Weight bias refers to discriminatory attitudes toward individuals based on their body size and weight. These attitudes influence how people with obesity are treated.

A person with obesity who is stigmatized is often ascribed stereotypes such as being lazy, lacking self-discipline or willpower, and being less intelligent or capable than a person without obesity. But there is no evidence to support these stereotypes as true characteristics of a person with obesity.

In part, it is the portrayal of persons with obesity in television shows, advertisements and news reports that reinforce biased attitudes. The bias is also reinforced on the internet, via talk shows and in books, perhaps most notably by the wide promotion of different products or strategies that “promise” quick and easy weight loss.

The truth is that weight gain is the result of a complex interaction of factors, including:

- environmental (e.g., increased reliance on the automobile);
- genetic (e.g., body size and shape);
• physiological (e.g., medications, other conditions and diseases); and
• psychological (e.g., eating according to different moods).

As with all complex conditions, there is no “one size fits all” approach to managing weight, or to promotion of physical activity.

Impact of Weight Bias on Physical Activity

Let’s consider the impact of weight bias on physical activity from two angles:

1. Impact on the quality of interaction between practitioner and client.

If a practitioner has the belief or perception that a client’s obesity is the result of laziness or lack of willpower, it can have serious repercussions on the interaction between a practitioner and their client. Such assumptions can lead to decreased expectations and increased aggressiveness on the part of the practitioner as they aim to motivate a person into action.

For example, in educational settings, it has been shown that teachers expect less of their student who are overweight or obese (Puhl & Heuer, 2009).

2. Impact on the length of time spent with the client.

Weight bias may also lead to less contact or time spent with clients (or other practitioners/health team members) who have obesity, due to the practitioner’s feelings of discomfort around people with obesity.

A practitioner’s overall lack of respect for autonomy, individual preferences, interests and abilities often leads to a “one size fits all” approach to physical activity prescriptions or programming. This is a recipe for failure for the practitioner and their client. Adequate time needs to be spent with clients who have obesity to ensure the physical activity prescription or programming being provided matches the client’s values and abilities, and the joint expectations or objectives of the individual and the practitioner.

Weight Bias Experiences Can Create Barriers to Physical Activity

An individual’s past or present experiences facing weight bias can create barriers to physical activity participation. For instance, research shows that young people with obesity often avoid physical activity because of weight-based teasing from teachers, peers and healthcare professionals (Puhl & Heuer, 2009).

In a study in which patients were asked about barriers to participating in activities of daily living, including physical activity, participants reported a fear of public humiliation through ridicule from others, falling and not having assistance to get up, and challenges accessing spaces in which exercise takes place (Forhan, Law, Vrkljan & Taylor, 2010). Participants in the study reported avoidance of structured physical activity because of such barriers.

These factors do not mean that people with obesity are not physically active. For practitioners, it’s important not to make incorrect assumptions about a person’s physical activity participation.
For instance, patients with obesity reported spending a similar amount of time to those without obesity on daily activities in the areas of work and self-care, all of which require some form of physical activity (Forhan, Law, Vrkljan & Taylor, in press). These results are similar to those reported in the most recent analysis of the Canadian Community Health Survey (CCHS) in which the physical activity of Canadian adults and children was measured (Colley, Garriguet, Janssen, Craig, Clarke & Tremblay, 2011).

These CCHS results indicate that physical activity, as measured by accelerometer readings, was not dependent on a person’s weight. The results of this study challenge the stereotype that people with obesity are not as active as those with lower body weights.

**Knowing the Facts about Obesity and PA Helps Overcome Bias**

For a practitioner to overcome their weight bias or discriminatory attitudes, it helps to better understand some of the issues that occur with obesity and how it affects physical activity participation.

Here are three key factors that affect many individuals who have obesity:

a. Muscle quality and strength differences: Some individuals with obesity have reduced muscle quality and strength, which impacts their tolerance for physical activity. This is true for individuals with sarcopenic obesity in which fat infiltrates muscle tissue.

b. Pain: Pain is a factor that results from increased pressure and changes in the loading of weight on certain joints including the lower back, hips, knees and feet. Physical activity designed specifically in consideration of painful joints is important.

c. Fatigue: Fatigue is another factor that can impact physical activity. For example, in one study (Forhan et al, 2010) that explored participation in everyday living in adults with severe obesity, it was found that the amount of energy required to participate in mandatory activities (such as work and child care) left very little for discretionary activities, such as formal or structured exercise.

**Am I Biased?**

To help you determine if you have a weight bias or not, it’s a good idea to do a “check-up” on your own attitudes and beliefs. One way to do this is use a self-assessment tool. (See the Useful Links associated with the online version of this article on the Alberta Centre for Active Living website.)

Many healthcare practitioners, including physical activity experts, report having negative attitudes and beliefs about persons with obesity (Teachman & Brownell, 2001). Such attitudes can translate into behaviours that lead practitioners to blame clients with obesity for their health concerns. The practitioner may also tend to attribute all treatment challenges to the client’s weight, size or shape, thereby neglecting the true causes (e.g., pain or fatigue) of the client’s concerns or complaints.

Conditions often overlooked by health practitioners in patients with obesity include cancer, arthritis, depression and attention deficit disorder. Patients often leave their health practitioner’s office with advice that seldom goes beyond “eat less and move more,” a strategy that seldom results in sustainable weight loss (Jay et al., 2009).

Here are some practical suggestions to avoid weight bias when working with your clients:

1. Listen to a person’s interests, needs, abilities and expectations.
2. Work with a client to find safe and accessible ways in which to integrate physical activity into everyday living, rather than adding a new set of activities to a day.
3. Focus on health and wellness, not on weight or weight loss.
4. Do not use your own experiences of physical activity as an example, unless directly asked to do so.
5. Never assume that you understand what it is like to live everyday with obesity, unless you have lived with obesity yourself.
6. Use evidence to support your recommendations to clients. Translate scientific knowledge into practical solutions.

7. Remove all magazines or brochures from your waiting area that stereotype people with obesity or portray obese bodies in a negative way.

8. Do not weigh clients or discuss their weight in public areas.

9. Be sure to have tape measures, scales, blood pressure cuffs and gowns in your office that are designed to fit large people, including your largest clients.

10. Have assistive devices available for your clients to use that make it easier to put on their socks (sock aid) or shoes (long-handled shoe horn).

11. Install grab bars in the washroom and workout rooms that can be used to assist clients from sitting to standing positions.

12. Focus discussions on the health aspects of physical activity, such as strength, endurance, cognition and mood, not on weight.

Information and knowledge is power; now is a good time to further explore your attitudes and beliefs about obesity. For instance, engage your peers and contacts in discussions about weight bias, to help each other consider possible changes in the way you serve clients. As long as you move forward with an open mind, while continuing to treat all clients equally, avoiding weight bias should be attainable.

To view a list of references and useful links associated with this article go to www.centre4activeliving.ca/publications/wellspring.html.