Dietetic Weight Stigma Q&A

Updated October 2024, with special thanks to Florence (Flo) Sheppard, MHSc, RD and Nooshin Alizadeh-Pasdar, PhD, RD for their valuable input and support for this update.

Disclaimer: Content below has potentially triggering language.

Unless otherwise specified, practice resources can be found here: [Dietitians – Resources | CHCPBC.]() These resources appear in **bold** in the following Q&A.

Q1: What is the difference between weight stigma, weight bias, and weight discrimination?
Weight bias involves negative attitudes and beliefs about people with larger bodies, occurring internally, interpersonally, or systemically [1]. Weight stigma refers to societal stereotypes and misconceptions about these individuals. Weight-based discrimination includes subtle and overt actions that lead to exclusion and inequities for people in larger bodies, which can be verbal, physical, or relational. These concepts are inter-related as depicted in Figure 1 below [1].

Weight stigma can be linked to two different types of weight bias: explicit and implicit.

Explicit weight bias refers to the negative viewpoints about weight that individuals are aware and conscious of. An example of this would be directly linking the diagnosis of type 2 diabetes in a patient to being overweight or the implication that a person experiencing severe underweight or a condition like anorexia can improve simply by eating more.

Implicit weight bias refers to the negative viewpoints of weight that individuals are not aware or conscious of [2]. An example of this would be being concerned for a patient that unintentionally and rapidly lost 10% of their weight when their initial weight was 75 kg but seeing this same outcome as a positive one for an individual that was initially 125 kg. Another example could involve cultural norms, whereby in some cultures, high body weight is associated with being wealthy, and low body weight is associated with being poor and an inability to afford food [3, Figure 2].

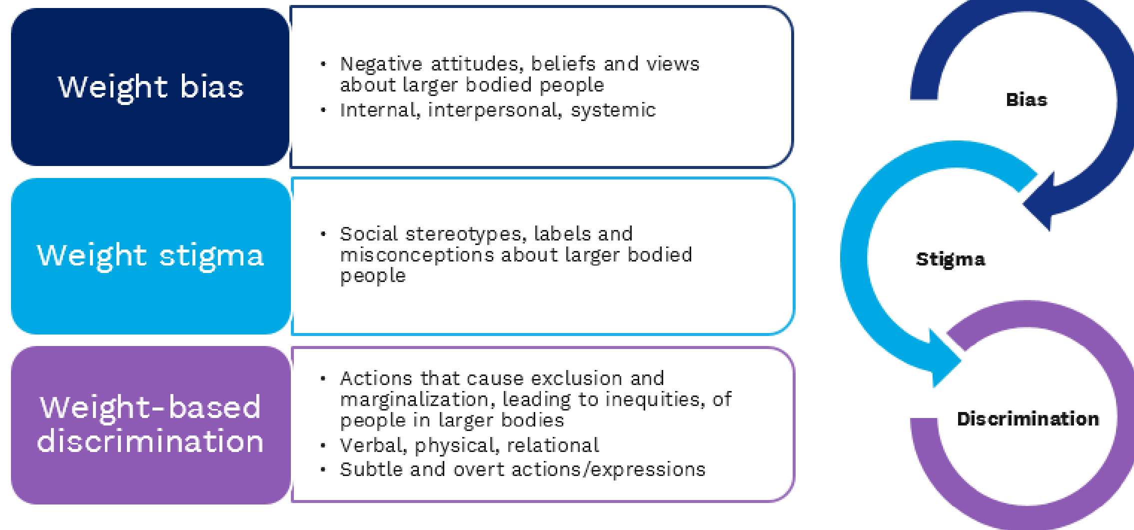

Figure 1. Definitions of weight bias, weight stigma, and weight-based discrimination.

Types of weight bias and stigma

Internalized/intrapersonal

- Self-directed stigmatizing attitudes people in larger bodies hold about their own abilities and worth, based on social stereotypes about their perceived weight status
- e.g., "If I just had more willpower, I could lose the weight."

Interpersonal

- Prejudice and discrimination that is directed to people in larger bodies by individuals or groups
- e.g., Providing unsolicited lifestyle advice

Systemic/structure

- Social forces and institutions, including mass media portrayals of people in larger bodies, and differential access to goods, services and opportunities
- e.g., Application of BMI cut-offs to access medical/surgical procedures

Figure 2. Types of weight bias and weight stigma.

Figures were developed by Florence (Flo) Sheppard, CHCPBC Dietitian registrant and adapted with permission from Northern Health Authority.

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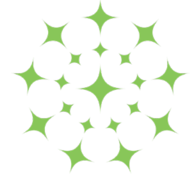


It is also important to take into consideration the potential for weight stigma experienced by people in smaller bodies, as pointed out by the National Eating Disorders Association definition of weight stigma: "*discrimination or stereotyping based on a person's weight*." [4]. This definition doesn't limit the experiences of weight stigma to individuals in larger bodies; rather there is a recognition that individuals who are underweight can also be impacted.

There are very few studies to measure the treatment of and discrimination against individuals who are underweight. One study notes that women tend to experience a proportional increase in weight stigma with body weight increase, while men experience weight stigma at the extreme ends of BMI [5].

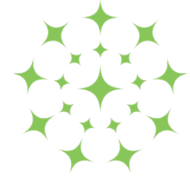
The stigma experienced for people in smaller bodies is different than for people in larger bodies. While there may be negative comments about low weight and/or assumptions of eating disorders, the scope and scale of the discrimination is different. People in larger bodies experience systems discrimination (e.g. medical equipment/chairs/airplane seats), policies (e.g. BMI cutoffs for access to surgery), etc. that people in smaller bodies may not.

Given the higher prevalence of weight stigma among those living in larger bodies, as well as the abundance of evidence for this, this Q&A will focus on weight stigma that includes feelings and attitudes established as prejudice, discrimination, and stereotypes towards people with higher weight. Weight stigma can appear in different forms which can include harassment, bullying, isolation, negative comments regarding weight, and microaggressions [6].

[1] Practice-based Evidence in Nutrition: Weight Stigma Background.
[2] National Association to Advance Fat Acceptance. The Size of It: NAAFA Study on Fat Bias in the Media.
[3] Bradley University. Cross-cultural perspectives.
[4] National Eating Disorders Association. Weight Stigma.
[5] Obesity. Weight Stigma in Men: What, When, and by Whom?
[6] Obesity. The Weight-Inclusive versus Weight-Normative Approach to Health: Evaluating the Evidence for Prioritizing Well-Being over Weight Loss.

Q2: What terms are acceptable when communicating with people who may experience weight stigma?

The best way to communicate about body weight with a client is neither clear nor simple [1]. It is important to prioritize your client's preference by asking them directly for how they would like to be addressed and described while receiving nutrition care [2,3,4]. This is unlikely to include use of the terms "obese" or "obesity" [4].



In a large meta-analysis, studies reported that participants, including those seeking treatment for weight loss, preferred "neutral terminology, including the words such as 'weight', 'BMI', 'unhealthy weight' or the phrases 'your weight may be damaging your health' or 'you are above your healthy weight range'." Less favourable terms included: 'fat', 'fatness', 'excess fat', 'large size', 'heaviness', 'obese' and 'morbidly obese' [1].

There is a growing "fat acceptance movement", which with a goal to end weight stigma and discrimination. This movement aims to reclaim the term "fat" as a neutral descriptor, empowering its use to be akin to describing someone as "short" or "tall" [2].

Person-first language is highly regarded as among the most respectful ways in which to address a client. For example, in a person-first approach, a client could be described as "person with a disability", avoiding using the descriptor of a disability to define the client (e.g. "disabled person") [1-4]. The preference for the use of this approach is highly dependent on the individual. For example, women and those seeking bariatric surgery prefer client-first language over others [1].

For more information on sensitivity in communication with a client and appropriate client-first language, refer to the **Dietetic Trauma Informed Care Q&A** and the **Dietetic Equity, Diversity and Inclusion Q&A**.

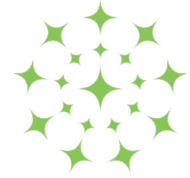
[1] Obesity Review. What words should we use to talk about weight? A systematic review of quantitative and qualitative studies examining preferences for weight-related terminology.
[2] Psychology Today Canada. Fat or Obese: Which Terms Are Least Stigmatizing?
[3] National Institute of Health. Obesity and People with Higher Weight.
[4] Annual Weight Stigma Conference (2024). Words are Heavy: A Scoping Literature Review and Discussion of Size Related Terminology Preference.

Q3: Why is it important to reduce weight stigma? How is weight stigma harmful?
Judging people because of their weight is unfair and should not be accepted in today's society. Weight stigma harms the health of individuals that face it and undermines human rights and social rights [1].

Weight stigma perpetuates the idea that body size and weight are related directly to health. Higher weight is wrongly associated with negative characteristics such as laziness or lack of self-control. This results in the dismissing of other unmodifiable factors, including genetic, biological, and environmental factors, that impact health [2,3].

Weight stigma may have many adverse effects on an individual that faces it. This includes but is not limited to:

- Experiences of discrimination, bias, and/or marginalization, impacting determinants of health.



- Psychosocial impacts such as depressive symptoms, lower self-esteem, increased anxiety, increased stress, increased risk of substance abuse, and mental health issues such as binge eating and bulimia [4].
- Physical and biochemical impacts of weight cycling, which may negatively impact blood pressure, heart rate, fluctuating levels of blood sugar and insulin levels, increase risk of depression, fractures, lean tissue loss, some cancers, and may be attributed to elevated risk of death [5-8].
- Higher cortisol levels and increased eating as a coping strategy can cause further weight gain and can be described as a positive feedback loop [3].
- There can be a delay in seeing health care professionals in order to avoid poor quality care including facing stigma, or misdiagnosis of conditions [9]. People with higher weight are at risk of many longer-term disease processes which may not be immediately apparent [10].

It is important for Dietitians and other health care professionals to reduce weight stigma within health care settings and their clients' environment to improve mental health, physical health, and body sovereignty [4,11]. To truly practice trauma-informed, patient-centered, and culturally safe care, weight stigma must be eliminated. See **Dietetic Trauma informed practice Q&A** for more information.

[1] Nature Medicine. Joint International Consensus Statement for Ending Stigma of Obesity
[2] PLOS. Dietitians and Nutritionists: Stigma in the Context of Obesity. A Systematic Review.
[3] Ontario Dietitians in Public Health Resources. Addressing Weight Bias. A Call to Action.
[4] Practice-based Evidence in Nutrition: Weight Stigma Background.
[5] Endocrine Society. Weight Cycling is Associated with a Higher Risk of Death.
[6] Obesity and Metabolic Syndrome. Weight Cycling and Its Cardiometabolic Impact.
[7] Preventative Medicine. Is Weight Cycling Associated with Adverse Health Outcomes? A Cohort Study.
[8] Obesity. The Weight-Inclusive versus Weight-Normative Approach to Health: Evaluating the Evidence for Prioritizing Well-Being over Weight Loss.
[9] Primary Health Care Research and Development. Weight Bias and health care utilization: a scoping review.
[10] Current Cardiology Reports. Association Between Obesity and Cardiovascular Outcomes: Updated Evidence from Meta-analysis Studies.
[11] Canadian Journal of Public Health. (Re)claiming Our Bodies using a Two-Eyed Seeing Approach: Health-At-Every-Size (HAES®) and Indigenous Knowledge.

Q4: What changes can I make to my practice to reduce weight stigma? How will this influence my clients?

Awareness

- Reflect on your bias**:** Take a Test (harvard.edu).
- View clients in larger bodies as competent individuals and reinforcement with positive attributes might increase their desire to seek care and benefit their self-

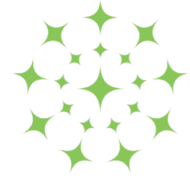


image. Access to bias-free and respectful care is important for clients to improve their health [1].

Language

- Ask your client about their language preference.
- Avoid praising weight loss or commenting on weight change.
- Use weight-inclusive language [2,3].

Spaces/environment

- Ensure that the healthcare setting, including private practice offices and waiting rooms. Create a welcoming space for clients with different body sizes [4]. You may have influence over your private practice office and waiting room supplies and furniture.
- Participate in discussions aimed to reduce weight stigma with work colleagues, client family members, friends, and significant others [4].

Policies

- Be active in your role to advocate for elimination of weight stigma by taking part in developing/revising policies/standards/guidelines in your workplace. (**Dietetic Code of Ethics Standard** 3c: "*Collaborate with others in the development and revision of policies to support ethical and quality healthcare services, lead policy change, engage with others in policy development/revision, implement and monitor impact of these initiatives*.")

Education Materials

- Incorporating the issue of weight stigmatization and its consequences into the CCP and integrating your learnings into practice is a crucial step that you can take to reduce weight stigma [1,5-7].
- Refer to Q6 for the College practice standards and ethical principles that pertain to addressing and mitigating weight stigma. Dietitians can also seek to improve their knowledge on the association versus causality of weight and chronic diseases.
- See Q7 and 8 for examples of advancing your learning and resources to help achieve this learning.

[1] PLOS One. Dietitians and Nutritionists: Stigma in the Context of Obesity. A Systematic Review.
[2] Weight and Healthcare. Inclusive Language For Higher-Weight People.
[3] Ontario Dietitians in Public Health. Towards a Weight Inclusive Approach in Public Health.
[4] Nature Medicine. Joint International Consensus Statement for Ending Stigma of Obesity
[5] iScience. Obesity Treatment: Weight Loss versus Increasing Fitness and Physical Activity for Reducing Health Risks.
[6] Practice-based Evidence in Nutrition: Weight Stigma Background.

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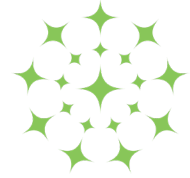


[7] Obesity. The Weight-Inclusive versus Weight-Normative Approach to Health: Evaluating the Evidence for Prioritizing Well-Being over Weight Loss.

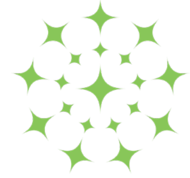
Q5: What are some barriers in my practice that might prevent me from reducing weight stigma?

Consider your own biases [1] and potential client biases [2], which are formed by previous beliefs, established preconceptions, and fixed viewpoints. Examples of beliefs that may prevent you from reducing weight stigma:

- Weight is a key indicator of health or nutrition status,
- Differing definitions of "health" and what it means to be "healthy",
- Someone's body size reflects their lifestyle,
- Weight can be changed by eating less and moving more,
- Clients may experience internalized fat stigma, believe it is their fault for any poor health they have experienced, and subsequently not deserving medical care, and seek weight loss guidance to gain access to health care.

External barriers may also impact your effective use of weight inclusive approach [2-6]. These may include:

- The pervasiveness of media portrayal of people in smaller bodies and its encouragement of weight-based discrimination:
  - Diet talk is still pervasive in the media.
  - People in larger bodies are almost exclusively discussed in stories about health and health care, and the vast majority of these stories make a baseline assumption that fatness is associated with or causes poor health.
  - That too few of these stories include the perspective of people in larger bodies, and almost none offer the perspective of fat activists and others talking about fat liberation.
  - Many of these stories quote "experts" who are part of institutions funded by diet companies and drug manufacturers, giving them a vested interest in continuing fat panic and encouraging weight loss.
  - Inconsistent nutrition messaging.
- Weight/BMI criteria to access care (e.g. surgery).
- Clinical practice standards/guidance that promote weight loss.
- Healthcare settings lacking sufficient equipment (e.g., MRI machines, chairs, beds, blood pressure cuffs etc.) to treat clients with diverse body size, shape and weight.
- The use of weight/BMI as the primary indicator for health and estimated nutrition requirements.
- Workplace policies that fail to identify and include efforts to reduce weight-based discrimination.



- Public health reports that focus on the health care costs associated with higher weights (but do not quantify the costs of weight stigma and discrimination).
- System pressure e.g., guidelines, physician directions, review resources with a critical lens (may apply to certain clients and not others).
- Refer to **Evidence-Informed Q&A**, **Equity Diversity and Inclusion Q&A**, **Cultural Safety and Humility Q&A**, and **ICSH and Anti Racism Practice Standards**.

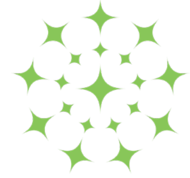
[1] Nature Medicine. Joint International Consensus Statement for Ending Stigma of Obesity.
[2] Frontiers in Psychology. Stigma in Practice: Barriers to Health for Fat Women.
[3] Practice-based Evidence in Nutrition: Weight Stigma Background.
[4] Ontario Dietitians in Public Health. Weight Inclusivity Checklist.
[5] National Association to Advance Fat Acceptance. The Size of It: Fat Bias in the News
[6] Critical Dietetics. Intuitive eating and Health at Every Size in community settings: Dietitian's perceptions of practice barriers.

Q6: Why is the College speaking about weight stigma? What Dietetic Standards of Practice, Code of Ethics Standards, and ICSH and Anti-Racism Standards apply to minimizing weight stigma?
As explained in Q5, weight stigma may affect dietitians' judgement and ultimately, client care and outcomes. This directly relates to expectations of practice which are established in **Standards of Practice** and **Code of Ethics**.

Dietetic Standards of Practice:
Standard 4. A Dietitian acts ethically in their professional interactions and while providing professional services.
Standard 6. A Dietitian provides information and obtains informed consent prior to the provision of professional services.
Standard 9. A Dietitian communicates in a clear, concise and respectful manner.
Standard 12. A Dietitian provides quality professional services that reflect the unique needs, goals, values and circumstances of the client. Indicators 1-6.
Standard 13. A Dietitian seeks information and incorporates an evidence-informed approach to their practice.
Standard 14. A Dietitian uses critical thinking to obtain assessment data, determine practice problems, plan, implement and evaluate professional services.

Dietetic Code of Ethics:
Standard 1: Provide services in the best interest of clients.

ICSH and Anti-Racism Standard:
Core Concept 4. Creating safe health care experiences
Core Concept 5. Person-led care (relational care)
Core Concept 6. Strengths-based and trauma-informed practice (looking below the surface)



Q7. It would be helpful to have some sample CCP goals so I can plan to incorporate reduction of weight bias in my CCP.

Here are a few sample learning reports related to weight stigma/bias. You may choose how you would like to develop your learning reports as long as that they comply with the **CCP guidelines**.
The learning activities section of the learning reports below has not been included. These opportunities can be specific to geographical region, time of year, and community/workplace engagement and can become easily outdated. For more information and to access resources for your learning needs, please see Q8 below.

Example 1
Standard 13. A Dietitian seeks information and incorporates an evidence-informed approach to their practice.
Indicator 2. Assess/ interpret clients' information/ evidence, considering contextual factors, ethics and client perspectives.

Learning Goal: In this CCP cycle, I will focus on learning and consistently applying the principles of intuitive eating in my private practice, with all clients, regardless of their weight, where these principles suit the client nutrition goals.
Learning Activities:

- See Q8 for resources and inspiration.

Learning Outcome:
I have been able to promote eating patterns and develop individualized eating strategies based on hunger, satiety, and pleasure, while also focusing on nutrition needs. This approach replaces weight control eating plans I have used for years for clients who wish to lose weight. I have been able to collaborate with clients such that they place emphasis on eating for pleasure and satiety, and referring to clinical counsellors where the interprofessional collaboration improves care, rather than solely focusing on numbers on a scale and calories in a food.

Example 2
Standard 10. A Dietitian contributes to the provision of quality professional services as a member of the clients' interprofessional team.
Indicator 1. Contribute professional knowledge to discussions and interactions with team members using an open, collaborative approach.

Learning Goal: In this CCP cycle, I aim to educate myself on inclusive language use in the context of people in larger bodies with a goal to using it consistently in my

communications and documentation, such that members of my interdisciplinary team can benefit and learn from my weight inclusive approach.
Learning Activities:

- See Q8 for resources and inspiration.

Learning Outcome: For many established members of my team, the "old school" train of thought is that body size is a choice that can be reversed by voluntary decisions to eat less and exercise more. By using inclusive language in my interaction with health care providers, as well as in my documentation, I am placing emphasis on the client first, while avoiding describing the client with weight-related descriptors, in hopes to reduce weight stigma and discrimination that so much of this population has experienced extensively. I am able to speak up confidently when discriminatory weight biased language is being used when the team is discussing client care.

Q8. What are some resources that I can use to learn more about weight stigma?
This list of resources is not meant to be exhaustive. If you work in this area and make use of other great resources, please be in touch with the College.

Background information
Practice-based Evidence in Nutrition: Weight-Inclusive Approach Background.
Practice-based Evidence in Nutrition: Weight Stigma Background.

Research articles
WIDIC Open Access Journal Articles Database.

Practice resources
Association for Size Diversity and Health: Health at Every Size Principles.
Obesity Canada: Weight Bias.
Ontario Dietitians in Public Health: Addressing Weight Bias Resources
University of Illinois Chicago School of Public Health: Addressing Weight Stigma and Fatphobia in Public Health.

Client resources
Holland Bloorview Kids Rehabilitation Hospital: Weight-Related Conversation Resources.
Look for patient resources at your local healthcare authority. Here are two examples:

- Northern Health: A Healthier You: Focus on Health, Not Weight.
- Vancouver Coastal Health: The Focus in on Health, Not Weight.

Education opportunities
Annual Weight Stigma Conference.
BC Children's Hospital: Balanced View.
WIDIC: Webinar Library.