National Eating Disorder Information Centre

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On the Importance of Considering the Role of Internalized Weight Stigma

Pre- and Post-Bariatric Surgery

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> "Get your bikini body now." "Rid yourself of the mom / dad bod." "Sweat like a pig, look like a fox." "Don't stop when it hurts, stop when you're done."

Enormous pressure is levied against bodies in the current age. Humans are compelled to dress a certain way and achieve a certain size or number on the scale. Under the obligation to fit into society's narrow standards of acceptability, 38 percent of boys and 50 percent of girls engage in unhealthy behaviours to lose or manage their weight (Lampard et al., 2016). One in five women struggles with disordered eating or an eating disorder (National Institute of Mental Health). Each day the world is presented with unrealistic standards of beauty from mass and social media sources. Children and adults are witness to images which are hyper-sexualized and digitally altered, featuring a limited representation of humanity. This nearly inescapable exposure to problematic media is linked to body dissatisfaction and disordered eating, according to the National Eating Disorder Association.

In this context high body weight is seen as a moral failing. Even among healthcare providers, overweight and obese individuals are assumed to be unintelligent, lazy, unattractive, greedy, and incompetent with poor personal hygiene and inadequate self-care behaviours (Puhl & Heuer, 2009). These attitudes result in unfair treatment in multiple realms including education, employment, healthcare, interpersonal relationships, and political elections (Puhl & Heuer, 2009). It is important to note, however, that this finding does not account for the multiple oppressed identities an individual may hold simultaneously. An individual's experience of weight-based stigmatization and discrimination is impacted or altered by their race or ethnicity (Saguy & Gruys, 2010), gender and age (Brewis, 2014), socioeconomic status (Rich, 2011; van Amsterdam, 2013), sexual orientation (Fikkan & Rothblum, 2012; Whitesel, 2014), and physical ability level.

One cannot help but adjust their belief systems to internally accommodate a lifetime of exposures to these systematic abuses. It is an automatic reaction to traumatic experiences: an attempt to reconcile the lack of justice one experiences as a member of an oppressed or marginalized group. When limiting the scope of oppression to the facet of weight or body size, the result is internalized weight stigma, or the acceptance of society's stereotypes and judgments as inherently true. Others describe this as self-stigmatization, or a process by which one applies society's prejudicial beliefs to themselves. And it is linked to real consequences including increased caloric intake, decreased engagement in physical activity,

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increased cortisol reactivity, lesser weight loss outcomes, increased symptoms of depression, recurrent binge eating behaviours, and increased HbA1C (Durso et al., 2012; Durso & Latner, 2008; Hilbert et al., 2014; Latner et al., 2014; Latner, Durso, & Mond, 2013; O'Brien et al., 2016; Pearl, Puhl, & Dovidio, 2015; Pearl, White, & Grilo, 2014).

> It's disgusting." "If I could just get rid of [my chicken arms, this belly, my thighs] I know everything will change." "Have you seen me? Of course I hate my body." "I need to be controlled."

Among those pursuing weight loss or bariatric surgery, internalized weight stigma is associated not only with poor weight loss outcomes but also detriments to emotional and physical quality of life. Such individuals have related their feelings of depression and diminished self-worth following surgery to experiences of weight-based oppression (Davis & Bowman, 2015). Bariatric patients' perceptions of weight stigma – both from healthcare providers as well as that which has been internalized – are significantly related to dietary adherence and weight loss outcomes (Raves et al., 2016). That is, individuals who perceived greater stigmatization from their treatment team and have greater rates of internalized weight stigma are more likely to have poorer dietary adherence and weight loss following surgery. This has concerning implications for nutrition, as the dietary guidelines and expectations can be demanding; if not closely followed one may experience complications including bone and muscle loss, low immunity, fatigue, and cognitive deficits (American Society for Metabolic and Bariatric Surgery).

Additional research indicates greater internalized weight stigma is associated with lower rates of engagement in physical activity following surgery (Hübner et al., 2016). Patients may not be aware of this connection, while providers attribute decreased activity to poor patient compliance (Raves et al., 2016). That is, poor outcomes are identified as the patient's fault. Yet in the general population, for each one unit increase in internalized weight stigma one's odds of maintaining their weight loss decreases by 28 percent (Puhl et al. 2017). Similarly, diminished weight loss outcomes are reported among bariatric surgery patients with greater internalized weight bias (Lent et al., 2014).

Concern for this patient population, as with all patients, ought to not be limited to biological functioning but also include quality of life. Recent research indicates that greater internalized weight stigma is associated with poorer quality of life (Palmeira, Pinto-Gouveia, & Cunha, 2016). These findings further suggest a greater potential for avoidance of situations in which the patient may anticipate being stigmatized, including healthcare. This may decrease adherence with important follow-up appointments to ensure ongoing health. Ultimately, the severity of internalized weight stigma is associated with poorer emotional and physical quality of life (Davis & Bowman, 2015; Farhangi et al., 2016; Sarwer et al., 2008).

These individuals present for treatment of their weight. They come to the surgical teams seeking solutions, but not only for their physical health. They also reach out for help with a profound sense of feeling they are not enough or are inherently unworthy. To put it succinctly: their health has diminished and they have come to believe it is their fault due to personal moral failings.

NO DECISION MADE FROM HATRED FOR YOUR BODY CAN LEAD TO HEALTH.

A colleague recently shared the story of a new client whose previous therapist recommended bariatric surgery to cure her body image disturbances and self-hatred. Unfortunately, this is not an uncommon story. Additional examples of microaggressions include moments of feeling criticized or judged by healthcare providers, such as being "advised to lose weight, but not often feeling that they received the tools, support, or help to do so" (Davis & Bowman, 2015, p. 278). What these individuals are not informed of is that they cannot care for a body that they hate.

We as providers must now ask of ourselves: when and how could we assess for internalized weight stigma prior to surgery? What services can our team provide to ensure each patient achieves their best possible quality of life – not just the greatest possible weight loss? Pragmatic alterations to the structure of programs could include the assessment of internalized weight stigma during pre-surgical psychological evaluations using available tools (e.g., Weight Bias

Internalization Scale; Durso & Latner, 2008). Additional possibilities include the development of specific interventions administered to patients prior to surgery with the intention of nurturing peace with one's body.

Patients must be given the opportunity to experience a shift in body image and self-perceptions which will alter how they approach their body and self-care. In fact, emerging research indicates that interventions which both take internalized weight stigma into consideration and directly address patients' experiences of it lead to improved emotional and physical health outcomes in the long-term (Mensinger, Calogero, & Tylka, 2016). In this manner the patients will have access to an internal ability to care for, not just about, their bodies from a stance of self-compassion. It increases the possibility of success not only in terms of the identified outcome of weight loss, but also for each person's emotional and physical quality of life. After all: this is the greater purpose of bariatric surgery.

The tenets of the Health At Every Size® (HAES®) approach allow for such sanctuary and body peace (Association for Size Diversity and Health). The principles explicitly discuss the importance of intuitive eating, joyful physical activity, and weight inclusivity. The core value of the philosophy (as it continues to evolve) offers a richer understanding of how others care about and for their bodies as they choose. The heart of this, in my opinion, is in addressing barriers which are individual as well as social or cultural – including internalized weight stigma and the oppression of marginalized groups. Although some may perceive the HAES® paradigm as inherently antagonistic to weight loss surgery, I believe the application of this philosophy within this patient population creates a series of opportunities in which they are able to define how they embody their lives, their bodies, and their values. For providers operating within bariatric surgery teams, this approach provides an opportunity to build trust with and empower patients. Given the connection between internalized weight stigma and the desired physical health outcomes of bariatric surgery, as well as overall quality of life, operating surgical programs from the HAES® stance could provide a much needed adjustment in how to care for these patients.

We as healthcare providers are byproducts of our environment. We are not immune to our culture. Just as those we serve, we cannot escape and are unmistakably impacted by exposure to toxic media, unrealistic standards of beauty, and harmful stereotypes. Although we may have very good intentions, our actions may cause harm without intention. Our duty, then, is to challenge ourselves to look beyond the simplest explanation for lack of 'success' following surgeries: that our patients have not tried hard enough, as research suggests we believe. It is time to consider the radical notion that it is not only 'okay' for those we label obese to believe they are enough just as they are, but that their lives depend upon it.

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