helpful.

4.2 What we learned through the key informant interviews

4.2.1 Approaches to addressing weight bias and stigma in health care

A major finding from this scan of the literature, which was augmented by the key informant interviews, is that there is a small group of researchers who are working in the area of weight bias and stigma, with the Yale-Rudd Center perceived by many as leading the way in the development of resources based on what we know from research to date. The people actively involved in research in this area acknowledge that there are no clear answers about the best approach to reducing weight bias amongst health professionals. In part this is because a lot of the research has looked at multiple strategies or components being used together, making it difficult to assess which of these strategies is most effective. Another is that little research has been conducted on weight bias reduction strategies targeted at practicing health professionals; much more research has been done with students.

As noted previously, the big focus in anti-fat prejudice research has been on attribution theory and trying to change attitudes, but used alone (i.e., not in combination with other strategies) this has not shown much success to date. Consistent with the research of Crandall and Reser (2005) regarding justification ideologies, this suggests that attributions of laziness and stupidity aren’t the core drivers of prejudice, but that this tends to be appealing because it fills the void about why we have negative emotional reactions against people who are fat. One informant referred to this as “justification theory” (i.e., we are justifying to ourselves why we feel the way we do about people who are heavy).

The bottom line with respect to weight stigma research described by one researcher who has been involved in systematic reviews of the research on this topic is that we really don’t know what’s going on, what works to decrease prejudice or why, in part because we still have a relatively poor understanding of prejudice. What is known is that prejudice functions for us, or we’d get rid of it. That is, prejudice makes us feel better about ourselves, making it extremely difficult to change. We can get rid of discrimination through social policies and
legislation, even when underlying prejudice is still there, making the development of anti-discrimination and equal rights policies and legislation, an important level to focus on. Working at a system and at a societal level is discussed more in sections 4.2.8 and 4.2.9.

One of the questions we asked the ‘experts in the field’ we spoke with was what components they felt should be considered for inclusion in a stigma reduction resource for health professionals, based on their knowledge of the research conducted to date and their experience. All of these individuals said that multiple strategies are needed, in part because we don’t really know what works or why. The components they described resonate with our findings from the literature review regarding potentially promising practices, and are briefly described below.

**Self-awareness**

Providing opportunities for health professionals to gain self-awareness through self-reflection and gaining an understanding of one’s own attitudes and biases, as well as its prevalence in our society was described by a number of people as an important component of any resource. It’s important to help learners realize how ingrained weight bias is in our society, and not something that’s unique to them, as you don’t want them to blame themselves for having these attitudes and/or feel that it’s unique to them in any way. You do, however, want to get people’s attention by engaging them in some kind of activity that helps them to relate to this issue at a personal level. As one individual said: “I’m in favour of freaking people out,” and having people go through an implicit test is one way of doing that.

Having people take an Implicit Attitudes Test (IAT), and then following this with discussion about the pervasiveness of these attitudes was described by many as a good way of approaching this. Helping health professionals to understand the distinction between explicit and implicit attitudes, and how our implicit attitudes affect our behaviour (e.g., may not be aware of their body language, how they spend less time with their overweight patients) is an important part of this discussion. There were mixed perspectives, however, on whether this was the best way to lead into the topic of weight bias and stigma with health professionals; and whether the best place to situate such a resource would differ across health professional groups.

Some of our informants also wondered whether this approach would work in a web-based environment, in that people doing the IAT as an individual can’t talk with others immediately and see that everyone exhibits weight bias. A lesson learned in the Indigenous Cultural Competency training program, for example, was that administration of the IAT online didn’t work well for beginning learners, in part because people kept trying to game the test and got hung up at that point. It was also thought that for some people, being made aware of one’s implicit anti-fat attitudes resulted in defensiveness and disengagement from the learning process. As one informant noted, “once learners become defensive, you will lose them.”

One informant spoke of the use of counter-conditioning through the use of environmental cues and imagery that could turn internal thoughts upside down – and, the more examples, the better: “For example, let’s talk about the words used by health care professionals to describe overweight people – lazy, unmotivated... Then explain how Oprah Winfrey happens to be constantly dealing with a weight issue – is she lazy, unmotivated? You
can use this example in working with patients too – if Oprah Winfrey struggles with weight, no wonder others are struggling.”

Finally, another strategy employed by key informants was to share their personal stories, describing their own weight bias and how it was affecting their practice, and how they came to change their own thinking. One person described this as follows: “I come at it from my own story of reflective practice – and how I came to change my thinking – and that it’s not an individual issue, it’s a societal issue and we all have it... and what I need to do to shift my practice....it’s not about right, wrong... it’s about changing our thinking...what we’re doing isn’t working – it’s not what you’re doing that’s wrong...”.

Information about the contributing factors to weight, and about the controllability of weight
Providing health professionals with information in a compelling way about the multiple, complex and intertwining contributing factors to weight and weight gain was described by all the people we spoke with as an important component of a resource. In addition to talking about the social determinants of health and the obesogenic environment, it will be important here to talk about genetics and to make the link between mental health and disordered eating and weight.

One patient key informant spoke eloquently about the obvious links between her mental health, her unhealthy relationship with food, and her weight. She has repeatedly tried to engage her family physician in discussion about these underlying issues that contribute to her weight gain, with no success. Her assessment was that the physician was uncomfortable talking about this and did not seem to have the knowledge and skills necessary to help her deal with these issues, nor did he know where to refer her for help. His understanding of weight and weight gain was purely physiological (i.e., you just have to eat less and be more active), and the dietitian she was referred to also had only this narrow physiological perspective.

Health professionals also need to be aware of the large and growing body of research showing that weight loss programs are not effective. A strong and common theme amongst key informants was that we really have to let go of our whole focus on individual behaviour change alone as an approach to managing weight, in addition to our focus on weight as being an indicator of health.

“We know for sure that behavioural approaches focusing on individual level behaviour alone, with a goal of losing weight, don’t work.” One key informant noted that evidence suggests that 60% of adult behavioural traits are genetically coded. “People who turn up to weight loss interventions are the most motivated people you’re going to work with - if they can’t lose weight no-one can.”

Not only are weight loss programs ineffective, they can often do more harm than good because of the dangers of weight cycling (i.e., the common cycle of weight fluctuations among dieters associated with the repeated loss and regain of weight). There is “mounting evidence from population-based studies of increased cardiovascular risks due to physiological changes associated with weight cycling, including insulin resistance and dyslipidemia... There is concern that the increasing incidence of weight cycling among girls and young women, at ever-younger ages, is likely to become a serious public health problem” (PHSA, 2013, p18).
The reluctance to let go of the idea that if we simply eat less and are more physically active, we lose weight, and that this is an easy thing to do in the context of the realities of our lives, to some extent reflects the focus we have in our society that we’re in control. We like to believe we’re in control of our behaviour. But we’re not. So although there does need to be a focus on behaviours and “lifestyle,” and not the numbers on the scale, it’s important to recognize that we can’t focus solely on individual responsibility for behaviour change. We truly need to be investing far more resources into focusing on societal and community level changes that can positively influence people’s lives, including changing societal attitudes toward health and weight.

**Information about the relationship between weight and health**

Another critically important component of a resource is addressing the myths regarding the connections between weight and health. So skill building and education is important as many health professionals lack knowledge and skills in this area. For example, there is often not a good understanding of the connection between disordered eating and weight, and an understanding that a lower weight isn’t always the healthiest thing – people don’t understand that.

We noticed that a number the people we spoke with were using the term “health at many or various sizes” *rather than “health at every size.”* This might be a middle ground approach that could work for more health professionals, given that the mantra of “overweight is bad” is so firmly ensconced in their way of thinking. Making the case that by focusing on weight so much, we may end up ignoring people of “normal” weight who are not healthy is one way forward here as health professionals care about their patients and don’t want to miss addressing important health issues.

Addressing some of the myths related to the “obesity epidemic” is also important. One key informant described her approach to discussing this issue with medical students as follows. We introduce the concept of the obesity epidemic and how it’s constructed and then we break it down and provide more recent evidence, and a whole body of critical obesity literature, refuting that. I also introduce some of the more mainstream literature (e.g., Arya Sharma’s work on the obesity scaling system; some of the longitudinal studies showing that being overweight can be protective). “*We’re causing some cognitive dissonance…*” Her experience has been that it’s easier to challenge this as an insider, in part because as a health professional working in the system you can gradually introduce it and keep reinforcing it. “*It’s harder for some of the critical obesity scholars to get in.*” This approach has worked well for her, and she has noticed that most health professionals “*know intuitively that our approaches to weight loss don’t work,*” and that many people who are “*obese based on their BMI*” are fit and healthy.

**Information about the health consequences of weight stigma**

The negative impacts on mental and physical health and well-being of weight bias are increasingly well known, primarily because of the work done at the Yale-Rudd Centre for Food Policy and Obesity, and are described in some depth in the PHSA technical report. These include: poor body image, low self-esteem, sense of self worthlessness, loneliness, mental illness, maladaptive eating behaviours, avoidance of physical activity, stress induced pathophysiology, and avoidance of medical care. These negative effects of weight bias are outlined below in Figure 1, which is re-produced here from the PHSA report.
A number of key informants talked about the importance of making physicians and other health professionals aware of the health consequences of weight stigma, with a major one being increased stress which in turn has all kinds of negative impacts on patient’s physical and mental health as well as negative social consequences. Cyclical frames were used to describe these negative impacts. One key informant described this cyclical process as follows:

- It’s stressful and psychologically damaging to be treated in a stigmatizing way;
- This in turn often leads to people turning to food as a coping mechanism;
- People are also less likely to engage in any kind of physical activity, particularly anything that makes them feel more visible;
- So if you stigmatize your patients you actually reinforce activities that have a negative impact on physical and mental health;
- When people feel stigmatized they don’t want to come back for future care; and,
- All of this has a huge negative impact on health and quality of life, or in other words we cause harm when we are truly here to support and help people optimize their health.

Another key informant shared a resource called “cycles of disconnection” (Jordan & Dooley, 2000)(see Figure 2). She has found that using this resource helps health professionals realize the harm that can be done to patients/clients by following a traditional health professional approach to weight loss. As a result of these cycles of disconnection people feel that they are the problem, which in turn means that the choices they make are often filled with guilt, shame, uncertainty which is turn can lead to depression and other mental and physical
health consequences. She described this as follows: “When I believe I am the problem the choices I make are often not healthful, but are simply coping...Coping is a survival strategy, but not a long term life-affirming strategy...It’s important for health professionals to look at the relational disconnections that lead to reinforcing the belief that I am the problem”.

Figure 2: Cycles of disconnection

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Cycles of Disconnection

Socio-Cultural Context → Relational Disconnections
Negative Social Esteem → Negative Self Image
Shame → Turn Away From → Isolation
Inauthentic Interactions → Depressed & Angry Feelings
Drop in Energy → Depressive Spiral
  Further Disconnection
    Feeling/Thought
      “There is no way out”
    Condemned Isolation
      “I am the Problem”
Disordered Eating → Poor Self-Care
Workaholism & Burn-out
Drug & Alcohol Abuse

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Adapted from the Relational Practice In Action Manual (p. 33)
www.jbmsl.org
Aligned with these components, key informants also spoke about two additional strategies for reducing weight bias that could be incorporated into a weight bias reduction resource for health professionals. These were: exposure to people are overweight and the experience of what it’s like living as a heavier person in a thin-obsessed society; and, using opinion leaders in the profession and/or society to raise weight bias, stigma and discrimination as an important social justice issue.

**Exposure to overweight people and the experience of being heavy**

As described previously in the review of the literature there are mixed perspectives on whether “contact” is an effective strategy for reducing weight bias, in part because of the prevalence and visibility of weight in our society. As one key informant stated: “The personal contact thing is tricky, because overweight people are all around us all the time, and they are visible.” This is somewhat different than interacting with people who have a mental illness and or HIV/AIDS and having no idea that the person is living with this condition. Nevertheless, a number of key informants felt that, at the very least, incorporating a contact component into training strategies might be a good idea. This could involve:

- Profiling people who challenge the weight-based stereotypes. For example, people who struggle with their weight and who defy stereotypes (i.e., individuals who are successful, energetic, and intelligent).
- Have health professionals do some training where they actually interact with an Avatar who is defined as “overweight or obese,” and/or using trained patient actors who are overweight.

One of the benefits of exposure to overweight people is having the opportunity to learn from their experiential expertise what it’s like to be a heavier individual accessing health care services and living in a society that values thinness. Other ways to enhance personal appreciation of the experience of heavy individuals, and how difficult it is to lose weight, were described by key informants. These included: having someone put on a “fat-suit” and go about their regular daily routine. Another was the study conducted with dietetic and health promotion students, and cited previously, where students were asked to go on a calorie-restricted diet for a week. At the end of the study, these students demonstrated less fat phobia; their journal entries illustrated a newfound respect for individuals struggling to lose weight and a change in prior negative attitudes (Cotugna & Mallick, 2010).

**Using opinion leaders in the profession and/or society to raise weight stigma as an important issue**

Consistent with social consensus theory (described above), several key informants spoke of the power of using respected professionals to deliver key messages to target audiences (i.e., in this case, health professionals). Having experts such as Rebecca Puhl, Arya Sharma, and Yoni Freedhoff speaking out on weight bias and stigma, and presenting the facts about weight, weight loss and health, was described by a number of key informants as helping to increase the visibility of weight bias and making people think more critically. As more people who are respected in our society, which would include health professionals, speak the truth about weight and health and talk about the harmful effects of weight stigma, the more socially unacceptable it will become to have and to express weight bias. Having opinion leaders in society speak candidly about their own struggles with disordered eating and/or weight, with the intent of confronting the stereotypes about people who are heavier can contribute again the development of a social consensus that weight bias and stigma is not acceptable in our society. Some key informants also mentioned the importance of using local and widely respected and trusted leaders to deliver key messages.
**Conclusion**

In conclusion, these suggested components and approaches come from our key informants’ experiences to date. At a general level, the individuals we spoke with felt that these same key components and strategies could be used with all health professionals with some minor tailoring for different professional groups, and different kinds of health care settings. Depending on the goal of the resource and the target audience(s), however, how to introduce these components, whether to include them all, and the approach taken to address them will differ. For example, many key informants felt that increasing awareness of weight bias was extremely important. However, some acknowledged that the approach with physicians might need to be different if they’re not open to personal or professional reflection. Also, as discussed previously, it may not be the thing you choose to start with.

As our experience trying combinations of these components in practice grows, along with building in strong evaluation and/or research programs to learn from these experiences, we will develop a better understanding of what works in which contexts and why. There are also numerous opportunities for incorporating conversations about health and weight in our interactions with patients and families across the lifecycle, continually emphasizing that thinness does not equate to health. In this next section we describe the importance of competency to health professionals, and why this is integral to weight stigma and patients experience with health professionals.

**4.2.2 Increasing competency**

As described in the background section, the professional expert model dominates the health care culture. As one informant noted: “Health care professionals are taught to be the expert – that’s in the air – the expert is going to do something to act upon the sick one.” The expectation that health professionals are experts that will fix what ails you also dominates our popular culture. So not only do health professionals expect and want to be able to “fix their patient’s health problems,” patients also often turn to them with that expectation. At the very least they expect that health professionals will be able to help and support them with both the physical and mental health issues that are related to weight, and in doing so help them address their weight as well.

If a patient wants to talk about weight in the context of their overall health, and the health care provider refuses to talk about it, this is bias. One individual described how bias is exacerbated by the lack of confidence that health professionals have in raising difficult issues. It is at these times, that health professionals are most likely to revert to where they are most comfortable, being the expert, meaning that complex and/or difficult issues are almost always raised in an authoritarian way. “When we’re talking about obesity we have to surrender that control...to be able to say, how can we work together?” If we can help the provider to have these difficult conversations, this can help remove the bias.

A number of key informants described extreme obesity as a complex, chronic health issue, making this a poor fit with our acute model health care system. A few key informants spoke about the importance of starting to build competency among all health professionals when they are doing their undergraduate training, so that they recognize obesity as a complex, chronic condition for which a patient often requires support over the long term and that patients will take many different kinds of paths to “get there.”
So a dominant theme from the key informant interviews is that health care providers strive to be competent care providers, and the majority truly want to be able to work with their patients in a way that will optimize their health and well-being. They truly just don’t know what to do, or where they can refer their patients for more in-depth help and support. One individual, in describing a research project conducted in eastern Canada that included talking to health professionals, said that health professionals told them they’re not equipped, that they don’t know what to do. They asked themselves questions like: “Should I even start this conversation? Am I just opening a can of worms? Should I just pretend it’s not going on? Do I have time to start this conversation?” This is intricately related to bias and discrimination, in that health professionals may feel uncomfortable working with patients who are heavy in part because they don’t know how to effectively help these patients improve their health.

As described previously, increasing health professionals’ understanding of the contributing factors to obesity and the connection between mental health, disordered eating and obesity is an area where more competency is required.

Increasing competency requires both increasing knowledge and then moving that knowledge into practice; something we know from the vast body of implementation and knowledge translation and exchange literature is incredibly difficult to do. Simply providing health professionals with evidence that the current way they are providing care is not effective, although important, is not enough to change practice. This is discussed throughout these findings, culminating in section 4.2.8 where the importance of taking a multi-level approach to system change is described.

So what is it that we want health professionals to know and do when a patient comes to them seeking some help to improve their health, which for some patients may include addressing their weight? Key points suggested by a number of key informants are summarized here in Table 3. This is not meant to be an exhaustive list, but it is included here to illustrate what competency might look like in the context of a health care encounter.

Table 3: Competencies for health professionals around weight management

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<th>Competency</th>
<th>Description</th>
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<td><strong>Initiate any conversation about weight respectfully</strong></td>
<td>Lead into any conversation about weight, with both patients who are overweight or underweight, if they would like to talk about their weight in the context of their health. This conversation is best had in the context of a relationship characterized by mutual respect and trust.</td>
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<td><strong>Listen to and try and understand the context of people’s lives</strong></td>
<td>Be aware of the many factors that can contribute to weight gain, and be willing to discuss openly with your patient what their thoughts are about the factors that are important to them. It’s no use telling people to change if they have no access to the conditions that enable them to</td>
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As described in the background section, people are reluctant to seek help from health professionals because the way they are treated causes a lot of stress. Making health professionals aware of how they can work with patients in a way that doesn’t increase stress is extremely important if the goal is to “do no harm.” Some of the resources identified through the environmental scan lead in with this improving competency focus, as it seems that some health professionals are more open to engaging in a program where increasing their patient care skills is the explicit goal. Bias and stigma reduction components are then woven through a “skills enhancement” kind
of curriculum. Two examples of such resources are the Canadian Obesity Network’s “Five A’s” and the Rudd Center’s Continuing Medical Education program.

### 4.2.3 What language should health professionals use when have a conversation about weight?

The Rudd Center recently conducted surveys in the U.S. of adults (n=1064), and of parents (n= 445, asking them what language they wanted health care providers to use when they were talking with them about weight. This study found that the terms “weight” and “unhealthy weight” were rated as most desirable, and the terms “unhealthy weight,” “weight problem” and “overweight” were rated most motivating. In contrast, the terms “morbidly obese,” “extremely obese,” “fat” and “obese” were rated as the most undesirable, stigmatizing and blaming language used by health providers (Puhl, Peterson & Luedicke, 2012; Puhl, Peterson & Luedicke, 2011).

One option suggested in the Canadian Obesity Network’s 5 A’s resource, in the context of opening up the conversation with a patient, is asking them whether they have always been big or large; so the terms are more size-related rather than weight-related.

The overwhelming theme that emerged through the key informant interviews is that the actual words used are generally of less importance to patients then the tenor of the conversation; or another way of framing this is that what exactly is said is less important than how it’s said. Many patients would like their doctor or other health professional to respectfully ask them how they feel about their weight or whether they want to talk about their weight, and if they are struggling with weight issues whether they’d like some help and support. The most important factor described is that health professionals aim to have a good relationship with their patient, and engage in open and respectful dialogue with them about their weight and their health.

As one of our informants said, in describing what the patients they interviewed in their research said: “They didn’t care what words were used – it was more how it was used. They didn’t want to be made to feel like a naughty child...may need different language for different audiences/people...it’s not what we say, but the way that we say it...it all comes down to being respectful and being open to people’s point of view” (S. Kirk). As another one noted: “The conversations about language and what underlies the words we use, is more important than the words we land on.”

This resonates with much of the literature on physician-patient relationships, as this quote illustrates: “The value of a warm and empathetic communication should not be underestimated.” As Stunkard (1993) has noted, health care providers have a golden opportunity. As with chronic illness, we rarely have the opportunity to cure. But we do have the opportunity to treat the patient with respect. Such an experience may be the greatest gift that a doctor can give an obese patient” (Fabricatore, Wadden & Foster, 2005, p355-6).

Having said that, a number of informants did describe how value-laden words can be, which makes this whole issue of what language to use when talking to patients a very challenging one. One informant felt that it might be helpful to reinforce that weight and height are just clinical markers like blood sugar levels, blood pressure; i.e., trying to ensure that weight is a neutral clinical term. This fit with what another informant was talking about with respect to the importance of separating the fat from the person. In addition, if the focus is kept on health
and lifestyle, rather than weight, then conversation about weight should be kept to a minimum anyway; so although it’s important to discuss weight if the patient wants to talk about it, weight loss should not be the main focus of the discussion.

Someone else noted that: “it’s different for everyone – people get offended by ‘fat’ or ‘overweight’ – these terms are attached to peoples’ past experiences and memories – no way to be sure. So key is to make professionals aware it is an issue that the terms they use may be offensive and it’s important to be aware this term can be difficult. Thus it’s important to ask patients what terms they are most comfortable with – “How should we discuss this”. Ultimately, if we make people feel bad by the language we use then we risk causing harm so its important to be sensitive to this.

Again, supporting what the Yale-Rudd survey found, a researcher doing work with youth noted that “kids hate the word obese, they also don’t like the word overweight.” She heard from kids that the Wii Fit requires you to be measured, and it calls people obese. “Kids can accept the fact that they’re bigger, but just the word obese to them has a lot of negative connotations...they see themselves as contributing to the demise of the population; that’s what’s portrayed to them.”

One informant highlighted a helpful resource she had come across called the No Fat Talk website. In a video she has shown it focuses on being mindful about changing the nature of the conversation that health professionals have with patients so that the focus can be on lifestyle changes and not weight, taking the Health at Every Size (HAES) approach where the emphasis is on health (i.e, both mental and physical) as a value rather than weight as a goal.

Although some activists are trying, including some people aligned with the HAES movement, are trying to reclaim the word fat it’s readily recognized that some patients would be really offended if you used that term, which again points to the importance of exploring with the patient what language they’re comfortable using. If the patient does introduce the topic, then the health professional can take the lead from the patient and consider using the language they’re using or if in doubt simply ask.

Finally, with respect to the language that we use in this resource and in our discussions at a health system level, many of our key informants stated that obesity is a medical and hugely stigmatizing word and felt that we should stay away from using this term; at least in part because of the obesity language all over the place. If it was felt that the term needed to be used for political and/or alignment reasons, then clearly explaining why this term was chosen would be important. One informant noted that “the political reality is that there still needs to be some connection to weight in our discussions with health, but that we could be moving away from talking about overweight and obesity toward talking about healthy weight...and overall well-being”.

4.2.4 What do patients say about their experience with the health care system?

Our review of the literature did not focus on the patient experience with the health care system, but this topic did come up in our interviews with key informants and the weight bias and stigma experienced by people in the health care system was described in the background sections of the articles reviewed. We also interviewed
three BC patients about their health care experiences, to augment what we know from the research. We asked these individuals about both their good and bad experiences with the health care system, and asked them what they needed and expected from the system. Key themes that emerged throughout conversations with patients are described briefly here.

One dominant theme is that **patients who are heavy want to be treated like human beings**, wanting health professionals to “check their bias and judgment at the door”, and look beyond the weight to see the person. Related to this is the desire to be like every other patient when they go to a health professional seeking help. By that, the people we spoke with meant that they wanted to be treated with dignity, respect and compassion, and have their presenting complaint listened to. These patients described a number of experiences where serious health problems were not identified and/or not dealt with appropriately because the health professionals could only see the weight issue.

“... when I go to a hospital, I go in there because I’m ill and I need you to look at me as a patient who has a sickness and I don’t know what to do about it so I come to you for help.”

Another dominant theme is that **when patients do see their weight as a health issue that they would like to address, they would appreciate the support of health professionals**. The three patients we spoke with, who all described themselves as morbidly obese or fat, said they appreciate it when their family doctor asks them if they are interested in discussing their weight. Patients said that weight seemed to be so stigmatized that health professionals were afraid to bring it up, and even reluctant to talk about it when patients brought it up. These patients felt that fear was the major barrier that was stopping health professionals from talking about weight, both fear that they might offend their patient if they brought it up and fear that if the patient did want some help they would have no idea what to do. These patients realized that overweight people could be very healthy, and they had that experience themselves. They did feel though that at some point weight can have a negative impact on their mental health and well-being, and felt that if they wanted some support from the health care system to be able to deal with this, they should be able to get some help.

“We’re human beings, not objects...we cry, we have pain...do not look at my weight when I walk through the door, look at me.”

“If I use the word fat, I’m opening the door for you to say it. I make a fat joke first so you won’t embarrass me by mentioning it. I shouldn’t have to do that.”

“But it’s a struggle to bend over and tie my shoes. That’s affecting my quality of life you know and trying to get somebody to understand that.”

Overall, these **patients felt that the health care system did a poor job of dealing with complex, chronic issues like obesity**. This discomfort around not knowing “how to fix it”, in combination with the stigma associated with obesity, meant that patients were not getting any help. It seemed to them somewhat ironic that obesity is so widely described as being harmful to health, and the obesity epidemic described as going to bankrupt the health care system, and yet there seems to be little if any help available from the health care system for people who want some help with their weight. Patients acknowledged that there were some system-level issues that prevented family doctors from providing effective
support, including ten-minute appointment times and the rule about only being able to talk about one health issue at a time.

“TALKED TO MY FAMILY DOCTOR—SEE, I’VE HAD A HISTORY OF BEING BULIMIC AND I’VE ALSO HAD A HISTORY OF BEING ANOREXIC. BUT HE LOOKS AT ME AND I’M 260 POUNDS AND HE SAID WELL, YOU’RE NOT DOING THAT NOW ARE YOU...WELL, THEN WE DON’T NEED TO GO THERE.”

Patients also described the kind of help from health professionals they would find useful, wanting to focus on the underlying issues that were contributing to their weight. The people we spoke with had struggled with their weight from a young age and described having dysfunctional relationships with food, disordered eating, and/or a food addiction. They felt they had underlying mental health issues that contributed to their struggle with their weight, and really wanted to get help with these underlying issues which they felt in turn would then contribute to weight loss. Focusing on weight loss as the primary goal, without trying to understand and address the underlying issues, was described as not helpful. These individuals found it very frustrating when their doctor would focus only on the narrow physiological aspect of weight loss, with the only help provided being an instruction to “eat less and exercise more”. Referral to a dietitian was also described as not helpful, once again because of the reluctance to have an open discussion about the underlying issues, and a singular focus on nutrition and calories. These individuals recognized there were multiple, complex contributing factors to obesity, and underlying mental health issues was not always one of those factors. Patients talked about the importance of not presuming what the underlying factors were for a particular patient, but rather seeking the patient’s perspective on and knowledge about their own struggles and issues.

“I TALKED TO MY FAMILY DOCTOR—SEE, I’VE HAD A HISTORY OF BEING BULIMIC AND I’VE ALSO HAD A HISTORY OF BEING ANOREXIC. BUT HE LOOKS AT ME AND I’M 260 POUNDS AND HE SAID WELL, YOU’RE NOT DOING THAT NOW ARE YOU...WELL, THEN WE DON’T NEED TO GO THERE.”

To conclude, these patients experienced weight bias and stigma in the health care system, in two quite disparate but equally damaging ways. The first was having health professionals focusing on their weight as the problem, when they were seeking help for another health issue; and the second was health professionals’ reluctance to talk about weight and provide some support when the patient asked for help. The latter usually involved going to see a family doctor. Patients wanted to be able to get help with other health issues, like a “normal patient” (i.e., without their weight being the sole focus). They also believed that obesity could become a health issue, and described how their weight affected their mental health, their physical health, and overall well-being and quality of life. They wanted to be able to turn to the health care system for help and support they could trust.

These themes that emerged so predominantly through these three patient interviews were very aligned with themes described by other key informants, from both their research and practice. One researcher described the following theme as dominating their interviews with patients as part of a Nova Scotia research project: “WHAT STOOD OUT FROM OUR PATIENT INTERVIEWS WAS: I WANT MY DOC TO BE WILLING TO HAVE THE CONVERSATION WITH ME ABOUT MY WEIGHT, AND MY WEIGHT AS A SYMPTOM OF OTHER PROBLEMS...DYSFUNCTIONAL RELATIONSHIP WITH FOOD AND MENTAL HEALTH ISSUES...SO THIS CAME OUT AS HUGE IN OUR INTERVIEW, MENTAL HEALTH ISSUES. WE NEED PEOPLE WITH LIVED EXPERIENCE TO TALK WITH HEALTH PROFESSIONALS AND SAY THIS IS WHAT WOULD HELP ME... WE’RE NOT THE EXPERTS ON THIS.”
Other individuals involved with a lifestyle program for youth described experiences that resonated with what we learned through our three patients interviews. They described children being referred to an “obesity treatment program” when they went to see their family physician for knee pain, or a specialist for allergy testing. For example, a parent described an experience of taking her child for allergy testing, and instead was told that she was feeding or son too much, with again the result being a referral to an obesity treatment program and no allergy testing. Youth participating in this program expected to be treated judgmentally by health professionals, and for there to be a focus on weighing and measuring.

“I expected it to be more...okay, so what's your waist size today? How much do you weigh today?” (Jordan, 12 year old girl)....“I thought it was going to be like one of those programs...like, oh look at you, you're fat. Let's weight you now on a scale.” (Nicholas, 12 year old boy) - Ward (2012)

4.2.5 Promising stigma reduction resources and/or initiatives from other jurisdictions

Briefly outlined here are the resources and initiatives described by the key informants we spoke with as having some potential, and would be worth considering and building upon in the development of this resource. It’s important to note that this section is labeled promising practices, in that they have not yet been subject to intensive research and evaluation across a wide variety of contexts so there is not a strong evidence base regarding their effectiveness as yet. Some of these resources are targeted at health professionals working with an adult population, and others at health professionals working with children and youth. They are also developed for different kinds of health professionals (e.g., family physicians, health professionals working in specialty treatment centres, public health nurses). Once again, this supports the importance of building in a strong monitoring and evaluation component to any resource developed that either uses or builds upon any of these initiatives.

The Yale-Rudd Center for Food Policy and Obesity

When asked about existing resources, many key informants described the Rudd Center resources as the first place they’d go to because their work is very credible and based on solid research; this was true of people we spoke with in Australia and the U.K., as well as Canada. As one informant stated: “what makes Rebecca Puhl’s work so important is that her work is so strongly evidence-based. So the non-believers are faced with actual, credible, scientific work that proves we have a problem. It’s science. It’s not some touchy-feeling discussion. It’s not coming out of some field that isn’t so credible. It’s credible science, published in major scientific journals – those that are very difficult to get published in. These are crucial. This idea of using evidence-based material is really important. It helps the orthopedic surgeons believe that there might be some truth to it.”

A few key informants feel that the Yale-Rudd Center is still overly focused on weight rather than health, however, with a few key informants describing the reducing weight bias while focusing on weight reduction as contradictory.

Resources included on the Yale-Rudd Center Weight Bias site include a Continuing Medical Education (CME) online module on weight bias and stigma; a variety of tools for weight bias and stigma researchers, such as fat phobia scales and an implicit attitude test; and a series of videos targeted at different audiences, including one for health professionals.
The seventeen-minute video developed for health professionals is being used widely in hospitals across the U.S. as part of their sensitivity training. It includes information about the prevalence of weight stigma, bias and discrimination, why health professionals need to pay attention to this, and how to deal with it in their practice. It helps health professionals understand that weight stigma is common in health care, in part because it’s a common type of bias in society and therefore difficult to be immune from. The video stays from away from judging individual health professionals for their attitudes, reinforcing how prevalent this bias is in our society including the health care system, and how harmful it is to patients. Of all the resources they’ve developed, so far the most positive response has been to the video. This is likely due to the combination of the dramatic scenarios and the fact that it’s a video, which is easy for people to watch and get something out of it. One shortcoming of the video is that does not provide explicit instructions that could support practice change (e.g., be able to print off a list of questions around how to talk to patients about their weight, setting behavioural goals). This is provided through the online CME resource.

Health at Every Size (HAES)

Another resource described by many key informants is the Health at Every Size (HAES) movement. “HAES principles cited by the Association for Size Diversity and Health (ASDAH) are strikingly resonant with health promotion principles. They include:

- Accepting and respecting the diversity of body shapes and sizes
- Recognizing that health and well-being are multi-dimensional and that they include physical, social, spiritual, occupational, emotional and intellectual aspects
- Promoting all aspects of health and well-being for people of all sizes
- Promoting eating in a manner which balances individual nutritional needs, hunger, satiety, appetite and pleasure
- Promoting individually appropriate, enjoyable, life-enhancing physical activity, rather than exercise that is focused on a goal of weight loss” (ASDAH cited in PHSA, December 2012, p50).

There is lots of support for HAES in their work on increasing self-awareness, and getting people to appreciate their bodies more. A strong and important message from HAES is that fear does not work as a motivator for behaviour change; rather the focus needs to be on helping patients/clients appreciate their body so that they are truly motivated to take care of it. There is also a lot of support for moving away from focusing on weight loss to focusing on behaviours, lifestyle issues and physical and mental health promotion.

Some key informants felt that the HAES approach, although it has many strengths, is somewhat radical and not likely to be accepted by health professionals in its entirety. As one key informant stated, as appealing as the HAES is in some respects: “Pragmatically you have to find a way to present something that people are willing to listen to...HAES is radical; have always been a strong believer in more radical approach, but putting the more radical approach on the table for the broad pop isn’t going to get us where we want to go... need to know who we’re dealing with – raise consciousness without hitting over the head with a hammer.”

Another noted: “I’m not a full subscriber of HAES – it’s more health at various sizes... There are health consequences to morbid obesity. We have to bridge that gap.... If you read any of the critical literature there are
two camps, obesity and HAES. I’m probably straddling the two camps… I am frustrated when I read critical obesity literature – it’s not helpful either… somewhere in the middle is where we need to go”.

Reflecting this perspective, a few key informants talked about health at many or various sizes rather than health at every size. Yet a few of the people we spoke with suggested that there is a misunderstanding about the underlying meaning of HAES. “Health at every size doesn’t mean that everybody at every size is healthy but if you start there then everyone has the potential to be healthy. As soon as we take someone out of that position, then they can’t identify as healthy.” Health at every size means that you can have health at every size, which is different from saying that every size is healthy. That is, the connection between health and size is complex, and what size is healthy for one individual may not be for another. This goes both for people who are very heavy and those who are very thin.

The Canadian Obesity Network, and the 5 A’s
The Canadian Obesity Network (CON) is an organization focused on:

- Addressing the social stigma associated with excess weight
- Changing the way policy makers and health professionals approach obesity
- Improving access to prevention and treatment resources

With respect to resources, CON has recently developed an obesity management resource primarily targeted at family physicians, called the 5 A’s (see inset box)

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<tr>
<th>The Canadian Obesity Network’s 5 A’s</th>
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<tr>
<td>o <strong>Ask</strong> permission to discuss weight. Weight is a sensitive issue; many patients are embarrassed or fear blame and stigma.</td>
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<tr>
<td>o <strong>Assess</strong> obesity-related risk and potential root causes of weight gain. Root causes of weight gain fall into 3 categories: metabolism, increased food intake, decreased activity.</td>
</tr>
<tr>
<td>o <strong>Advise</strong> on obesity risks; discuss benefits and options</td>
</tr>
<tr>
<td>o <strong>Agree</strong> on realistic weight-loss recommendations, and a SMART plan to achieve behavioural goals (i.e., no more than a total of 5-10% of initial body weight year). For some patients the prevention or slowing of weight gain may be the only realistic target.</td>
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<tr>
<td>o <strong>Assist</strong> in addressing drivers and barriers, offering education and resources, referral to providers, and arranging follow-up.</td>
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Dr. Arya Sharma stated that when the CON was developing this resource they couldn’t find anything out there that includes all the components they’ve included in their resource. They determined that the first and most important part is how to bring this subject up: The “ask” component. They made a purposeful decision to lead in with a competency building focus, but treating patients with compassion, dignity and respect is woven throughout the resource. Although it was developed for physicians, other health care professionals are accessing the training and using it as well. Dr. Sharma felt that the 5 A’s was a good starting point, and that any gaps could then be addressed through whatever BC is developing.
Many key informants described the resource as including some good components, and going in the right direction. The Canadian Obesity Network, and the development of the 5 A’s resource, was described as a positive indicator of how some of the critical obesity work has begun to seep into the more mainstream obesity work. Having specialist physicians question more traditional approaches to weight management, including the focus on BMI as a measure of health, and champion a new approach was noted by some as a ray of hope.

Some key informants described the 5 A’s as still taking a too weight-focused and/or an over-medicalized approach to obesity, however, and a few wondered whether there was anything about positive mental health in this approach. Others felt that the 5 A’s was missing a self-awareness component; that is, there is nothing about the prevalence of weight bias in our society, nor about increasing self-awareness about our own bias and why we have it. Finally, some key informants commented that there was still too heavy a focus on “weight management” and no prevention focus at all. The bottom line appears to be that this is a good resource, and likely very helpful for many physicians and potentially other health professionals, but with respect to weight bias and stigma reduction it may need to be used along with other resources.

LENS (Leveraging Equitable Non-Stigmatizing health promotion delivery)
LENS (Leveraging Equitable Non-Stigmatizing health promotion delivery) is a program of research led by Dr. Gail McVey (a psychologist and health systems research scientist at The Hospital for Sick Children in Ontario) with members of her research team (Dr. Kathryn S Walker, Heather Harrison), and developed in partnership with health promotion specialists from public health (Joanne Beyers, Sari Simkins, Lesley Andrade, Elaine Murkin) with expert input from Alberta (Dr. Shelly Russell-Mayhew). The LENS team is an established multi-disciplinary team of academic researchers, knowledge users, and collaborators who have worked together on the development of the research questions, the development of the intervention components and sharing of networks; the LENS project, then, embodies an integrated KT approach in their work. The project team has focused on integrating what has been learned through the eating disorders prevention field into mandates for healthy weights promotion, with a goal of supporting public health professionals to “take a broad and balanced perspective on the complex factors that influence obesity”; the emphasis here is on an ecological rather than an individualized approach to healthy eating and active living. Promoting positive mental health is the underlying strategy for addressing the broad spectrum of weight-based disorders (i.e., disordered eating, eating disorders, and obesity) together with other issues (e.g., addictions; mental illness). Another important learning from eating disorders prevention is that adult influencers should be a main focus, as their attitudes and sensitivity about weight and body image affects what they do. Both increasing awareness about these issues and how it affects their work, and then skill building once they realize their impact, are important.

The LENS project is conceptualized as having a number of interventions. Right now, the most well developed intervention, and the one that has been piloted is the one-day professional development workshop. This workshop is designed to reach out to public health professionals who work in the area of healthy lifestyles, and to identify effective ways to increase weight bias awareness and to optimize the delivery of non-stigmatizing and equitable health promotion. Note that this workshop is focused in improving public health professional practice in health promotion (not treatment) with the general public, not with referred clients. It is a group-based, day-long workshop that uses a variety of strategies (i.e., didactic presentations; multi-media; case studies; personal
reflection; and collaborative group reflection) built around three themes (see Table 4) (McVey, Walker, Beyers, Harrison, Russell-Mayhew & Simkins, 2013, in press).

**Table 4: LENS Professional Development Workshop**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
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<tr>
<td>Weight bias awareness</td>
<td>• Reflection on personal beliefs about the causes of obesity, the sources of these beliefs, and the influence of one’s own upbringing on these beliefs  &lt;br&gt;• One’s own weight bias, and how these factors influence daily work practice  &lt;br&gt;• Weight stigma and discrimination  &lt;br&gt;• What is known from research about the negative consequences of weight bias, and in particular the impacts on mental health and the uptake of health promoting behaviours</td>
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<tr>
<td>Balanced approach to healthy eating and healthy weight messaging</td>
<td>Increasing awareness of:  &lt;br&gt;• The benefits of intuitive eating and a taking a flexible approach to healthy eating  &lt;br&gt;• Early warning signs of disordered eating and excessive exercise  &lt;br&gt;• Aspects of the obesogenic environment that influence eating and activity  &lt;br&gt;• Potentially negative consequences of focusing on weight rather than health through obesity prevention messaging, including triggering of food and weight preoccupation  &lt;br&gt;• Repeated cycles of weight loss and regain  &lt;br&gt;• Distraction from other personal health goals and the wider determinants of health  &lt;br&gt;• Reduced self esteem  &lt;br&gt;• Disordered eating and other health problems</td>
</tr>
<tr>
<td>Mental health promotion</td>
<td>• Increasing awareness about the association between mental and physical health, and between the experience of stress and engaging in healthy lifestyles  &lt;br&gt;• What is known from research on resiliency building in youth as a strategy for preventing, smoking, mood disorders and depression, and disordered eating  &lt;br&gt;• Reflection about one’s own personal style of coping  &lt;br&gt;• Self-assessment of stress management skills, including assertive communication</td>
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Adapted from McVey et al (2013) – in press.

Feedback from participants in the LENS work is that although the awareness raising about weight bias and one’s own anti-fat attitudes is valuable, it would have been helpful to get more information about how to actually integrate this new understanding into their practice. That is, public health professionals want to engage in more practical skill-building activities, beginning this at the first workshop. They also recognize a need for additional mentoring support in their workplace to help them integrate their new knowledge into practice, as well as a need for organizational support to help them reframe their obesity prevention work using a mental health promotion and social determinants lens (McVey et al, 2013, in press). Also, given how difficult it can be for some public health professionals to participate in a full-day workshop, there was potential interest expressed in having
some of the pre-workshop learning assigned, with a half-day workshop to maximize the face-to-face time for group exercises and reflection, and some skill-building activities.

Because of the recognized limitations of any workshop, regardless of how well designed, LENS is being conceptualized as encompassing a number of interventions or “innings” that take place over a longer period of time. The first inning consists of both an A and a B component, with the A component being the piece that is addressed through the full day workshop. The B component involves supporting people to incorporate their new understanding and knowledge into practice, and could involve having the workshop facilitators doing site visits where the emphasis is on doing some pragmatic skill-building exercises and some case studies to practice re-framing their practice. A second inning could involve building a community of practice, so that public health professionals could continue to learn from each other, and from the facilitators, how to integrate this into their practices.

Key informants aware of the LENS project, and the work of Gail McVey in general, spoke very positively about it. Many liked the approach taken in the LENS program (i.e., self reflection about weight bias, increasing awareness of the prevalence and deeply embedded nature of weight bias, and that weight discrimination is the last socially acceptable discrimination we have). “It’s so important to raise awareness of this!”

**Project Invisibility, Nova Scotia**

Another promising resource comes out of Nova Scotia, where a research team led by Sara Kirk explored the experience of how we approach weight management in the health care system, from three different perspectives: patients who are overweight; health care professionals; and policy-makers. This study, Project Invisibility, used a feminist post-structuralism lens, which involves looking at issues of power in relationships; this is useful for situations where there is a power imbalance between experts and individuals such as between health professionals and patients. The multidimensional project had three primary objectives:

1. To determine the perceptions and experiences of overweight and obese people about their weight management as they interact with health care professionals and the health care system.
2. To determine how health care professionals, when assisting with weight management, perceive and experience interactions with overweight/obese clients and the health care system.
3. To determine how policy makers, responsible for commissioning health services, perceive obesity and its management within the health care system. What are the barriers and enablers within the current system, from the policy maker’s perspective, that inhibit or support the attainment of best practice guidelines for weight management? (Applied Research Collaborations for Health, n.d.)

A key theme that emerged across all three groups was the existence of weight bias and stigma. Patients had experienced it, health professionals observed it but never expressed “doing it”, and policy makers were aware of it. A lot of disrespectful language emerged through the in-depth interviews; even among those you would think had a good understanding of the complexity of weight and weight management. For example, they heard things like: “A 500 pounder who cost the system a lot of money”. There was a lot of blaming of individuals for not being able to lose weight and patients blaming themselves for not losing weight, with the latter being an indicator of the internalization of weight bias. This prevalence of weight bias and stigma spoke to a need for an upstream
approach. Policy makers seemed to want to move completely to the prevention of obesity, but the key informants involved with this research project believed that it was also important to provide some support to people who were struggling with their weight and were seeking help from the health care system. As one key informant stated: “My feeling is we can’t ignore 60% of the population...We have to offer them something that can help...and moving to a more supportive relationship with people is key to this.”

Another remarkable feature of this eastern Canada research project was the innovative knowledge exchange strategies used to disseminate the research findings, strategies that included engaging patients in sharing their experiential expertise with health professionals. These strategies were a one-day workshop, and the development of two videos, the goals of which were to raise awareness about weight bias and stigma and to get people to challenge their way of working. In the workshop, the actors from the videos stayed in character and went around the tables, and the patients living with obesity who participated in the interviews, came and talked to workshop participants in the round-table groups. The patients and the health professionals all found this to be a fantastic experience. In addition to the goals articulated above, the workshop provided an opportunity to start the dialogue around practice change.

In conclusion, there are a number of promising weight bias and stigma projects and initiatives going on across Canada and internationally that can serve as a foundation and inform the development of this BC resource. We specifically asked the key informants we spoke with if they had come across weight bias and stigma resources that they have found useful in their work in health professionals. A number of these have been noted throughout the findings section, and many have been developed through the initiatives and projects briefly described here. A list of these resources can be found in Table 6 in section 5.0.

4.2.6 BC initiatives that this resource might build upon or align with, and some delivery strategies

Because this resource is being developed in BC, special attention was paid to finding BC initiatives and resources that might be helpful either to build upon in the development of this resource and/or to initiatives that this resource might align itself with. They also spoke about potential delivery strategies that might work in the BC context. What we learned through our conversations with key informants is briefly described here.

Existing BC weight bias and stigma reduction resources to build upon

A few key informants mentioned the Fraser Health Region’s forum that was developed and facilitated by mental health professionals, with the intent of increasing health professionals’ awareness and understanding of weight bias. Rebecca Puhl’s work was heavily drawn upon in the planning and development of this forum. Carrie Matteson’s presentation, that was the foundation for this workshop, is something that could be referred to in the development of this resource.

One key informant had been involved in presentations to BC PH nurses (two workshops, one in Vancouver and one in Richmond). The goal was to have public health nurses become more aware of their own personal beliefs about weight, and where they come from, and to question those beliefs. Eating disorders always take a back seat to obesity/weight, but really they run parallel in terms of impact and can have some of the same underlying dysfunctional relationships with food. An objective of this presentation was to bring to light that our current approach to addressing obesity could be causing harm, and that even the innocuous hallway comments can get
picked up on. The approach taken in this workshop was a mixture of didactic presentation, videos, exercises and discussion questions; with a goal of wanting to get thinking, questioning and discussion happening. The videos were described as particularly effective.

**Existing initiatives that a module on weight bias reduction could be aligned with**

There are a number of initiatives going on in the BC health sector that this weight bias and stigma resource could be aligned with in some way. Key informants described some of these initiatives as possible homes or delivery vehicles for this resource. Others were described as sensitivity training and/or capacity building initiatives where lessons had been learned that could inform the development of the resource, not so much form a content perspective but from a delivery and a format perspective. These are described here briefly, recognizing that individuals sitting on the Weight Bias Steering and Advisory Committees are aware of these initiatives, as well as many others that might be worthwhile exploring further.

**Health Compass: Transformative practices, embracing well-being**

Health Compass is a cross-PHSA project that aims to build the capacity of PHSA health care providers to further promote the mental well-being of patients, clients and families that access PHSA’s health care services. This resource offers education and training regarding how interpersonal skills, inter-professional health care interactions and healthy environments can promote positive mental well-being. It contains four modules: 1) health promotion concepts and principles; 2) communicating to empower; 3) healthy teams and mental well-being; and 4) healthy organizations and mental well-being. Health Compass was described by a number of key informants as a possible home for a module on weight stigma, because of its philosophical fit. This resource is still in its pilot-testing phase, however, so it will be important to pay attention to how this resource is received by health professionals before exploring what might be possible here.

**Indigenous Cultural Competency (ICC) training**

A number of people described the ICC as a good example of an effective health professional sensitivity training resource. It was felt to be effective in increasing understanding and awareness about indigenous peoples and their experience in the health care system. There were multiple contributing factors to its effectiveness, including the interesting and engaging way in which the material was presented, and the creation of a safe learning environment. Some of the key lessons learned in the development and delivery of the ICC training is described in more depth in the following section: “What kinds of approaches to learning might work with health professionals and why?”

**Self-management resource**

The BC health system has developed a self-management resource that is meant to support health professionals’ work with people living with chronic conditions in a collaborative, patient-centred way. One key informant felt that a module on weight bias and stigma might be a good fit here, both because of the philosophical fit and the chronic nature of weight issues.

In addition to these three resources, there are a number of healthy weight initiatives going on in the BC health and related systems that a weight bias and stigma module might be aligned with. A few such initiatives described by key informants include:
• BC Northern Health Authority’s work on obesity, including their position statement
• Action Schools! BC - Being Me: Promoting positive body image initiative
• Shapedown BC - a program that helps children, adolescents and their families achieve healthy weights.

Potential delivery strategies
Many of the people we spoke with, including key informants in BC, felt that the resource being developed should be able to be readily integrated into other existing professional development and learning initiatives (e.g. Health Compass, new staff orientations), rather than developing it as a standalone resource – at least initially. This is an important consideration, as even health professionals who are very interested in taking advantage of a learning opportunity often find it difficult to fit it into their busy schedules. One individual, for example, described finding it difficult to find time to do the eight-hour ICC training. Starting off with a resource that is shorter than this, that can be built upon might be, might be a good way to go. Strategies worth considering that were described by key informants are briefly described, and offered here as ‘food for thought’.

Given that many health professionals turn to their professional associations for their ongoing professional development opportunities, working with professional associations to ensure that the resource is accepted and promoted to their professionals was described by a number of key informants as being a potentially useful strategy. For example, a number of key informants felt that the BC Medical Association has a number of vehicles that this resource could be promoted through, including their journal and their newsletter “Doc on the Go”.

Many key informants felt that exposing future health professionals to the realities of weight bias and stigma, during their undergraduate education, before they “go into the real world” is important. This doesn’t mean that the learning ends there, but it can lay an important foundation that can be built upon. Having said this, it can often be difficult to get material added to undergraduate curriculum, and in particular medical school curriculum. As one person noted: “This is on the radar of medical schools, but it’s really difficult to get it introduced...it’s not that people don’t get that it’s important, it’s just the reality of how much is also crammed into the medical school curriculum.”

A number of key informants view the reduction of weight bias and stigma as being a natural fit with the advancing patient centred care and relational practice agenda, or really any equity-focused approach to care and service provision such as BC’s Health Compass initiative. The core concept here is recognizing that health care at its core is about people caring for and about people, meaning that the development of relationships between patients and health professionals based on mutual respect and trust is critically important.

One individual, for example, spoke eloquently about ensuring that this resource is firmly anchored in what she called the relational-cultural model. This is about relational practice, which is the foundation of patient-centred care. She spoke about needing to break through some of the professionalism barriers we learn as health professionals (i.e., knowing all the answers; becoming stoic ‘experts’). Rather the goal is to get learners to understand that: “I as a professional can learn from the client and their experience; that both partners in this inter-personal encounter have knowledge and wisdom to bring to this relationship.” Another informant described how Newfoundland-Labrador has connected weight bias and stigma to patient-centred care. She explained that In Newfoundland-Labrador, their quality, patient-centred care initiative “has identified sensitive
weight management as a priority, just because it’s so evident that “we are so far away from any level of self-awareness about this.” She went on to say that in her experience in Newfoundland-Labrador, rural folks do see physicians as gods and will do anything they say. So if physicians treat patients in a judgmental way, then they believe they deserve it; which of course makes weight bias and stigma reduction such an important issue.

Given that this resource is being informed by research and practice across Canada, it may make sense to align it with a national initiative. One such initiative is the National Prevention Network being led by Gail McVey. This initiative involves bringing together people across the country who are interested in blending healthy eating and healthy living, body image and healthy weight so that they can talk about how to move this agenda forward. The people involved in this network would include both researchers, practitioners, and policy makers with an interest in developing and implementing an evidence-based prevention practice training model that is anchored in both prevention science (i.e., the “what” of effective prevention) and implementation science (i.e., the “how” to mobilize this knowledge in practice). The goal here is to build on the good work that is going on across the country, so that each province does not have to re-invent the wheel. This weight bias and stigma reduction resource being developed in BC could be a component of a national model, as could the LENS project components.

Ultimately, regardless of the strategy(s) selected to promote the delivery of this resource, people described needing to build on what we know about effective education and learning. One individual spoke about the importance of teachable moments, which fits with the concept of coaching and mentoring. It doesn’t always have to be a workshop; rather the goal is trying to embed this way of thinking and acting everywhere. Many recognized the complexity of this whole area and the amount of time it’s going to take to change attitudes and behaviours in the health system, wondering if perhaps “we should be starting with a harm reduction approach, and then keep building from there.”

4.2.7 What kinds of approaches to learning might work with health professionals and why?

It’s beyond the scope of this report to look at pedagogy and learning in any depth. We would be remiss, however, not to discuss this at all. We did come across both through our review of the literature and some of our key informant interviews perspectives on what makes for good learning. Note that this is not about the content of a weight bias reduction resource or what should be learned, but rather on how to structure a resource in a way that supports effective learning. The issues described briefly here are more about the “how” of learning rather than the “what”. Some of what was described by key informants fits with the concepts of adult learning, experiential learning, and transformational learning, so working with someone who has some experience supporting this kind of learning will be helpful. Also, before embarking on the development of any learning resource it’s important to be clear about what the learning goals and objectives are (i.e., what you want people to come away from the course with).

Briefly summarized here are some key emergent themes about creating a good, effective learning experience for health professionals.
Make the experience as interactive, interesting and as fun as possible through the use of lots of videos, reflection exercises, online chats, etc.

- Use humour to make the learning fun, and to help defuse tension
- Use a mix of modalities as people have different learning styles.
- Recent research that involved the use of one of the Rudd Center videos concluded that “short films might offer a novel, alternative way of tackling negative attitudes in this population. Once production costs have been met, short films can be made widely available for little or no cost, making this a relatively inexpensive mode of intervention” (Swift et al, 2013).

Be strategic about who is featured in video presentations

- Use individuals who are known and respected by the target audience to present key material
  - For example, in the Indigenous Cultural Competency (ICC) training a mix of experiences from indigenous presenters – positive, negative, spiritual – was strategically included. NB of the balancing of positive and negative stories – value of having highly credible and respected people playing that ‘bad’ role – finding ways to make it palatable...
- “We need to identify local champions for this – known and respected in their area – presentations where they will have impact on lots of types of people.”
- Some of these champions could be people who are heavier, and who can demonstrate how they were effectively supported to take control over and improve their health and well-being. “There are so many success stories out there that we don’t hear about. But whenever you hear about success story – you automatically think of someone moving from overweight to skinny marathon runner. We really don’t want that. What we want is people who have done behaviour change and found great success around that and have thus reduced their chronic disease burden and are more productive (e.g., playing with grandchildren) – but not route of stardom and thinness – more reality-based imagery, messaging and discussion... we’re looking for people who can accomplish behaviours to address chronic disease burden – improved quality of life... happier better life... and who can speak to that... it’s all about behaviours – improvements in metabolic health [and mental health and well-being] even if still overweight...”
- Expose program participants to heavier individuals in a variety of ways (e.g., have heavy individuals who are experts present key information; feature heavy people sharing their experiences)

Be purposeful about the learning environment you are trying to create, with an emphasis on safety

- Have participants engage in the online environment anonymously, to encourage open and honest discussion
- Ensure that the material does not come across as ‘preaching’, patronizing or judgmental
- Don’t want to make the learner feel guilty (i.e., increase awareness and understanding, but not guilt – help them realize that this bias and stigma is widespread)
  - The learner needs to feel safe, or they won’t learn (i.e., don’t want them to feel preached to, defensive, upset, angry - as this gets in the way of learning)
  - “As soon as people start feeling defensive, you’ve lost them”
Create opportunities for social learning

- Learning in a cohort is important, but perhaps not learning with people they work with directly so it makes it safer
- Trying to purposefully establish a diverse cohort with different kinds of professionals, makes for better learning
- If there is going to be an online chat component to the learning, then this needs to be facilitated and managed (e.g., inappropriate posts do need to be removed)
- Online webinars can be a way to truly facilitate discussion, but do need to be well-facilitated so that questions can be dealt with openly and ideally in a way that keeps the conversation flowing
- Can learn something from good blogging about how to facilitate open but respectful dialogue

Use narrative

- Using video vignettes or digital storytelling to stimulate a dialogue about our vulnerability as professionals, and how this vulnerability plays out when health professionals are faced with a complex health issue such as obesity
- Using narrative as a vehicle for sharing and transformative learning experiences (i.e., health professionals who’ve had a transformative experience around seeing weight and weight bias differently)
- Digital storytelling isn’t perfect or the only way to capture narratives, but what is good about it is that the stories are authentic, in that they show vulnerability, and include emotion
- Can create a repository of stories, along with comments that people post related to the stories

Pay attention to how the learning can be translated into practice (i.e., if going beyond increasing awareness to practice change is a learning goal)

- Incorporate opportunities for experiential learning during the training. As one key informant noted:
  - Need to consider levels of remembering – hear it, see it, ... do it - people learn more when they are integrally involved in the content (i.e. doing things in practice)
- Provide ongoing coaching and support for health professionals as they work at changing their practice
- Create communities of practice
  - Such communities provide the opportunity for people to share their real-life experiences trying to change their practice, talking candidly about where they have had success and where they are struggling and seek advise and support from their peers

Another issue we discussed with key informants was whether one resource and approach to learning could work for all health care professionals, or whether there would need to be some tailoring for different audiences. There were mixed perspectives on this issue. The importance of starting where people are at and being sensitive to the environments within which they work was brought up by a number of key informants, including the patients we spoke with. There was considerable discussion, for example, on whether starting with reflection about internal weight bias was a great place to start with physicians or whether having the entry point be the evidence about the lack of effectiveness of weight loss programs, the increased understanding of the nuanced relationship between weight and health, and the known harmful effects of weight bias on health might be a better place to start if the goal is to really grab physicians’ attention.
So how do you actually deliver anti-fat bias reduction interventions to health professionals, incorporating these approaches? To date there has been little published research or evaluation of the effectiveness of different intervention formats. Researchers and practitioners working in this area describe the development of web-based initiatives as showing some promise for a couple of reasons. First, it is a cost-effective way of reaching a large number and variety of health professionals. Second, individuals are becoming increasingly used to media as a way of obtaining information, gaining experience about a phenomenon, and increasing knowledge.

There are also limitations to web-based resources, however. A major one is that it can be challenging to tailor the resource for different learners based on their health professional background, and probably more importantly where they’re at and what approach is going to resonate most with them. Another potential limitation is that only people who recognize that the way the health care system treats people who are overweight is problematic will seek out a web-based resource. This makes the marketing and delivery mechanisms set up to promote and optimize access to the resource important. Other limitations of a web-based resource described include:

- It makes it tricky to have dialogue and to address the questions that come up and to provide the support that is needed;
- It’s hard to implement the things you’ve learned without talking about it, and that can be hard to do in a webinar; and,
- There’s something about face-to-face that seems to be more in the moment, more in control.

Finally, there was a call for ongoing and “co-learning” here with a commitment to the ongoing evolution of whatever resource is developed based on this learning. By co-learning we mean that the people involved in developing and delivering the material will be learning along with the people we tend to label as the learners. Co-learning models something different than the typical ‘expert model’, where all the knowledge gets imparted by the expert and the learner is a passive recipient. Going back to a key message outlined at the start of this findings section, we are still learning about the roots of stigma and bias and about the approaches to stigma reduction that might be effective and why; that is, the research is in its early stages of development here. Web-based or online learning is also a field where knowledge and understanding is evolving quickly.

Embedding this ongoing commitment to learning through doing from the very beginning of the development of this resource, through the initial piloting phases, and then forever more, will be critically important. This will require engaging a diversity of people in the development of the resource, and building in monitoring and evaluation processes from the very beginning that facilitate honest reflection about what’s working, what’s not, and why and then tweaking things along the way to continually improve the learning experience for the participants. One informant described how they were continually learning from people involved in the Indigenous Cultural Competency training about how to improve it, with this learning starting at the pilot phase and continuing with each learning cohort. As well as having each learner complete an evaluation of the program along with the post-test, continually monitoring the online program in order to figure out where people are struggling and/or dropping out and then paying attention to making changes to those components is extremely important.
4.2.8 Putting this stigma reduction resource into context

Through both the literature review and environmental scan, another theme that emerged was the importance of recognizing the limitations of ‘training modules’ alone as a strategy for reducing weight bias among health professionals. Hiejnders and Van der Meij identify five levels (see inset Table below) at which stigma reduction strategies need to be developed if meaningful stigma reduction is to occur. Note that the development of a web-based intervention for reducing weight bias would fit under the organizational/institutional level here.

<table>
<thead>
<tr>
<th>Level</th>
<th>Strategies</th>
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<tbody>
<tr>
<td>Intrapersonal level</td>
<td>Treatment</td>
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<tr>
<td></td>
<td>Counselling</td>
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<td></td>
<td>Cognitive–behavioural therapy</td>
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<td>Empowerment</td>
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<td></td>
<td>Group counselling</td>
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<tr>
<td></td>
<td>Self-help, advocacy and support groups</td>
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<tr>
<td>Interpersonal level</td>
<td>Care and support</td>
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<tr>
<td></td>
<td>Home care teams</td>
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<tr>
<td></td>
<td>Community-based rehabilitation</td>
</tr>
<tr>
<td>Organizational/institutional level</td>
<td>Training programmes</td>
</tr>
<tr>
<td></td>
<td>(New) policies, like patient-centred and integrated approaches</td>
</tr>
<tr>
<td>Community level</td>
<td>Education</td>
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<tr>
<td></td>
<td>Contact</td>
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<td></td>
<td>Advocacy</td>
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<td></td>
<td>Protest</td>
</tr>
<tr>
<td>Governmental/structural level</td>
<td>Legal and policy interventions</td>
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<tr>
<td></td>
<td>Rights-based approaches</td>
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</tbody>
</table>

From: Hiejnders & Van der Meij, 2006, p.354

Although thinking that developing a web-based resource is the way to go to reach a large number of health professionals, this will always only be one component of a more system-wide approach to addressing this issue. One informant talked about the best process involving contact, people having conversations that help them reflect on their belief systems and values and the ways in which they hold some thoughts or feelings that are not very positive.

Two of our key informants spoke at length about lessons learned regarding the limitations of a single workshop or training session in changing practice. Any workshop or online training module, even if phenomenal, will always only be one small component of an effective weight bias and stigma reduction initiative. They emphasized that people need ongoing support to actually incorporate any change in attitudes toward patients/clients who are overweight into practice (i.e., training modules/days/workshops can be helpful, but are in and of themselves not enough to result in actual change in practice).
This is the kind of work required to get a paradigm shift at a system level. With respect to how you reinforce and sustain a change in practice by building it into the system level, two key informants described the importance of needing an implementation team within the organization to support this. Both top-down and bottom-up approaches are necessary, as well as consistency across all health regions and all levels of care (from public health to primary care to tertiary care to long term care). Overall, it’s critical that we use what is known about effective implementation if we truly want to move toward practice change across a health care system.

Aligned with this concept of the importance of working at a systems level, numerous informants described the importance of changing the health culture in addition to focusing on changing one-to-one encounters between a particular health professional and their patient/client. For example, one informant said: “The picture we get in our mind is 1-1 patient-doc conversation -- but it’s the outside stuff going on in the hallways everyday that is so important in changing culture -- the way that health care professionals see these patients. Every day you can walk into hospital and hear an incredibly inappropriate conversation… waiting with friend in OPD – very openly a loud conversation between 2 nurses about “hauling this fat blob out of here is going to be very difficult once the anesthetic wears off” — casual conversations between health care workers flows over into the mainstream experience of all of us.” A number of key informants spoke about the importance of introducing this into undergraduate health care provider curriculum, so that we can begin to see this necessary culture change.

Rebecca Puhl stated that through her time doing this work she has been humbled by how difficult it is to reduce this kind of bias. She said that ultimately this is about changing societal attitudes and beliefs about obesity and people who are heavy. That is one reason why the Rudd Center works hard on addressing media portrayals of obesity, developing legislation etc., in an effort to begin to shift societal attitudes and at the very least to protect people who are heavy from discrimination. She too recommended reinforcing the big picture, and encouraging interested health professionals in getting involved and advocating for bigger environmental changes that would actually help their patients live healthier lives. Others also recognized that influencing policy is important, but also messy. Government will do things like fund a positive body image network, but then also fund things that do the opposite. This means that we all have to “become better at redefining the problem for policy-makers, and therefore help them redefine the solutions.” Ultimately, to influence weight bias and stigma requires attention at multiple levels, including family, health system, community and society. When people speak about their “heartbreak about their wrong body”, much of the damage is coming from the people closest to these individuals such as their families, friends and lovers. Although the media is an important target, “you can’t just blame the media, as the media get their messages from somewhere.”

One example of working at a systems level is in Newfoundland-Labrador, where a group of people are focusing their efforts at a number of levels and in a number of settings in an effort to begin to re-conceptualize health. They’re consciously doing more work at a policy level, working with Provincial government departments and getting “great support”. “I’m very optimistic that things are changing here...we have seen changes in education policy around body image and health, and have seen public health nurses talking with moms about weight in a positive way... The HAES messages are being increasingly accepted.”

Finally, a number of the people we spoke with commented on the propensity of health professionals to take a reductionist approach to everything. This desire to take something complex and reduce it to something simple
that we can do something about immediately does not work well when dealing with complex health issues such as obesity. More than one person mentioned Diane Finegood, as a key BC resource in the area of complex, adaptive systems and the paradigm shift required. She was described as being able to convey complexity and “talk about it in a way that doesn’t freak people out”.

4.2.9 A Social Movement

A number of the people we spoke with who are engaged in critical obesity studies and/or do research on eating disorders and body image, describe how our image of the ideal body and our views on health are socially constructed. Health care professionals, because of the power they are given with respect to defining health, can contribute to beginning to change the social construction of health, and our views of a healthy body. Changing the discourse around health is something that health professionals have a lot of power to influence.

Historically, social movements have been successful in decreasing discrimination based on race, sex, sexual orientation, mental health, HIV/AIDS status, etc. These social movements, although not creating change overnight, have had success in gaining equal rights for people. How is discriminating against people who are heavy different? Is there something unique about weight bias and discrimination, with respect to growing a social movement, which warrants further reflection? What role could health professionals play in contributing to such a social movement? There may be lessons here that can be learned from the experience with HIV/AIDS and mental illness.

Supporting a broader social movement on opening up public discourse about our conceptualization of health, and how health as a resource for everyday living is something that goes beyond the development of this resource. The idea of health professionals becoming part of such a movement if it’s something that is of interest to them, however, could be introduced.

Key informants from Newfoundland-Labrador spoke eloquently about how children have picked up on these societal messages about obesity and health. Pam Ward, who interviewed youth attending a hospital-based lifestyles program (formerly called an obesity management program), described how youth “recognized that in our society to be identified as healthy you need to be thin, which makes it difficult for these youth to identify as healthy. These kids thought to be healthy they had to have chiseled abs. So that was so far away from them....Would ask about their activity levels and things they enjoy doing. Kids were quite active but self-identified as couch potatoes and lacking willpower. They looked at themselves as failed citizens, not living up to societal expectations.
5.0 Potential Components of a Weight Bias Reduction Resource Targeted at Health Professionals: “At-a-Glance”

As we reviewed the literature and spoke with key informants, it soon became clear that key informants were, whether consciously or not, drawing upon many of the theoretical approaches to weight-related bias reduction that are outlined in the extant literature (i.e., attribution theory, self-awareness about implicit bias, contact and evoking empathy, social influence theories). As noted previously, key informants also alerted us to a gap in the literature, which is the importance of moving beyond information provision to skill or competency building. That is, once people are aware of weight-related bias and its significance, they need to develop new skills and competencies to address bias and to conduct their practice in ways that do not perpetuate discriminatory practices. To provide only information without also helping health care professionals to change their practice accordingly may only generate anxiety and frustration. To say this succinctly, we could say that the aim should be not just to inform but also to transform practice.

Another strong finding from both the literature and the key informant interviews is the value of using multiple approaches. This is in part because the current evidence base for effective weight bias reduction strategies is weak, and essentially non-existent in the health care system setting. That said, at a high level we do know that using a mix of approaches that strive to capture both peoples’ minds, though the provision of credible evidence-based information and people’s hearts through the use of strategies that evoke emotion, is more likely to be effective.

Based on the findings we have developed a list of five key components for potential inclusion in a weight-related bias reduction resource that is targeted at health professionals. These are briefly described below and then presented in Table 5. This table is cross-referenced with Table 6, and is meant to be an “at-a-glance” summary of what is described in more depth throughout the findings section of this report. The table was developed based on the assumptions that the resource will likely be web-based and the initial target audience will be primary care and public health professionals. We have also included competency development here as we felt it was important to highlight the need to consider how learning generated from a web-based resource would ultimately be integrated into practice.

We have organized the components according to main themes found in the literature review and in the environmental scan: that, invariably, four main approaches are in play, often simultaneously in the practice world. The first is efforts to provide information and education about the complex relationship between weight and health, the controllability of weight, the prevalence of weight-related bias and its effects on health and well-being, and so on. There are links here with attribution theory (providing information about the genetic and socio-environmental factors associated with weight that are not under an individual’s control) but also addressing gaps in knowledge by providing potentially new information about these matters. We have used the term, ‘myth busters’ to describe this component.

The second component, self-awareness, focuses specifically on personal and professional reflection on one’s own biases and the extent to which they are manifested in, and impact the care that one provides to patients
with weight-related issues. The third component focuses on fostering empathy for people who are subject to weight-related bias, discrimination and bullying, while the fourth draws from practical experience of key informants and social influence theories that emphasize the importance of using opinion leaders to encourage condemnation of weight-related bias and/or acceptance of people with weight-issues. Finally, based primarily on the key informant interviews, a fifth component is the development of competencies for working with people who are experiencing health concerns related to the sensitive issue of weight.

A word about adult learning
Before presenting the components, it is important first to highlight the importance of developing this resource based on the principles of adult learning. As noted previously, there are large bodies of evidence on adult learning and on moving knowledge into practice (i.e., implementation science), which could not be reviewed here. We do know, however, that adult learning is most effective if it emphasizes experiential learning (i.e., bringing in learners’ work and life experiences, and providing opportunities for embedding learning in practice) and provides opportunities for transformational learning (i.e., learning as making meaning, with critical reflection as the central dynamic). Transformational learning seems particularly suitable for reducing weight bias and stigma since its focus is on helping learners to:

1. Understand and explore how and why they see the world;
2. Shed the constraints of limiting experiences; 
3. Understand the structural factors that shape the way they see the world; and,
4. Find ways to change dysfunctional beliefs (Cercone, 2008).

In the description of potential content for each of the components outlined here, we have tried to keep both experiential and transformative learning principles in mind.

We also note that the use of multiple approaches is resonant with adult learning principles and the reality that people have different learning styles and preferences. Given that some of these learning preferences may differ across health professional groups, means that any resource developed should ultimately have the flexibility to enable customization for different groups, and this could also take into consideration work design and available time.

A final caveat
One final and significant caveat is that the resource to be developed will inevitably be only one piece of the “solution” for weight-related bias amongst health care professionals. Broader interventions will also be needed, including those that focus on changes in organizational culture and the inclusion of instrumental organizational supports that facilitate the movement of new knowledge into practice. This is noted in the competency development component (see #5 in Table 5).
Table 5: Potential components of a resource for addressing weight bias and stigma among health professionals

<table>
<thead>
<tr>
<th>Component</th>
<th>Description of potential content</th>
<th>Resources to use and build on (see Table 6)</th>
</tr>
</thead>
</table>
| 1) Myth Busters: Providing evidence about weight, weight bias and health | - Multiple, complex and intertwining contributing factors to weight and weight gain, at both individual and environmental levels.  
- Many of the factors contributing to overweight and obesity are beyond the control of the individual - that is, they are genetic or are manifested at an environmental level (e.g., obesogenic environment).  
- Behavioural approaches focusing on individual level behaviour alone, with a goal of losing weight, don’t work and often cause harm (e.g., stress, disordered eating & eating disorders, weight cycling).  
- Need to let go of the idea that if people simply eat less and are more physically active they will lose weight.  
- When weight poses threats to health, a focus on ways of living and health behaviours is much more important than the numbers on the scale.  
- Mental health is just as important as, and is integrally intertwined with physical health; thus, attempts to address weight-related issues must also consider the influence of, and impacts on mental health concerns and mental well-being.  
- Thus it is important to work collaboratively with patients/clients to address underlying issues related to weight, including the effects of weight bias. | 1, 2, 3, 4, 5, 14, 18, 27, 28  
Also see: PHSA technical report |
| The complex relationship between weight & health | - Weight does not equate to health  
  o Make the case that by focusing on weight we may end up ignoring people of ‘normal’ weight who are not healthy.  
  o Longitudinal studies showing that some excess weight can be protective.  
  o See other content presented in PHSA (2013) regarding the relationship between weight and health.  
- Myths about the ‘obesity epidemic’.  
- The history of BMI, and introduction of the obesity scaling system as an alternative. | 2, 3, 4, 13, 14, 15, 18, 27, 28  
Also see: PHSA technical report |
| The effects of weight-related bias, stigma, discrimination and bullying | - What is weight-related bias, stigma, discrimination and bullying, and how prevalent is it in society? How prevalent is it in the health care system and amongst health care professionals?  
- Many negative effects of weight bias that have a negative impact on mental and physical health and well-being. These include: poor body image, low self-esteem, sense of self worthlessness, loneliness, mental illness, maladaptive eating behaviours, avoidance of physical activity, stress induced pathophysiology, and avoidance of medical care. | 5-12, 18, 28  
Also see: PHSA technical report |
<table>
<thead>
<tr>
<th>Component</th>
<th>Description of potential content</th>
<th>Resources to use and build on (see Table 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>Weight-related bias also translates into health inequities which further compromise health.</td>
<td></td>
</tr>
<tr>
<td>2) Self awareness</td>
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</tbody>
</table>
| Self-reflection & understanding of one’s own biases & attitudes | - Help health professionals to understand the distinction between explicit and implicit attitudes, and how our implicit attitudes affect our behaviour.  
- Help health professionals to reflect on their own biases and assumptions about weight, and about people who have weight issues while ensuring this is done in a safe and compassionate manner.  
  o Use of an Implicit Attitudes Test (IAT) for weight/obesity, followed with facilitated discussion about implicit attitudes and their prevalence is one approach for doing this. However, potential unanticipated consequences (i.e. defensiveness and withdrawal from the learning process) need to be considered.  
  o Another approach is to hear the personal stories of other respected health professionals who have become aware of their own personally held weight-related biases and found ways to address them in their day-to-day practice.  
- Acknowledge that this bias is widely prevalent in society and carried by many health professionals if not most. The first step to change is becoming aware of personally held views and assumptions and how they may be impacting one’s practice.  
- Encourage health professionals to do some self-reflection around their own body image and weight issues, and the contributing factors to these (e.g., pivotal points in childhood & adolescence). | 15-21, 28 |
| 3) Exposure to overweight people and the experience of being heavy | | |
| Evoking empathy | - Help health professionals understand what it’s like to be a heavier individual accessing health care services and living in a society that values thinness.  
- This overlaps with contact, as empathy can be evoked through developing relationships with people who are heavier, listening to patients’ narratives about their experiences both in the health system in broader society. | 5-12, 27-38  
*Note: our patient key informants expressed their willingness to tell their personal stories in this resource.* |
| Contact & counter-conditioning | - Profile people who challenge the weight-based stereotypes; that is, people who struggle with their weight and who defy stereotypes (e.g., individuals who are successful, energetic, intelligent, and/or live active lives).  
- One strategy is to use people who are heavier as “hosts” of videos (e.g. one of the Rudd Center videos uses a “plus-size” model as the key figure of the video). | 5-12, 27-38 |
<table>
<thead>
<tr>
<th>Component</th>
<th>Description of potential content</th>
<th>Resources to use and build on (see Table 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4) Influence of opinion leaders in the professions and/or society</strong></td>
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</tbody>
</table>
| **Respected leaders raising weight stigma as an important issue** | - Have respected and trusted leaders and/or peer opinion leaders in the health care system and/or society:  
  o Speak the truth about weight and health, and talk about the harmful effects of weight stigma.  
  o Speak candidly about their own struggles with disordered eating and/or weight, with the intent of confronting the stereotypes about people who are heavier. | 2, 4, 5-12 |
| **5) Competency development** | | |
| **Learning skills** | - Focus here on how to work with patients who are living with weight issues.  
  - Working with patients should be based on philosophy of patient and family-centred care with a goal of optimizing health and well-being.  
  - Shift from a focus on weight to a focus on health and well-being.  
  - Within these frames, particular skills to develop could include:  
    o Initiating conversations about weight in a respectful way.  
    o Developing caring, collaborative working relationships with patients based on mutual respect and trust.  
    o Listening to patients in order to understand their perspectives on their weight and themselves, and the context of their lives.  
    o Developing an understanding of food as something more than fuel.  
    o Understanding & sharing with patients how much sustainable weight loss can be expected.  
  - Could be progressive content, from changing individual practice to building skills for advocacy at a system and societal level | 2, 3, 4, 11, 12, 16 |
| **Putting new skills into practice** | - Practicing skills in a safe setting, which could include role-playing (e.g., workshop; online learning environment).  
  - Mentoring and coaching in practice settings.  
  - Learning from peers through communities of practice.  
  - Organizational processes and structures developed to facilitate moving these skills into practice. | 3, 4, 10, 16, 22, 23 |

Initiatives, projects and resources that could be helpful to build upon or include in the weight bias and stigma resource being developed are summarized below in Table 6. Many of these resources are referred to in the findings section of this report. The intent here is to gather them together in one place, so that they can be easily referred to. This table is meant to accompany Table 5 above, in that the numbers corresponding to the resource column in the table refer to the resource numbers included here.
We have also grouped the resources in this table under five headings: information on weight bias & stigma & its effects, along with suggestions for practice; measuring bias and stigma; implementation and taking a systems approach; facilitating critical reflection; and other resource lists. Some of these resources fit under more than one of these groupings. Where this is true we have located them under the heading that appears to be the main focus of the resource. Finally, the numbers identified in the resource column in Table 5 are just a starting point, with many of the resources listed in Table 6 applicable to many of the components.

Table 6: Some resources provided by key informants

<table>
<thead>
<tr>
<th>#</th>
<th>Resource</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Information on weight bias &amp; stigma &amp; its effects, along with suggestions for practice</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Video illustrating the complexity of obesity</td>
<td><a href="http://www.chsrgevents.ca/shared/video/presentation_holder.html">http://www.chsrgevents.ca/shared/video/presentation_holder.html</a> A reasonably short video (8 min) that illustrates the complexity of the underlying factors which contribute to obesity.</td>
</tr>
<tr>
<td>2</td>
<td>Canadian Obesity Network (CON)</td>
<td><a href="http://www.obesitynetwork.ca">http://www.obesitynetwork.ca</a> A Canadian organization focused on: addressing the social stigma associated with excess weight; changing the way policy makers and health professionals approach obesity; and improving access to prevention and treatment resources. Two blogs on this site worth following are A. Sharma’s blog, and Y. Freedhoff’s blog “Weighty Matters”.</td>
</tr>
<tr>
<td>3</td>
<td>CON 5 A’s</td>
<td><em>The 5 As</em> (i.e., ask, assess, advise, agree, and assist) comprise a manageable evidence-based behavioural intervention strategy that has the potential to improve the success of weight management within primary care.</td>
</tr>
</tbody>
</table>
| 5  | Yale-Rudd Center for Food Policy and Obesity                             | [http://www.yaleruddcenter.org](http://www.yaleruddcenter.org) The Yale-Rudd Center is an internationally renowned centre that seeks to improve the world’s diet, prevent obesity, and reduce weight stigma.  
[http://www.yaleruddcenter.org/resources/upload/docs/what/bias/OriginsOfWeightBias-WaysToReduce.pdf](http://www.yaleruddcenter.org/resources/upload/docs/what/bias/OriginsOfWeightBias-WaysToReduce.pdf) The Centre has a wealth of resources, including this set of PPT slides on reducing weight bias. Some other resources are described below. |
<p>| 6  | Short Rudd Center video on weight bias &amp; stigma                          | <a href="http://www.youtube.com/watch?v=bCJe42LGnB4">http://www.youtube.com/watch?v=bCJe42LGnB4</a> Short video (4 min) that gets key points about weight bias and stigma across succinctly.                                                                                                                                                                                                                                                                       |
| 7  | Rudd Center video: Weight Bias in Heath Care                             | <a href="http://www.yaleruddcenter.org/what_we_do.aspx?id=254">http://www.yaleruddcenter.org/what_we_do.aspx?id=254</a> This video on weight bias in health care provides some of the basic facts about weight and health, and the negative effects of weight bias. It provides some practical suggestions for health professionals and medical offices about how to decrease weight bias and stigma in health care settings.                                                                 |</p>
<table>
<thead>
<tr>
<th>#</th>
<th>Resource</th>
<th>Description</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>This video dispels the myths about weight gain and the obesity epidemic. The presentation is framed as a student project, and narrated by a young person who is larger is size. Has been successfully used, in combination with the weight bias in health care video, with a student audience.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Engaging video narrated by young people and researchers; effectively raises awareness about weight bias as an important social justice issue that’s affecting increasingly more people around the world.</td>
</tr>
<tr>
<td>10</td>
<td>Rudd Center web-based CME course</td>
<td><a href="http://learn.yale.edu/rudd/weightbias/login.asp?ec=60852">http://learn.yale.edu/rudd/weightbias/login.asp?ec=60852</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>This CME web-based educational module on weight stigma has some good content, including print-off tip sheets for busy physicians.</td>
</tr>
<tr>
<td>11</td>
<td>“No blame, no shame” video (Kirk et al, Project Invisibility, NS)</td>
<td><a href="http://youtu.be/J6rFS5mARf8">http://youtu.be/J6rFS5mARf8</a></td>
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<tr>
<td></td>
<td></td>
<td>Video drama showing interaction between a patient and a physician, where the thoughts of and challenges experienced by both are illustrated (14 min).</td>
</tr>
<tr>
<td>12</td>
<td>“Balancing the scales” video (Kirk et al, Project Invisibility, NS)</td>
<td><a href="http://youtu.be/oo_sadCrMo8">http://youtu.be/oo_sadCrMo8</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Educational video where findings from the research and integrated with pieces of the drama video (28 min).</td>
</tr>
<tr>
<td>13</td>
<td>23 &amp; 1/2 hours: What is the Single Best Thing We Can Do for Our Health?</td>
<td><a href="http://www.youtube.com/watch?v=aUaInS6HIGo&amp;feature=youtu.be">http://www.youtube.com/watch?v=aUaInS6HIGo&amp;feature=youtu.be</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>This YouTube presentation provides a powerful case again for shifting from a focus on weight to a focus on health, which includes incorporating enjoyable activity into your life.</td>
</tr>
<tr>
<td>14</td>
<td>Fraser Health weight bias reduction workshop</td>
<td>This presentation by Dr. Carrie Matteson was developed with the objective of increasing health professionals’ awareness and understanding of weight. This has been successfully used with health professional audiences.</td>
</tr>
<tr>
<td>15</td>
<td>Workshop on body image and weight bias for BC public health nurses</td>
<td>The purpose of this presentation by Vanessa Lam was to have public health nurses become more aware of their own personal beliefs about weight and where they come from, and to question those beliefs. This has been successfully used with two public health nurse audiences.</td>
</tr>
<tr>
<td>16</td>
<td>LENS (Leveraging Equitable Non-Stigmatizing health promotion delivery) intervention workshop</td>
<td>The goal of the LENS workshop and project is to support public health professionals to take a broad and balanced perspective on the complex factors that influence obesity. The emphasis here is on an ecological rather than an individualized approach to healthy eating and active living, with promoting positive mental health as the foundation.</td>
</tr>
<tr>
<td>17</td>
<td>LENS resource on reframing healthy weights messaging</td>
<td>This document outlines age-specific considerations (cornerstones for optimal development) to embed in the formulation and delivery of healthy weight messaging to avoid triggering unintended consequences.</td>
</tr>
<tr>
<td>#</td>
<td>Resource</td>
<td>Description</td>
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<tr>
<td>18</td>
<td>Obesity &amp; Health: Shifting focus (Beausoleil &amp; Ward, 2012)</td>
<td>Presentation to medical students at Memorial University in Newfoundland that: encourages critical reflection on how obesity is constructed as a health problem; and, summarizes emerging evidence that supports shifting our focus from weight to health.</td>
</tr>
<tr>
<td>19</td>
<td>Implicit Attitudes Test</td>
<td><a href="https://implicit.harvard.edu/implicit/demo/takeatest.html">https://implicit.harvard.edu/implicit/demo/takeatest.html</a> An online approach to IAT is available through Harvard Medical School’s Project Implicit.</td>
</tr>
<tr>
<td>20</td>
<td>Measuring weight self-stigma (Lillis et al, 2010)</td>
<td>This journal article describes the reliability and validity of a short questionnaire that can be used to measure weight self-stigma.</td>
</tr>
<tr>
<td>21</td>
<td>Fat phobia scale</td>
<td><a href="http://www.yaleruddcenter.org/resources/bias_toolkit/toolkit/Module-1/1-08-SelfAssessmentTools/1-0808-FatPhobia.pdf">http://www.yaleruddcenter.org/resources/bias_toolkit/toolkit/Module-1/1-08-SelfAssessmentTools/1-0808-FatPhobia.pdf</a> RDD Center resource for measuring fat phobia.</td>
</tr>
<tr>
<td>22</td>
<td>Systems approach to knowledge exchange initiatives (2012), prepared for the Chronic Disease Interventions Division, Public Health Association of Canada</td>
<td>This report summarizes lessons about a systems approach to knowledge mobilization, and identifies recommendations and strategies to inform how best to develop and support innovative knowledge mobilization approaches relevant to public health and health promotion.</td>
</tr>
<tr>
<td>23</td>
<td>Review of the literature on implementation (University of South Florida)</td>
<td><a href="http://cfs.cbcs.usf.edu/publications/detail.cfm?id=137">http://cfs.cbcs.usf.edu/publications/detail.cfm?id=137</a> Reviews current state of implementation science (i.e. translation of policy mandates for effective programs into the actions that will achieve them). Outlines what is known about effective implementation strategies.</td>
</tr>
<tr>
<td>24</td>
<td>Considering the embodied experience of children in obesity treatment (Ward, 2012)</td>
<td>Conference presentation summarizing key findings of Pam Ward’s research. This is highly relevant research to support moving from a focus on weight to a focus on health, particularly for children and youth.</td>
</tr>
<tr>
<td>25</td>
<td>Body Image Network, Newfoundland and Labrador</td>
<td>On Facebook. A group of individuals and organizations committed to promoting a positive social environment through sharing information about body image, self esteem, obesity, eating disorders and disordered eating.</td>
</tr>
<tr>
<td>26</td>
<td>Academy for Eating Disorders</td>
<td><a href="http://www.aedweb.org//AM/Template.cfm?Section=Home">http://www.aedweb.org//AM/Template.cfm?Section=Home</a> The Academy for Eating Disorders is a global professional association committed to leadership in eating disorders research, education, treatment, and prevention. They are a wealth of potentially pertinent resources and links to other resources on their website.</td>
</tr>
<tr>
<td>27</td>
<td>Health at Every Size</td>
<td><a href="http://www.haescommunity.org">http://www.haescommunity.org</a></td>
</tr>
<tr>
<td>#</td>
<td>Resource</td>
<td>Description</td>
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<tr>
<td>28</td>
<td>Unmasking Weight Bias and Thin Privilege: Developing Strategies for</td>
<td>This seminar developed and delivered by Linda Bacon in 2010 to health professionals emphasizes: reflecting on one’s own weight bias and thin privilege; some of the myths re the connections between weight and health, and the controllability of weight.</td>
</tr>
<tr>
<td></td>
<td>Responsible Embodiment and Health Promotion</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>National Association to Advance Fat Acceptance</td>
<td><a href="http://www.naafaonline.com/dev2/">http://www.naafaonline.com/dev2/</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>A non-profit civil rights association dedicated to ending size discrimination. NAAFA’s goal is to build a society in which people of every size are accepted with dignity and equality in all aspects of life. Website offers numerous resources related to reduction of weight-related discrimination.</td>
</tr>
<tr>
<td>30</td>
<td>Association for Size Diversity and Health –</td>
<td><a href="https://www.sizediversityandhealth.org/index.asp">https://www.sizediversityandhealth.org/index.asp</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>An organization composed of individuals committed to Health at Every Size (HAES) principles. Numerous resources related to holistic view of health and weight and HAES materials.</td>
</tr>
<tr>
<td>31</td>
<td>Fat panic in Canadian public health policy: Obesity as different and</td>
<td><a href="http://www.radicalpsychology.org/vol8-1/fatpanic.html">http://www.radicalpsychology.org/vol8-1/fatpanic.html</a></td>
</tr>
<tr>
<td></td>
<td>unhealthy (Beausoleil &amp; Ward)</td>
<td>This article, written from a critical obesity perspective, argues for government to take a broader approach to health policy. The authors note that as long as governments continue to seek solutions within the context of an obesity epidemic frame, the fear of being labeled as overweight or obese will heighten already unhealthy levels of obsession with weight, ultimately resulting in negative health consequences for the population as a whole.</td>
</tr>
<tr>
<td>32</td>
<td>Biopolitics and the obesity epidemic (Wright, Jan, 2010)</td>
<td><a href="http://books.google.ca/books?id=jCtRVlqMSN0C&amp;printsec=frontcover&amp;source=gbs_ViewAPI&amp;redir_esc=y#v=onepage&amp;q&amp;f=false">http://books.google.ca/books?id=jCtRVlqMSN0C&amp;printsec=frontcover&amp;source=gbs_ViewAPI&amp;redir_esc=y#v=onepage&amp;q&amp;f=false</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>This book offers a comprehensive discussion of critical perspectives re: the “obesity epidemic” and health, obesity and society.</td>
</tr>
<tr>
<td>33</td>
<td>Fat Talk Free Week video</td>
<td><a href="http://www.youtube.com/watch?v=RKPaxD61lw">http://www.youtube.com/watch?v=RKPaxD61lw</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Compelling 3 minute video to raise awareness of weight-related bias. Provides an argument to stop chasing the “thin ideal”. Has been used successfully with public health practitioners.</td>
</tr>
<tr>
<td>34</td>
<td>Love your Tree video</td>
<td><a href="http://www.youtube.com/watch?v=UEUsbLNAfW0">http://www.youtube.com/watch?v=UEUsbLNAfW0</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 minute video featuring Eve Ensler who provides a warm appeal for viewers to “love your body”. Has been used successfully with public health practitioners.</td>
</tr>
<tr>
<td>#</td>
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<td>Description</td>
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</tr>
<tr>
<td>36</td>
<td>“Dances with fat” blog</td>
<td><a href="http://danceswithfat.wordpress.com">http://danceswithfat.wordpress.com</a> A blog by a self confessed, “fat” dancer whose motto is that life, liberty and happiness are not size dependent and that people of all sizes deserve respect.</td>
</tr>
<tr>
<td>37</td>
<td>“Obesity time bomb” blog</td>
<td><a href="http://www.obesitytimebomb.blogspot.ca">http://www.obesitytimebomb.blogspot.ca</a> A blog about fat, fat activism and... “fat everything” by counselor, psychotherapist, researcher and writer Dr. Charlotte Cooper.</td>
</tr>
</tbody>
</table>

### E. Other resource lists

<table>
<thead>
<tr>
<th>#</th>
<th>Resource</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>LENS intervention workshop; supporting resources (McVey et al)</td>
<td>This document outlines a range of supporting resources (i.e., articles, books, videos, websites) grouped by theme, which was pulled together by the LENS project team to support their intervention workshop.</td>
</tr>
<tr>
<td>40</td>
<td>LENS inning 2 resource list (McVey et al)</td>
<td>This document outlines a range of supporting resources for a LENS ‘reframing healthy messages’ workshop (inning 2).</td>
</tr>
<tr>
<td>41</td>
<td>Jacqui Gingras’ list of publications</td>
<td><a href="http://www.jacquigingras.ca/publications.htm">http://www.jacquigingras.ca/publications.htm</a> A listing of publications by Jacqui Gingras who advocates for an alternative view of nutritional health practices and who emphasizes the importance of reflexivity and the value of relational practice.</td>
</tr>
<tr>
<td>42</td>
<td>List of critical obesity scholarship references (Beausoleil, 2012)</td>
<td>A list of critical obesity scholarship references from Natalie Beausoleil, Memorial University Nfld (compiled November, 2012).</td>
</tr>
</tbody>
</table>
6.0 Questions to Consider in Developing the Resource

There are a number of potential components to this resource, and many possible formats and/or delivery strategies to consider. Outlined in this section are some questions for consideration that can be used to shape the development of this resource. Given the well known architectural “rule-of-thumb” that form follows function, it is particularly important to have a clear vision of what is to be achieved before beginning to design the resource. This is where we begin.

What are the desired outcomes of this resource; what do you hope to achieve?

- Is it an increased awareness about the prevalence of weight bias and stigma in the health care system and the impact this has on people (i.e. a change in knowledge)?
  - Increased awareness about how our attitudes affect our practice?
  - Increased awareness about how weight bias and stigma generally affect our patients/clients/all of us?
- Is it an actual change in how health professionals interact and work with patients who are larger (e.g., a change in actual practice)?
- If the latter, what kinds of changes are you wanting to achieve?

How can the concepts and importance of mental health and well-being and mental health promotion be most effectively integrated into this resource?

How can this resource be a bridge for the obesity and the eating disorders communities?

What is the target audience for this resource?

- For example, is it every person in the health care system or health professionals providing direct care and services to people?
- If it’s the latter, then is the focus all health professionals or a particular sub-group of health professionals (e.g., public health nurses and/or primary care providers – family physicians, nurse practitioners, and/or allied health professionals working in primary care settings)?

What process for developing the resource is most likely to help you achieve these outcomes?

- Given what we know about implementing new practice and change management, who are some key people you want to engage in the development of this resource?
  - Some of these should be people who are respected in their professional communities and will be key champions for the resource.

What kind of learning approach would best accomplish these outcomes?

- Experiential learning?
- Transformational learning?
- Ongoing learning and knowledge generation?
- Collaborative or social learning?
What formats and/or delivery mechanisms will best enable you to achieve the desired outcomes and the kind of learning you envision?

Would it be useful to develop a basic “module” and add other modules in the future?

- It may be helpful to develop a series of modules that move from the basic level (the one discussed in this paper) to progressively more sophisticated levels that address broader issues and skill development such as advocacy and policy development for weight bias reduction, for example.
- Another module might examine the power of the health system and health professionals to define what is “normal” and what is not. This would fit with an examination of the medicalization of weight and its unintended consequences.

How could this resource be aligned and integrated with other provincial and national initiatives, in order to maximize its traction and impact?

- It may be helpful to view the current spectrum of activities and resources that are available across the country and find ways that this new resource could complement those resources, and also ways that BC could access other things being done in the country to complement this resource.
- Given the scarcity of resources for this work, finding ways to pool resources or at least to build complementary rather than similar or competing resources could result in a comprehensive national approach that would be available to all provinces.
- Given that the community of weight-related bias professionals and interest groups is relatively small in Canada, this may be quite doable.

7.0 Some Final Thoughts from the Writers

A number of threads were woven throughout the literature and environmental scan, and they become thicker as our conversations with the key informants become deeper and more exploratory in nature. One such thread was the reductionist nature of our health care system in the face of an increasingly complex world. This is reflected in the well-known sentiment that we have designed an acute care system that is ill equipped to address chronic illness and health issues. We have a tendency to reduce everything to a simple cause and effect model, and so focus on developing simple interventions to try and fix complex issues.

Another was how health professionals and the health care system have contributed to the medicalization of health, and in the guise of health promotion have perpetuated the damaging myth that health is mostly about healthy eating and active living, which in turn has solidified the North American societal conception of health as being physically fit, which in turn has led to equating health with being slim. This contributes to the societal preoccupation with body image and beauty, which has nothing to do with health. The broader notions of health that encompass concepts such as well-being and flourishing are nowhere to be seen. At an even simpler level, positive mental health is rarely considered. It’s as if we are perfect bodies wandering around, and the only purpose for having a head is to maximize our beauty – so we’re only truly concerned with our head’s surface – not what we have inside.
So not only does the health care system contribute to these harmful societal attitudes about weight, the health professionals working in the system bring with them all of this societal baggage. The perspectives of health experts shape government policy and society, and the health care system is in turn shaped by the society that it helps create. It’s hard to imagine in such a context how we could possibly tackle one small piece of such a complex puzzle, reducing weight bias and stigma amongst health professionals in that they are all citizens of this unusual world we have created together.

There is another thread though, that maybe we can label the “hope” thread, and perhaps it’s a gold thread in that glimmers of it can be seen popping out in many places. We saw it reflected in the voices of all the people we spoke with, although it often was travelling alongside a sadness thread. The words of the critical obesity researchers are beginning to infuse some of the more traditional health care literature, and in turn this is starting to influence our health care practice. These glimmers are the small changes that are being made in health care programs that were initially targeting obesity, and now are focusing on health and in some cases even well-being. Many of our key informants spoke to BC’s progressiveness in the realm of weight-related bias. Time and time again, we heard sentiments of respect and admiration for the progress that has already been made in the province. And, we felt privileged to witness the vision, passion, innovative spirit and courage of the people who are leading development of this resource, including the advisory committees who provided so much valuable insight and advice.

While the issues we raise here are daunting, they can’t be addressed by one resource alone. Yet, “one resource” is the only place to begin. If this resource can help individual practitioners learn and understand these issues in their minds and their hearts, and if it can help them to identify any biases or attitudes they may have about weight, and as a result, change their practices, then this is a magnificent place to begin.

In retrospect we fear we may not have placed enough emphasis in this report on the fundamental encounter in the health care system – that of the “patient” and of the health care provider – so we will reiterate it here. The essence of mental health promotion lies in this encounter – in the way that the health professional receives the “patient”. Before diagnosis and treatment comes basic respect and regard for each individual, no matter their stature in society, nor their shape, form, or malady. To find the time to understand and get to know “the patient” as a unique person, and to listen, to give credence to his or her history (his/her “experiential expertise”) and concerns and strengths is the crux of care and compassion upon which the health care system was built. If we could do one thing to address weight-related bias in the health care system, it would be to ensure that this philosophy was manifested in every health care encounter particularly with those at risk of weight-related bias and discrimination. One person on the Weight Bias and Stigma Advisory Committee shared with us a quote by Carl Rogers that we saw as very fitting:

“In my early professional years I was asking the question: How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth?”
This statement represents the essence of true health promotion, as well as the essence of relational practice and patient centred care, at least from our perspective.

In conclusion, our hope is that the golden threads we observed in this work will become woven together, creating a strong tapestry of approaches that will be the death knell for weight-related bias, stigma, discrimination and bullying - at least within the health care system and ideally, far beyond. Herein lies both the promise and the challenge of the development of this weight bias and stigma resource in the BC health care system. The promise is development of this resource as another glimmering thread; the challenge is finding ways to connect this work with other activities and strategies and in so doing, to maximize its contribution to the bigger movement.
References


Appendices
Appendix 1: Search strategy

Research Question:
What are evidence-informed practices (i.e., based on evidence) for decreasing weight bias and stigma amongst health professionals?

Primary Search Strategy:
Search strategies for each electronic peer reviewed database will be derived from common sets of keywords based on four main themes:

Theme 1: Health care Professionals and Health care Delivery
Theme 2: Obesity/Overweight
Theme 3: Stigma/Bias
Theme 4: Evidence-Based Practices to Reduce Stigma/Bias

Three key articles have been identified and will be used to ensure the search strategy is targeted appropriately:


Databases to Search:
MEDLINE (OVID)
PubMED
CINAHL (nursing and allied health database)
PsycINFO
SocINDEX
Social Services Abstracts
Social Work Abstracts

Search Terms:

<table>
<thead>
<tr>
<th>THEME 1</th>
<th>THEME 2</th>
<th>THEME 3</th>
<th>THEME 4</th>
</tr>
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<td>Health care Professionals and Health care Delivery</td>
<td>Obesity/Overweight</td>
<td>Stigma/Bias</td>
<td>Evidence-Based Practices to Reduce Stigma/Bias</td>
</tr>
<tr>
<td></td>
<td>Body mass index</td>
<td>Stigma reduction</td>
<td></td>
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| Health care professionals  
Health care professionals  
Health personnel  
Health care providers  
Health care providers | [MeSH] Obese  
Morbid obesity  
Morbidly obese | Rejection  
(psychology) [MeSH]  
Social stigma [MeSH]  
Attitude of health personnel [MeSH]  
Social perception [MeSH]  
Stigma  
Bias  
Discrimination  
Intolerance  
Victimization  
Negative attitude  
Negative perception | Discrimination reduction  
Negative stereotyp* reduction  
Bias reduction  
Anti-fat attitude reduction  
Negative attitude reduction  
Contact-based education  
Contact education  
And/or in combination with:  
Technique  
Method  
Intervention  
Modification  
Change  
Strategy  
Practice  
Program  
Initiative  
Approach  
Education |
|---|---|---|
| Anti-fat  
Anti-fat attitude  
Anti-fat prejudice  
Weight-based discrimination | | |

**Search Method:**
Theme 2 (obesity/overweight) **AND** Theme 3 (stigma/bias) **OR** anti-fat terms 
**AND**
Theme 4 (practices to reduce stigma/bias) 
**AND**
Theme 1 (health care professionals and health care delivery)

**NOTE:** Reference lists of key articles identified in the database searches will be reviewed.

**Limits:**
Humans 
2002 – Current 
English Only 
Exclude Publication Types: comment, editorial, letter
**Secondary Search Strategy:**

If there is not enough research and/or experiential evidence-based promising practices on weight bias and stigma reduction specific to health care professionals the search strategy will be adapted to address either or both of the following questions:

1. What are evidence-informed practices for decreasing health professional bias and stigma towards clients/patients which might be adapted for weight bias and stigma?  
   (Examples could include: patients with AIDS, mental illness and/or addictions, disability; patients from other cultures/races/religions)
2. What are evidence-informed practices for decreasing weight bias and stigma in other target audiences which could be adapted for use with BC health care professionals?  
   (Examples could include: adolescents, school populations)

**NOTE:** Based on the search results from MEDLINE (OVID) and PubMed it should not be necessary to develop searches specific to the Secondary Search Strategy. Key articles related to both of the questions noted above were picked up in the searches addressing Question 1 under search terms related to Themes 2 through 4 and text words related to Theme 1. Other articles will be identified while searching the reference lists of key articles captured in the preliminary search.
### Appendix 2: Key informants that participated in an interview

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>Beverley</td>
<td>Patient Voices BC</td>
</tr>
<tr>
<td>Jeanie</td>
<td>Patient Voices BC</td>
</tr>
<tr>
<td>Terry</td>
<td>Patient Voices BC</td>
</tr>
<tr>
<td>Dr. Linda Bacon</td>
<td>Nutrition Professor&lt;br&gt;City College of San Francisco&lt;br&gt;HAES</td>
</tr>
<tr>
<td>Dr. Natalie Beausoleil</td>
<td>Associate Professor of Social Science and Health&lt;br&gt;Faculty of Medicine&lt;br&gt;Memorial University&lt;br&gt;Newfoundland</td>
</tr>
<tr>
<td>Dr. Connie Coniglio</td>
<td>Provincial Executive Director&lt;br&gt;Children’s and Women’s Mental Health and Substance Use Programs&lt;br&gt;BC Mental Health &amp; Addiction Services</td>
</tr>
<tr>
<td>Dr. Manuela Ferrari</td>
<td>Doctoral Student&lt;br&gt;University of Toronto&lt;br&gt;School of Public Health</td>
</tr>
<tr>
<td>Dr. Jacqui Gingras</td>
<td>Associate Professor&lt;br&gt;School of Nutrition&lt;br&gt;Ryerson University</td>
</tr>
<tr>
<td>Dr. Sara Kirk</td>
<td>School of Health Administration&lt;br&gt;Applied Research Collaborations for Health&lt;br&gt;Dalhousie University</td>
</tr>
<tr>
<td>Melanie Kurrein</td>
<td>Public Health Nutrition Project Manager&lt;br&gt;Healthy Schools, Healthy Workplaces, Healthy Weights&lt;br&gt;Population and Public Health&lt;br&gt;BC Ministry of Health</td>
</tr>
<tr>
<td>Vanessa Lam</td>
<td>Community Nutritionist&lt;br&gt;Infant, Child and Youth Program&lt;br&gt;Vancouver Coastal Health</td>
</tr>
<tr>
<td>Dr. Carrie Matteson</td>
<td>Scientist&lt;br&gt;Chronic Disease Systems Modelling Lab&lt;br&gt;Simon Fraser University</td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
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<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>Dr. Gail McVey</td>
<td>Psychologist and Health Systems Scientist, Community Health Systems Resource Group</td>
</tr>
<tr>
<td>Dr. Kerry O’Brien</td>
<td>Behavioural Studies</td>
</tr>
<tr>
<td>Dr. Rebecca Puhl</td>
<td>Director of Research and Weight Stigma Initiatives</td>
</tr>
<tr>
<td>Sari Simkins</td>
<td>Health Promotion and Food/Nutrition Specialist</td>
</tr>
<tr>
<td>Dr. Arya Sharma</td>
<td>Professor of Medicine, Chair in Obesity Research and Management</td>
</tr>
<tr>
<td>Dr. Judy Swift</td>
<td>Division of Nutritional Sciences</td>
</tr>
<tr>
<td>Dr. Michael Vallis</td>
<td>Psychologist, CDHA Behaviour Change Institute, Associate Professor, Dalhousie University</td>
</tr>
<tr>
<td>Leslie Varley (ICC resource, BC)</td>
<td>Director, Aboriginal Health, Provincial Health Services Authority</td>
</tr>
<tr>
<td>Dr. Pamela Ward</td>
<td>Faculty, Centre for Nursing Studies</td>
</tr>
<tr>
<td>Anne Wareham</td>
<td>Coordinator/Psychologist, Janeway Lifestyle Program, Child Health Program, Eastern Health</td>
</tr>
</tbody>
</table>
Appendix 3: Interview guide for researchers and people working in the field

Addressing obesity stigma and discrimination in the health care system

Questions to guide key informant interviews

Introduction

- THANK YOU for taking the time to do this, & introductions
- Purpose of this project
  o Doing a lit review and environmental scan to inform the development of a resource to begin to address weight bias and discrimination in the BC health care system
  o Resource is to be web-based
  o Main target audience for this initial resource is primary care & public health practitioners
- Consent
  o Will be identifying you as a key informant in the report
  o Will be taking notes
  o Permission to audio-tape as back-up, so we’re sure to get down everything you say

Questions

<Wanting to inform the development of a resource that has the potential to reduce obesity stigma among health professionals>

1. What approach should be taken to reduce stigma amongst health professionals? Why?
   a. What are the theoretical foundations or roots of stigma, generally? Of weight-related stigma in particular? How is obesity stigma different from other kinds of stigma?
   b. How do these foundations inform stigma reduction strategies?
      i. Probe around: evoking empathy; counter-conditioning; dispelling myths about the contributing factors to obesity; changing beliefs about controllability of obesity.
   c. How do health professionals, and the health system cultures, differ from other target audiences?
      Probe around:
      i. And are there other things about health professionals that need to be considered in reducing weight bias (e.g., their perceptions of their role as “expert” professionals; perceived futility in treating obesity; other factors/characteristics???)
      ii. Are there different approaches for different types of health professionals – e.g. family practice docs, public health nurses, nutritionists etc???

2. What language is being used in the field? Why? (e.g., obese, fat, overweight, stigma, prejudice, discrimination)
   a. Does the language used vary depending on who you’re talking to?
   b. Is there certain language that’s preferred by people who are obese?
3. Do you know of obesity stigma reduction resources and/or initiatives you think are promising?
   Probe around:
   a. Target audiences
   b. Components (e.g., contact, education, skill development, other)
   c. Levels
   d. Links/access to these resources
   [For BC key informants: What’s currently going on in BC with respect to addressing weight bias and discrimination? Are there resources out there being used in other settings (i.e., not in health care)?]

4. What are your thoughts about the best ways of designing/delivering weight bias resources with health professionals?
   [For BC key informants:
   • Are there existing health professional development resources in BC that a resource on weight bias and stigma reduction could be integrated into?
   • What would work well for BC health professionals, in which contexts and why?]

5. Any other people we should be talking with?

6. Anything else you wanted to say?

THANK YOU!!
Appendix 4: Patient Experience Interview Guide

BCMHAS Weight Bias Reduction for Health Care Professionals

Introduction
- BC is developing a resource to help decrease the stigma and discrimination experienced by people who are “overweight” in the health care system.
- We have been contracted to review the research literature and to interview some “key informants” to inform the development of this resource.
- Key informants include people who have experienced some stigma and/or discrimination in the health care system because of their weight.
- With your permission we would like to tape record our conversation. This is purely for the purpose of ensuring we capture your comments accurately. No one else will have access to the recording and we will destroy it when our report is completed (end of January, 2013). You are free to refuse to be tape recorded and do not need to provide an explanation for this.

Interview questions
1. What has been your experience with the health care system (e.g., going to your family doctor, seeing medical specialists, visiting a public health nurse)?
   a. How do you feel you’ve been treated?

2. If you’ve had any experiences in using the health care system when you felt you weren’t treated very well because of your weight, could you please describe these?
   a. What happened?
   b. How did this affect you?
   c. What could have been done differently by the health care professional and/or the health system such that you would have had a better experience?

3. Could you please describe any positive experiences you’ve had in using the health care system – that is, when you felt you were treated well?
   a. What happened?
   b. How did this affect you?
   c. What was it that made this a positive experience?

4. What are the most important things that health care professionals should know about working with people who are “overweight”?

5. If you could change one thing about the way health care professionals treat people who are “overweight”, what would that be?

6. Is there anything else that you’d like to say?

Thank-you!