Fat stigma has been identified as an area of concern in healthcare. Scientific literature argues that people labelled as fat are often treated differently in healthcare – constantly lectured on weight loss, receive blame, have weight focussed on to the detriment of other aspects of diagnosis. Numerous studies have suggested poorer physical and mental health, reduced exercise levels, more disordered eating, reduced trust in health professionals and avoidance of health care appointments. Weight stigma might, ironically, also promote weight gain.

I discuss a theory driven approach to developing and implementing a method of reducing fat stigma in the context of a particular healthcare profession (physiotherapy).

Part 1. Thinking fat stigma in physiotherapy

Fat stigma

Post-structuralist perspectives provide an opportunity to understand the socio-political reasons behind the current rise in fat stigma, and may help provide some guidance as to how to reduce it. There are a number of potential explanations for the current intensification of fat stigma. For example, increasing medicalisation, where attributes (including fatness) not previously considered ‘an illness’ become the subject of medical attention. Fatness has been constructed by medical discourses as abnormal. For example, Murray (2007) discusses medical constructions of fatness as ‘deviance’, and Tischner and Malson (2012) demonstrate that health approaches to ‘obesity’ often present fatness as ‘failing’. Physiotherapy discourses construct fatness in similar ways, particularly in the context of the profession’s increasing interest in public health (more on this later).

Another likely prevailing political context behind the recent intensification of weight stigma is the global rise of moral agendas based on individualistic and economically rationalised ways of thinking (often called ‘neoliberalism’). In neoliberal societies, individual responsibility and self-regulation (as opposed to institutional or governmental responsibility) are upheld as important moral imperatives. Foucault’s work on governmentality and biopolitics details how economic rationalism has been extended beyond its original application to politics and economics and is now often applied to all aspects of daily life (Foucault, 1979). When writing on the ‘obesity epidemic’, Wright and Harwood (2012) explain in the context of fat bodies, how governmentality ‘places individuals and populations under surveillance’ (p. 2). This can readily be seen in medical literature where, for example, perceived financial costs are given as the rationale for reducing ‘obesity’ in individuals or populations. Fat stigma (an aspect of the disciplining of fat bodies) is therefore the ‘correct response’ to the currently championed individualism, where people are increasingly seen as responsible for their own health and its presumed effect on societal wellbeing. As a result, people with so called ‘lifestyle diseases’ (i.e. what are seen as controllable diseases), including ‘obesity’, are constructed as failing because they are seen as making harmful choices – and not only for themselves.
Apart from these sociopolitical aspects of weight stigma – its important also to remember that fat stigma is an embodied experience, where bodies matter, feel things, have effects.

When I first entered into the field – only about 4 years ago – there were only a couple of intervention studies – most literature about demonstrating that fat stigma existed. But now there are quite a few studies that have tried to change fat stigma around 40 or so studies. Unfortunately, most studies have tried to pinpoint a single, simple cause of weight stigma (mainly tried to reduce blame by changing the idea that people are at fault for putting on weight). Unsurprisingly they have largely been unsuccessful. This is, I think, due to:

3 main problems (largely stemming from research methodologies based post-positivist epistemologies):
1) lack of studies in the real world (labs)
2) causes of stigma studied – too simple - like any stigma fat-stigma is socio-politically imbedded. Using post-structuralist thinking we can recognise this complexity and open possibilities for using a variable combination of these factors in weight stigma interventions, depending on which are most relevant to the context.
3) passive and short term - Considering the complexity of weight stigma’s integration with moral norms, it seems unsurprising that these interventions have little lasting effect.

Physiotherapy
As stigma is situated and created socially, culturally and politically. It follows that it is important to investigate the context in which one wishes to reduce that stigma. In this case it is physiotherapy – but much of this is relevant to other HPs.

1) physiotherapy is about bodies
   • To state what might appear obvious physiotherapy is inherently about the body - including body weight.
   • Bodies are observed, weighed, touched, lifted, supported, measured and moved during physiotherapy.
   • Fatness (and other body-related things) are thus likely to take on a particular salience in physiotherapy interactions.
   • From patient interviews: it is not uncommon to feel vulnerable or judged when rolls of fat suddenly seem more obvious as the body is touched, weighed, measured or observed in physiotherapy.

2) normalisation
   • Physiotherapists (and most HPs) typically seek normalisation of the body, eg its patterns of movement or joint range.
   • Physiotherapists are likely to apply a similar biomechanical, machine-like perspective to body weight as the profession increasingly considers elements of public health, including weight management, to be part of its scope of practice.
   • Physiotherapists thus may (usually unintentionally) ‘discipline’ larger patients with the objective of restoring a ‘normality’ that fits a biomechanical ‘truth’ such as simplistic diet versus exercise weight loss theories.
3) material objects in physiotherapy (physiotherapy as part of health and fitness)
   • Use of images that privilege thin bodies, visible exercise equipment
   • Possibly by disciplining their own bodies to become thinner.

5) lack of reflexivity
   • Profession-wide
   • Individual/clinical
   • Physiotherapists are often unaware of this potential discomfort of patients.

Summary
Fat stigma involves embodied and social aspects and is complex and embedded (and created) in specific historical political and cultural settings. Many underlying mechanisms have been proposed to be producing a recent intensification of weight stigma including: perceiving weight as controllable, the medicalisation of fatness, social consensus, lack of empathy, and an economically rationalised ‘disciplining’ of the fat body. Interventions intended to reduce weight stigma have generally been unsuccessful. I suggest this lack of success may be due to insufficient consideration of the complexity of fat stigma evident in the singular causes addressed in most interventions and the simplicity of the methods of intervention. Physiotherapy is one environment where weight may be particularly salient and consequential due to the profession’s focus on bodies, its biomechanical viewpoint, its role as part of the health and fitness industries, and its lack of reflexivity.

Part 2. Empirical exploration of (re)thinking fat stigma
I designed a collaborative process where I worked with clinicians to rethink their ‘logics’ about fatness in the context of their work. To address the theory outlined above I had three main aims: to create an process that involved: 1) active learning, 2) sustained and repeated learning, and 3) situated learning. I situated the study situated within physiotherapy in a number of ways:
   ➢ Participants carried out much of the intervention in own work environments
   ➢ Group sessions in a physiotherapy setting
   ➢ Reflexivity about the profession and about the participants as individual HPs.

The intervention comprised three main elements:
1) Group discussion (6hrs – 3x 2hrs, 3 weeks between each)
   Semi-structured questions.
   • Session 1: two papers discussed on weight stigma in physios.
   • Session 2: discussion of changes in practice or thinking after the first session. One more paper discussed
   • Session 3: centered on changes to practice or new thoughts.
After each discussion, participants summarised the main points and used these points to facilitate individual reflection and planning.

2) Individual learning
   • Weekly diary (6 weeks)
   • Individual responses to papers
   • Written exercises planning changes after group discussions during 3 group discussions
3) One-to-one discussions

- By phone.

Participants spoke of a number of changes in ‘logics’ of practice after participating in the study:

“things that [were] in the too hard basket [previously]. [I thought] I might just stick to muscles and joints. Things that I might have just glossed over and moved onto something more in my comfort zone, [now] I’m more happy to address that then and there.”

They said they approached patients differently including addressing weight in an indirect, gentle and tentative manner. This caused some conflict for physiotherapists as it contrasted with physiotherapy’s usual ‘body as a machine’ approach. “I perceived my interaction as awkward and clumsy rather than being as smooth as it could have been”. However, the patient felt comfortable during the exchange: “She didn’t feel awkward at all, she was fine, she was completely fine and happy. It was more me”.

Participants also spoke of becoming more aware and involved in the political aspects of stigma: including advocacy (ally status if not fat themselves), less judgment.

Reflexivity was also more apparent than usual:

“The other thing that I have been more aware of is as a professional, we are desensitised to other people’s bodies. We see them all the time. Every half an hour I see somebody’s body. For me, I don’t mind if they are tall, short, big, small. I don’t think about it but obviously the patient themselves, if they have a poor body image - self-image, they may be more sensitive about it. So I need to kind of put myself into their shoes”

“Well, I thought of myself as being fairly neutral….But now, actually, I realise that that’s not enough. You know, having a neutral feeling that is not enough”.

“I’ve been a bit more aware of how patients might be looking at, like, me and at our reception staff and our advertising material and our website and thinking of what we project by what we look like and how we appear. So I’ve never really thought of it from that point of view. So that’s got me thinking about how we do things and how we present and thinking what people might be wondering about us”.

Summary

- Developed a theoretical understanding of stigma highlighting weight stigma as a complex, socially embedded (and produced) phenomenon.
- Employed this theoretical understanding to (re)consider how to reduce weight stigma given that most weight stigma reduction interventions have been largely unsuccessful.
- Described a process that applied these theoretical concepts in the context of physiotherapy.
- Involved integration of many contributors to weight stigma, active learning (via group and one-to-one sessions, reflexive diaries) and interactions with reading materials.
Physiotherapy specific considerations included providing time to develop skills and knowledge about reflexivity, reconsidering the physiotherapist as a ‘neutral observer’ and an ‘expert’, and a greater awareness of the influence of bodies.

Questions for consideration:

- What do you think about the connection between theory and clinical intervention in my study? Can you see how the theoretical aspects are brought across into the intervention? In what ways is this un/useful for thinking change?
- How adaptable/practical do you think this type of intervention is? Can you see similar interventions being put in place in other settings?