Editorials

Learning the ABCDs of Weight Stigma and Bias

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Obesity affects millions of Americans each year, with a prevalence of 41.9% in adults.[1] Traditionally, body mass index (BMI) has been the singular criterion to define obesity (BMI greater than 30 kg per m^2). However, BMI is an inadequate predictor of health outcomes and does not integrate ethnic or sociocultural context.[2] In 2017, the American Association of Clinical Endocrinology (AACE) proposed a new framework for evaluating obesity that would impact how physicians diagnose and manage this common condition.[2]

The framework shifts away from treating elevated BMI and to a comprehensive evaluation of weight using two components: (1) anthropometric, which uses BMI as a screening tool that requires further confirmation of central adiposity by examination and waist circumference; and (2) clinical, which identifies the presence and severity of obesity complications.[2] The term adiposity-based chronic disease, or ABCD, was recommended to replace the term obesity for those who meet the criteria.[2] ABCD emphasizes that adiposity is the primary driver of the pathophysiology and complications of the condition. ABCD is a chronic disease and not solely determined by patient behavior. Patients with ABCD have a multifactorial condition with many interrelated contextual factors.[2]

A 2023 AACE consensus statement focuses on the need to address stigma and bias in the diagnosis and management of ABCD.[3] Internalized weight bias is "when a person applies negative weight stereotypes (bias) to themselves and engage in self-devaluation," and it is a determinant of disease severity in ABCD cases.[3] Family physicians should gain a deeper understanding of how internalized weight bias affects a patient's ability to manage their ABCD. Furthermore, adopting tools to assess weight-based stigma can prove pivotal in offering compassionate and effective patient care.[3]

Weight-Related Bias/Stigma and ABCD

ABCD is a chronic disease like diabetes mellitus and hypertension; however, weight-related bias and stigma persist across many aspects of daily life in social media, educational settings, relationships, employment, and health care systems.[4,5] These biases disproportionally affect women, people of color, and gender-diverse individuals who may be more impacted by mainstream cultural ideals of thinness, further contributing to health disparities.[6] This stigma leads to unhealthy behaviors that perpetuate weight gain and worsen clinical and psychological outcomes, such as depression, disordered eating, anxiety, and avoidance of health care.[6] Members of the patient's health care team should recognize and mitigate their own implicit and explicit biases related to weight by using resources such as the Harvard Implicit Association Test (https://implicit.harvard.edu/implicit).[7,8]

Health care bias can contribute to internalized bias, which is associated with psychological distress, lower engagement, and worse responses to medical and surgical interventions for obesity.[8] Physicians can use validated tools, such as the Weight Self-stigma Questionnaire and the Weight Bias Internalization Scale, to screen, identify, and support patients with internalized weight bias using a biopsychosocial perspective. This approach can improve treatment adherence and health outcomes by implementing measures such as cognitive therapy and psychotherapy support.[9,10] *Table 1* lists additional resources for learning about weight stigma.

PHYSICIAN-LEVEL INTERVENTIONS

Family physicians are positioned to reframe and address ABCD and weight-related stigma. Historically, emphasis was placed on excess weight in patients with ABCD, which may inadvertently contribute to weight-based stigma and internalized bias, especially in patients with ABCD complications, such as type 2 diabetes.[8] It is important to note that approximately 50% of these patients experience weight bias in health care settings.[3]

To mitigate these issues, family physicians should emphasize management of ABCD-related cardiometabolic markers (e.g., A1C levels, blood pressure, lipid levels, nonalcoholic fatty liver disease risk reduction), which are already used to manage chronic disease, as treatment goals rather than focusing on reductions in weight or BMI.[3] Physicians should work with patients to develop a comprehensive understanding, rather than a single metric focus, of the patient's health risk factors and align goals with the patient's values to create a patient-centered approach. With this approach, family physicians may improve health outcomes in patients with ABCD, reduce weight-related stigma, and strengthen the patient-physician relationship.

The 5A's (ask, advise, assess, assist, and arrange) motivational interviewing technique is a patient-centered approach to discussing weight and the impact of ABCD on health[3] *(Table 2*[3,11]*)*. Family physicians can help ensure patients feel

TABLE 1

Resources to Learn More About Weight Bias and Stigma

American Academy of Family Physicians CME https://www.aafp.org/cme/all/online/weight-bias.mem.html
Measuring Weight Self-stigma: The Weight Self-stigma Questionnaire https://onlinelibrary.wiley.com/doi/10.1038/oby.2009.353
Obesity Action Coalition https://www.obesityaction.org/resources/weight-bias-in-healthcare
University of Connecticut Rudd Center for Food Policy and Health https://uconnruddcenter.org/research/weight-bias-stigma/healthcare-providers

TABLE 2

5A's Approach for Discussing Obesity/ABCD

Ask if you can discuss weight and the health impact of ABCD
Assess health status and complications
Advise on treatment options based on severity of ABCD
Agree on treatment plan and goals for weight loss
Assist in the ongoing process of weight management and reassessment of goals and treatment options

Note: Commonly used in tobacco cessation counseling, this motivational interviewing technique is easily applied when discussing ABCD with patients.

ABCD = adiposity-based chronic disease.

Adapted with permission from Nadolsky K, Addison B, Agarwal M, et al. American Association of Clinical Endocrinology consensus statement: addressing stigma and bias in the diagnosis and management of patients with obesity/adiposity-based chronic disease and assessing bias and stigmatization as determinants of disease severity. Endocr Pract. *2023;29(6):423, with additional information from reference 11.*

heard and are involved as they work toward attainable and shared goals.

PRACTICE- AND SYSTEM-LEVEL INTERVENTIONS

Clinics and hospitals should provide comprehensive support for patients with ABCD and reduce weight bias and stigma.[3,8,12,13] Ensuring proper accommodation in clinics is essential for delivering high-quality care. These accommodations include chairs, blood pressure cuffs, scales, gowns, and examination tables for a variety of body sizes. Special attention should be given to creating environments where patients feel safe and respected.

To ensure a patient-centered continuum of care, institutions should prioritize training staff to recognize and understand weight bias to avoid retraumatizing this stigmatized population. The Centers for Disease Control and Prevention still defines obesity as solely based on BMI, highlighting that the paradigm shift proposed by the AACE is a long way from integration.[14] Advocacy efforts by specialty organizations are needed so that physicians are provided with appropriate reimbursement and educational resources to improve outcomes for patients with ABCD.

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