# Communicating About Weight in Dietetics Practice: Recommendations for Reduction of Weight Bias and Stigma

WEIGHT BIAS REFLECTS negative societal attitudes based on body weight and may include judgments about a person's body shape or size if that size is not in concordance with societal expectations.[1] A significant focus of weight bias research has been the stigma directed toward people in larger bodies, known as obesity stigma or, more commonly, weight stigma.[2] Weight bias has been shown to be pervasive throughout American society and culture,[3] including among some within the field of dietetics.[4] Negative beliefs and attitudes may include perceptions of people in larger bodies as lazy, sloppy, noncompliant, or lacking self-discipline.[5] These stereotypes may implicitly or explicitly influence how Registered Dietitian Nutritionists (RDNs) interact with people with obesity within the many different professional roles in which RDNs serve. This article discusses the importance of addressing weight bias and weight stigma in the dietetics field and presents current controversies relating to weight stigma. The authors propose actionable strategies for communicating about weight across different aspects of dietetics, from policy to training to practice.

Preferences for the language used when discussing weight vary; there is no single lexicon or paradigm used by health care practitioners, researchers, or social activists, which may lead to certain groups feeling alienated or stigmatized by another group's messaging.[6] People-first language[7] (ie, the use of the phrase "person with obesity") has gained support among the academic community and is endorsed by many professional organizations,[8] including the Academy of Nutrition and Dietetics,[9] and has shown promise as a way to decrease weight stigma.[10]

A predominant theory for the existence of weight stigma toward people with obesity is attribution theory, first conceptualized in relation to weight by Weiner,[11] then further developed by Crandall,[12] who posited that people with obesity are denigrated because of their discordance with traditional Protestant values and the belief that weight status is a reflection of the degree of personal willpower. The Protestant ethic, which has a strong focus on individualism and personal responsibility, is a common ideology in the United States that can lead to the belief that weight is controllable and thus reflects a person's hard work or lack thereof.[13] Some evidence suggests that obesity research[14] and public perception[15] in the United States have begun shifting toward recognition of more external factors such as socioeconomic status and environmental supports that affect body weight. There is growing consensus that obesity is a complex condition impacted by both biological factors, including genetics, environmental exposures, and physiological adaptations,[16] and social and economic factors, such as lack of access to healthful foods.[17]

Weight bias has been observed in many settings where RDNs practice, including public health, health care, and universities.[4] Many well-intentioned efforts to improve health in these settings may be stigmatizing to people with obesity and have the potential to cause harm when weight is the primary target of an intervention, when the myriad complex causes of obesity or non-weight health behaviors are not considered.[18] Weight stigma has been shown to lead to many negative psychological effects on those who experience it, including depression, anxiety, disordered eating, and body image dissatisfaction.[19] Other health consequences also may result from experiencing weight stigma, such as binge eating behavior, reduced physical activity motivation and behavior, and increased physiological stress responses, which can lead to increased risk of cardiovascular diseases and other chronic diseases.[20] The stress of experiencing weight stigma is even proposed as a mechanism for further weight gain through physiological stress pathways.[21]

Continually experiencing stigma in health care can lead to health care avoidance and ultimately poorer health outcomes for patients.[22] Many health care providers struggle with conversations about weight, feeling frustrated, underprepared, or ineffective in helping patients with obesity.[23] In response to the difficulty in communication regarding weight, some have proposed a shift to a "weight-neutral" or "weight-inclusive" approach, removing the focus on weight altogether.[24]

Given that more than 40% of US adults are now classified as obese, there is a need to explore how to talk about weight in a respectful, nonstigmatizing manner among RDNs and other health professionals.[25] RDNs are uniquely positioned to advocate for weight bias reduction because of their wide range of professional roles that can impact weight bias at many different levels of the social ecological model.

## CURRENT CONTROVERSIES IN FRAMING OBESITY RESEARCH AND TREATMENT

Among RDNs, a rift has emerged in recent years between professionals who advocate for a "weight-normative" paradigm and professionals who prefer a "weight-inclusive" approach.[24] In the 2016 position statement on "Interventions for the Treatment of Overweight and Obesity in Adults,"[26] the Academy advocates weight loss for adults with overweight or obesity

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through the use of an individualized approach. The Academy's position statement cautions RDNs to be aware of the potential for weight bias and advocates for an understanding of the multifactorial antecedents to weight status.[26] Conversely, the weight-inclusive approach described by Tylka et al[24] calls for a shift away from an emphasis on weight and proposes a focus on the promotion of positive health behaviors, regardless of weight change.[24] This position has gained interest from the medical community as well, as demonstrated by the recent focus of the Canadian Guidelines for Treating Obesity in Adults on non-weight outcomes.[27] A fundamental principle of the weight-inclusive approach is rejection of the idea that an overt focus on weight loss is necessary for health improvement among people with obesity.[24]

In many ways, this dichotomy of views can impair progress in research and practice. Ideological disputes can create polarization and division, which inhibits cooperation based on shared goals.[28] However, regardless of viewpoint, weight stigma is a significant issue inhibiting respect and effective communication for those in a variety of body shapes and sizes.[29] Taking a patient-centered approach may help RDNs find common ground in working to combat weight stigma in practice.

## COMMUNICATING ABOUT WEIGHT IN HEALTH CARE

It has been well established that experiences of weight stigma often occur within health care settings. People with obesity may experience weight stigma from interactions with doctors, nurses, RDNs, and mental health professionals.[30] Enacted weight stigma in the health care setting can take many forms, including providers making assumptions about patients with obesity, overattributing health problems to a patient's weight, or giving less health information to patients with obesity.[31] The physical environment also may contribute to weight stigma if there is insufficient furniture or equipment (eg, scales, blood pressure cuffs) to accommodate patients of diverse body sizes.[32]

Both quantitative and qualitative studies provide insight into best practices for communication about weight in the health care setting, including the work of RDNs.[32-34] Patient preferences for conversations about weight are varied; they can range from patients feeling very comfortable with candid discussion of weight status and recommendations to patients feeling stigmatized by provider recommendations.[33] As an important caveat, Meadows and Daníelsdóttir[6] (2018) emphasized that many studies on patient preferences for talking about weight in the health care setting have used groups of individuals with higher weight who are actively seeking weight loss, which excludes the perspectives of those in the fat activism movement (The term *fat* is the preferred term used by the fat acceptance movement to describe body size.[35]), who reject the idea of weight loss as health improvement.[6] Regardless of these methodological issues, patient preferences show variation; therefore, it is recommended that RDNs ask about patient preferences, including language preferences, before initiating any discussion of body weight or behavioral modifications to respect a wide array of patient needs. A recent systematic review on language used to discuss obesity indicated that words such as *weight* or *unhealthy weight* were the most accepted by a range of different groups when discussing weight, whereas the words *obese* and *fat* were least preferred.[36]

RDNs could ask patients whether they desire weight loss before providing diet or physical activity advice intended to promote weight change. An RDN may initiate a conversation about a patient's weight by first asking the patient about their health goals and addressing weight loss if it is identified by the patient as a goal. The language used by the patient when talking about weight may be a good starting place indicating which words and phrases the RDN should use, but it can also be helpful to directly ask the patient if this is unclear.

In terms of how the provider interacts with the patient, Hayward et al[34] found in a simulation of a patient–provider interaction that participants responded more positively to supportive conversations with a doctor that proposed reasonable behavior changes such as walking and mindfulness at mealtimes, rather than stigmatizing conversations that suggested extreme behavior changes.[34] Participants in the supportive conversation condition also expressed higher willingness to visit the provider in the future and to comply with recommendations, suggesting that communicating in a supportive, empathetic manner could improve health outcomes.[34] These findings support the use of motivational interviewing by RDNs focusing on reasonable, patient-generated goals, when counseling about weight, as recommended by the Academy's 2016 position.[26]

Qualitative studies exploring patient experiences supports the need for human connection and respect, regardless of body size, when initiating conversations about weight.[37] Some study participants expressed feeling dismissed by doctors when they felt their personal experiences about their health were not being heard or believed.[32] To avoid contributing to weight stigma, RDNs could listen to patient concerns and provide opportunities for patients to use autonomy and choice whenever possible in their nutritional treatment.

Another common theme in studies of patient preferences in communication is the need for nuance and context when discussing weight. RDNs could seek to acknowledge the many complex determinants of weight,[38] many of which are outside of personal control,[37] when working with patients of diverse body sizes. The importance of recognizing this complexity, including social and environmental factors, is acknowledged by those in both "weight-normative" and "weight-inclusive" paradigms.[24,26] Nutter et al[29] proposed the use of a social justice framework to conceptualize the social factors leading to differences in body size and weight bias. The mutual recognition that inequities within society can converge to produce disparities that influence which groups are affected by obesity, and which groups experience weight bias, can become a unifying goal for RDNs working to combat weight bias.[29] RDNs might implement this social justice framework in practice by raising awareness of health disparities around obesity and the societal factors that lead to those disparities and advocating for greater health equity within their workplaces, in their communities, and through health policy.

## COMMUNICATING ABOUT WEIGHT IN PUBLIC HEALTH

In the public health sector, messaging about weight has also been

| Area of practice | Recommendations to reduce weight bias and stigma | Examples |
|---|---|---|
| Organizational governance | Include language denouncing discrimination based on weight in organizational codes of ethics.<br>Include education about weight bias in training programs for students and professionals: include specific language about reducing weight bias in organizational priorities for students.[45] | "Practitioners shall act in a caring and respectful manner, mindful of individual differences, weight diversity, and cultural and ethnic diversity."<br>"Students and professionals should be able to demonstrate an understanding of how weight bias may inhibit quality care in health care settings." |
| Health care | Ensure furniture, equipment, and facilities can accommodate diverse body sizes.[32]<br>Ask about patient preferences when initiating conversations about weight.[33]<br>Use motivational interviewing to set patient-generated, reasonable goals in nutrition counseling.[26]<br>Respect patient concerns and preferences, including language preferences for talking about weight.[36]<br>Acknowledge social and environmental factors that can impact weight and health when making recommendations.[24,26] | Provide chairs, gowns, scales, and blood pressure cuffs that can accommodate a wide range of body sizes.<br>"I'd like to take your weight now. Would you like to discuss your weight? Do you have any concerns you would like to share?"<br>"What goals do you have related to nutrition? Where do you feel you are able to start making changes? What challenges might you face in achieving your goals?"<br>Include questions about preferred weight terminology on intake questionnaires, such as those from the Weight Preferences Scale,[46] and discuss with patients in their first meeting.<br>Provide recommendations consistent with a patient's ability to make changes. Consider financial resources, the food environment in which they live, cultural preferences, and family support. |
| Public health | Create interdisciplinary teams when designing public health messages.[43]<br>Advocate for the consideration of weight stigma when designing public health messages.[42]<br>Use behavioral rather than weight-based outcomes to design and evaluate public health programs.[18]<br>Pilot test proposed campaigns with individuals across the weight spectrum.[44] | Include team members with varying professional expertise, such as psychology, weight stigma, and mental health, in addition to physical health experts.<br>Educate public health colleagues about potential harms of weight-based messaging[43] and strategies to avoid harm.<br>Include behavioral measures in program evaluation plans, such as dietary screeners, and use existing behavioral surveillance such as BRFSS[a] when considering the impact of public health programs.<br>Organize focus groups to evaluate the impact of public health campaigns before campaign launch. Recruit individuals with varying body sizes. |
| Universities | Implement and evaluate weight bias reduction interventions with dietetics students in didactic and supervised practice programs.[45]<br>Encourage a culture of respect when discussing weight in dietetics courses. | Use interventions such as videos about weight bias, role playing activities, or course content on the uncontrollable factors that contribute to obesity.[45]<br>Avoid stereotypical portrayals of people with obesity in case studies and other examples given in dietetics courses. |
| Research | Design and conduct randomized controlled trials testing weight bias reduction interventions among dietetics students, dietetics interns, and Registered Dietitian Nutritionists.[45] | Improve existing weight bias reduction interventions or design new interventions based on theory; evaluate using a randomized controlled trial design. |

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**Figure.** Opportunities for reducing weight bias and stigma in dietetics practice.

| Area of practice | Recommendations to reduce weight bias and stigma | Examples |
|---|---|---|
| | Use non-stigmatizing language when discussing weight in scientific communication.[10] | Use people-first language ("person with obesity") when writing journal articles about obesity. |
| | Reduce reliance on body mass index for defining obesity in clinical studies, when appropriate.[47] | Consider the use of additional metrics such as waist circumference or body composition to define obesity in clinical studies, rather than body mass index only. |
| | Use measures of health-promoting behaviors for evaluating the success of health interventions. | Consider the use of behavioral measures such as dietary intake, physical activity, or quality of life, for measuring the impact of interventions beyond changes in weight. |

[a]BRFSS = Behavioral Risk Factor Surveillance System.

**Figure.** *(continued)* Opportunities for reducing weight bias and stigma in dietetics practice.

contentious. There have been several instances over the past decades in which public health campaigns and policies[39] targeting weight have been publicly criticized,[40] including one campaign in Georgia that used what many considered stigmatizing messages to address childhood obesity.[18]

One study on public perceptions of obesity-focused public health campaigns found that people responded most positively to messaging that did not discuss weight status, and most negatively to messaging that implied that weight was under personal control.[18] Qualitative data from Australia corroborates this sentiment, with many individuals commenting on the "blaming" nature of many public health messages regarding weight.[41] This study also demonstrates that weight stigma is not only a US issue. Although body weight or body mass index may be more direct outcomes to measure when evaluating campaigns, measures of health-promoting behaviors may be a less stigmatizing way to measure a campaign's effectiveness, and they could measure intermediate outcomes that could potentially lead to later weight loss if sustained.

As with health care settings, evidence suggests that public health messaging that carries blame for weight or health outcomes can be perceived as stigmatizing, which can undermine the effectiveness of the messaging and may even lead to harm.[42] One proposed solution for decreasing unintended harm is to use an interdisciplinary approach to develop public health messaging by involving researchers and practitioners from multiple fields to incorporate a variety of perspectives.[43] RDNs can be a valuable asset by providing suggestions for actionable dietary behaviors to use in public health campaigns, rather than a focus on only weight. Pilot testing proposed that public health campaigns with a group representative of the intended audience also may help to identify possibly harmful messages and provide a voice to potentially stigmatized groups.[44]

## WEIGHT BIAS REDUCTION EFFORTS AND OPPORTUNITIES FOR PROGRESS

RDNs working in multiple areas of dietetics have the opportunity to take action to reduce weight stigma within their field (Figure).

Previous work on weight bias reduction efforts has suggested that beginning with trainees, such as dietetics students,[48] is the most effective way to change the culture of weight stigma within a profession.[45] One way in which the Academy can demonstrate its commitment to decreasing weight bias among dietetics students is to explicitly state a commitment to decreasing weight bias in the core knowledge and competencies distributed by the Accreditation Council for Education in Nutrition and Dietetics.

In the didactic setting, dietetics educators can address weight bias through curriculum and learning activities aimed at increasing understanding of weight bias, activities designed to increase empathy with people of diverse body sizes, or activities prompting self-reflection of personal biases.[45] Insufficient evidence exists to support greater effectiveness of any one type of intervention to promote lasting weight bias reduction; thus, rigorous evaluation of interventions by RDNs who are skilled in research in university settings is important for continued progress. In the supervised practice setting, the commitment to reducing weight bias in the profession can be reinforced through curriculum and learning activities that allow students to practice nonstigmatizing communication when working with patients and other community members. Faculty and preceptors working with students should receive training in weight bias awareness and reduction as part of orientation to their role in the students' education. Reduction of weight bias within the dietetics profession at large will require a change in social norms, and dietetics educators serve as students' first role models for appropriate conduct.[45]

Dietitians who work in research can advocate for decreasing weight bias by using people-first language in scientific publications and seeking to reduce the reliance on body mass index alone to define obesity when designing research studies. Dietitian researchers also can play a major role in evaluating the effectiveness of the weight-inclusive approach at promoting health outcomes, which would lend more support to an alternative approach that may help decrease weight stigma[24] and improve the overall health and wellbeing of people with obesity.

Although much effort has been focused on decreasing the impact of weight stigma on patients, RDNs in larger bodies can also face weight bias and discrimination in their careers. Of note, weight discrimination in employment is not expressly prohibited in many areas, with the

exception of the state of Michigan and some additional municipalities, and has shown to be especially salient among women with obesity.[49] At the organizational level, the Academy can help decrease weight stigma within the dietetics profession by including language denouncing discrimination based on weight in the Code of Ethics for the Nutrition and Dietetics Profession and offering continuing education on how RDNs and nutrition and dietetics technicians, registered, can decrease weight bias in their own dietetics practice.[50]

The complex nature of obesity demands a similarly complex and nuanced approach to addressing the needs of people with obesity. Although different groups may disagree about the paradigm through which to view weight status, promoting respectful communication and reducing weight stigma is a unifying strategy that can be addressed from research to training to practice. This increases the likelihood that RDNs take a patient-centered approach to working with people with obesity.

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## AUTHOR INFORMATION

Address correspondence to: Erica Howes, MS, MPH, RDN, Virginia Tech, Department of Human Nutrition, Foods, and Exercise, 295 West Campus Drive, 335 Wallace Hall, Blacksburg, VA 24061. E-mail: ericamh@vt.edu

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