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Breaking WEIGHT BIAS

Promoting Health without harming through digital training tools

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3.1. Factors that contribute to the internalisation of weight bias

Table of Content

TRAINING CONTENT

3.1. Factors that contribute to the internalisation of weight bias

Weight bias internalisation (WBI) occurs when individuals apply negative weight stereotypes to themselves and self-derogate because of their body weight. Individuals may come across negative stereotypes and turn inward to apply these to themselves. This creates internal beliefs within the individuals that the negative stereotypes are true and exist within them. It is a complex relationship with social, psychological, and behavioural variables at play:

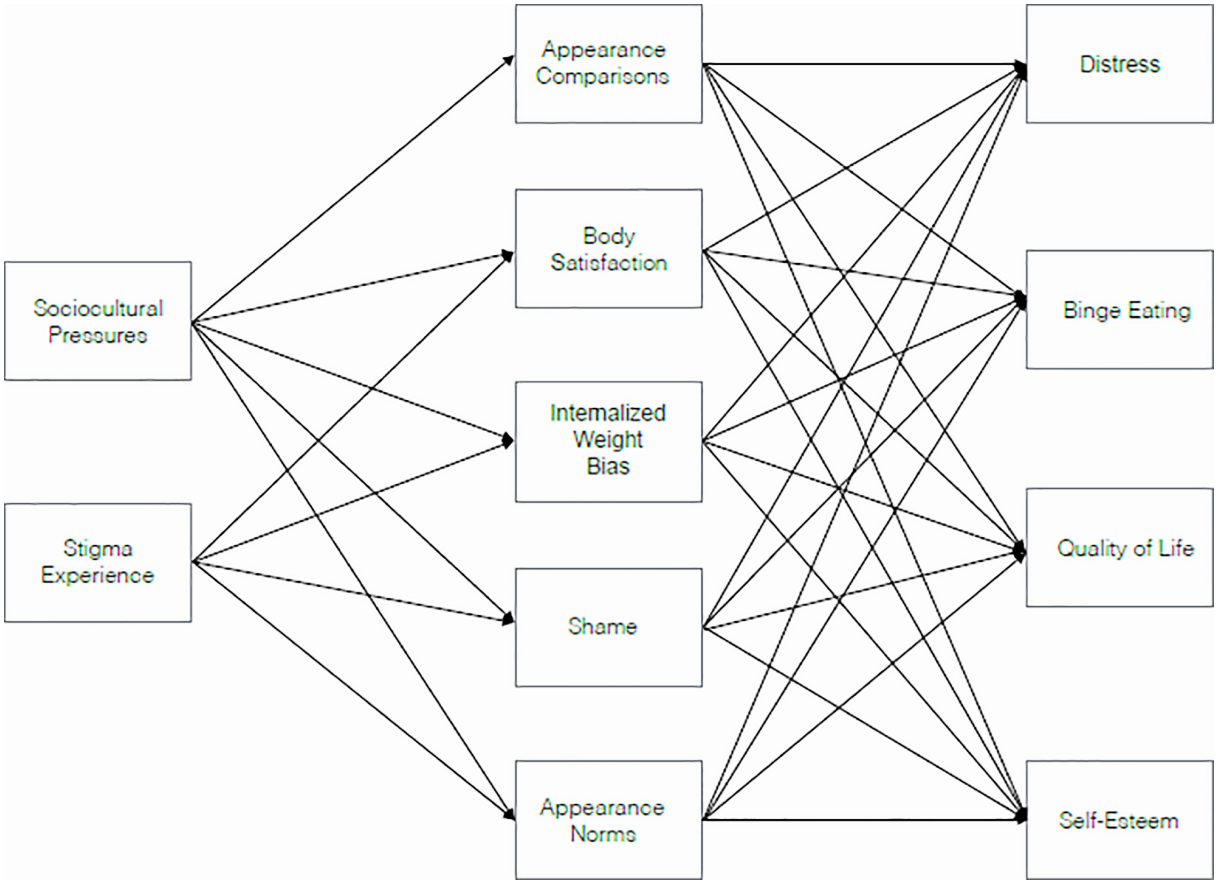

Figure 3.1.1.: https://doi.org/10.1371/journal.pone.0216324 (Lee et al., 2019)

Contributing factors:

Individuals are more likely to experience weight bias internalisation if they are exposed to weight discrimination or 'weight teasing' by others. This constant exposure leads individuals to internally believe the negative stereotypes and fully internalise them. This is supported by a study by Menzel *et al*., (2010), which found a **positive correlation between the amount of weight teasing experienced by participants and the strength**

of their internalised weight bias. This, in turn, leads to declining mental health and an increase in negative beliefs about oneself. It is therefore important to minimise exposure to weight stigma in order to ensure these beliefs do not become internalised.

Another contributing factor to weight bias internalisation is family weight history. Pearl et al., (2018), has explored the relationship between family history and internalisation of weight bias. This study used questionnaires and health data to measure the factors influencing weight bias internalisation. It was found that weight stigmatisation within the family as well as at work contributed to a higher internalisation of weight bias. Therefore, **patients' family history** is an important factor to consider as a source of weight bias internalisation, as well as their **work situation**. Negative weight stereotypes experienced in these settings are likely to lead to internal beliefs within individuals living in large bodies.

A further factor contributing to weight bias internalisation, specifically in adolescents, is the amount of binge eating and eating to cope with distress (Puhl & Himmelstein, 2018). Puhl and Himmelstein found a link between weight bias internalisation and maladaptive eating behaviours, such as eating to cope with stress. These behaviours made the individuals more likely to internalis e negative beliefs about their weight and believe negative weight stereotypes. This study had a further finding, which related to **family weight communication**. It found that when the participants' mothers commented on weight, those adolescents were more likely to internalis e weight bias. This further supports family history and family communication as contributing factors in weight bias internalisation.

Moral dimension of weight bias:

The moral dimension of weight bias is discussed in studies by Hoverd & Sibley (2007), as well as Täuber et al. (2018). These studies present the finding that there is often a moral dimension to weight discourse, in particular a Christian one. For instance, living in a large body is often seen as a sin because of the connection with sins of Laziness and Gluttony. Conversely, behaviours such as exercising and eating healthily are seen as 'pious'. Hoverd & Sibley (2007) also found that this connection between religion and weight was internalis ed in their participants. This means they did not only display these ideas publicly but internally believed that it is sinful to live in a large body. Tauber et al.'s study (2018) also goes on to state that this internalisation is maladaptive. This is because it has a devastating effect on the individual's mental health, especially because they blame themselves for their weight, increasing feelings of self-loathing.

This is important to consider when dealing with patients that use moral discourse to talk about their weight. Noticing references to morality may help to figure out the source of the patient's worries and their reasons for internalising weight bias. It is best to **avoid moral discourse when talking about the patient's weight** because moral

motivation results in maladaptive responses. Tauber et al.'s study (2018) mentions that encouraging patients to adopt healthier habits using moral discourse actually results in a rejection of the desired behaviour. They may comply with the healthier behaviour temporarily, but the internalised belief that living in a large body is sinful will result in unhealthy long-term consequences. It is, therefore, best to avoid moral discourse, and reassure patients that their body weight has nothing to do with any aspects of morality.

Gender differences in weight bias internalisation

A study carried out by Boswell & White (2015) has looked at weight bias internalisation among men and women. It found significant challenges experienced by both groups, in terms of dissatisfaction with body weight/shape and risk of eating disorders. It also discovered that "Although both men and women experience weight stigmatisation and body dissatisfaction, women experience more eating-related psychopathology" (Boswell & White, 2015). This suggests that there is a gender dimension to be considered when dealing with patients experiencing weight bias internalisation, as it may affect men and women differently. Specifically, women are at a higher risk of developing maladaptive behaviours after exposure to weight stigmatisation than men. This study focused on eating behaviours, but it is important to recognise that there may be other key differences between the genders.

So, a **personalised approach** may be required to ensure that patients are given appropriate support. While both men and women are affected by weight bias internalisation, this has different impacts on them. A recognition of the different symptoms in men and women is essential to ensure they are adequately treated. Therefore, when dealing with female individuals living in a large body, who have internalis ed weight bias, it is important to recognise they are at a higher risk of eating-related psychopathology. This would ensure each patient is treated appropriately while recognising individual differences that exist among different genders.

EXTERNAL RESOURCES

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