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Original article

Weight stigma in physiotherapy practice: Patient perceptions of interactions with physiotherapists

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ABSTRACT

Background: Weight management is increasingly considered part of physiotherapists' scope of practice in order to improve patient outcomes by, for example, reducing load on joints, or improving chronic pain. However, interactions with patients involving weight may result in patient perceptions of negative judgement from health professionals, which can result in poorer health outcomes. How physiotherapist/patient interactions involving weight are perceived by patients has not yet been investigated.
Objectives: To explore patients' perceptions of interactions with physiotherapists that involved weight, and investigate how these perceptions may inform physiotherapy practice.
Design: Face-to-face interviews with physiotherapy patients, with follow up interviews conducted by telephone. Data were analysed thematically.
Method: First interviews were held in a physiotherapy practice with follow up interviews conducted two weeks later. Interviews were audio recorded, transcribed and analysed using an inductive thematic method established by Braun and Clarke.
Findings: Thirty interviews with 15 patients were analysed. Four main themes relevant to weight were identified: 1) perceptions of being 'in physiotherapy' including pre-conceptions, the physical environment, and exposing the body, 2) emphasis placed on weight in physiotherapy interactions, 3) communication styles, and 4) judgement perception.
Conclusion: Some patients perceived negative weight judgements from elements of physiotherapy interactions and environments. Physiotherapists need to be aware of this perception because it may result in poorer patient outcomes and patients avoiding physiotherapy appointments. The results suggest strategies to counteract weight stigma include: adjusting the physical environment of the clinic, portraying an understanding of complex determinants of weight, and employing collaborative, non-judgemental communication styles.

1. Introduction

Weight management is increasingly considered part of physiotherapists' scope of practice (Rea et al., 2004; Snodgrass et al., 2014). Messages encouraging integration of weight management into physiotherapy have become fairly commonplace from physiotherapy leaders and in popular physiotherapy forums (e.g., Physiopedia, 2011; Dripps, 2014). Furthermore, as the body is the focus of physiotherapy, weight is likely to be salient regardless of whether weight management is a focus. Body weight is, therefore, likely to be involved in physiotherapy interactions. Whether physiotherapists are helping or harming patients with interactions involving weight has not received much attention. This is important from an ethical standpoint given that physiotherapy codes of conduct include 'do no harm' (Guttman and Salmon, 2004). Physiotherapists likely focus on weight to improve patient outcomes by, for example, reducing the load on joints, or improving chronic pain. However, weight is a sensitive topic and perceptions of weight stigma (negative attitudes towards weight) result in poorer health outcomes (Puhl and King, 2013). Thus, an intervention intended to improve the health of the patient may, if it is perceived as stigmatising, result in harm. Whether patients perceive weight stigma from physiotherapists is, therefore, an important consideration.

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Weight stigma involves negatively stereotyping people perceived to be overweight with characteristics such as laziness, sloppiness, ill-health and lower intelligence (Carr and Friedman, 2005). Weight stigma in the general population has been reported as prevalent (Puhl and Heuer, 2009) and increasing (Andreyeva et al., 2008), and having adverse effects on health (Puhl and King, 2013). A minority view suggests weight stigma or 'fat shaming' may have positive effects on health behaviours (Ogden, 2013), but the contrary has been demonstrated consistently. People who perceive they are recipients of weight stigma avoid health care appointments (Drury and Louis, 2002), exercise less (Vartanian and Shaprow, 2008) and have more disordered eating (Tomiyama, 2014). Weight stigma has been discussed as widespread in society i.e. in media, government policy and within health (Campos et al., 2006; Lupton, 2012). For example, the complex and multifactorial causes of weight are frequently depicted as a simplistic energy imbalance, with causes assigned to individual responsibility (Gard and Wright, 2005; McAllister et al., 2009). This is despite consistent findings, including Cochrane reviews, that dieting is ineffective in reducing weight beyond short-term changes (Norris et al., 2005) and exercise has inconsistent effects on weight (Shaw et al., 2006). A variety of health professionals exhibit weight stigma including doctors (Sabin et al., 2012), nurses (Mulherin et al., 2013), exercise scientists (Chambliss et al., 2004) and dieticians (Stone and Werner, 2012). Sack et al. (2009) reported that physiotherapists had neutral attitudes to people who are obese, despite finding over 50% believed people who are obese were weak-willed, non-compliant and unattractive. These results suggest physiotherapists likewise possess negative stereotypes of overweight people. Setchell et al. (2014) found physiotherapists demonstrated implicit weight stigma in responses to case studies, and explicit (overt) weight stigma in responses to an anti-fat attitudes measure. However, whether weight stigma affects physiotherapist/patient interactions, or is perceived by patients, has not yet been explored.

In other areas of health, weight stigma affects health professional–patient interactions. Overweight male patients perceived poorer quality of care from physicians, including reduced length of consultation (Hebl et al., 2003). Pregnant women with a BMI greater than 30 kg/m^2 reported accusatory responses, a lack of respect and insufficient helpful advice from their general practitioners (Lindhardt et al., 2013). Patients who perceived negative judgement about their weight trusted their health professionals less than those who did not (Gudzune et al., 2014). Moreover, a survey of public opinion regarding language used to discuss weight by doctors found that more negative language resulted in lower patient motivation levels and participants expressing a greater likelihood of changing health care providers (Puhl et al., 2012b). In a study of obese women's experiences of healthcare, Buxton and Snethen (2013) highlighted the importance of respect and communication styles in weight loss discussions.

To date, no studies have investigated how physiotherapy patients perceive weight related interactions. To address this deficit, this study explored the following research questions: How do patients perceive interactions with physiotherapists involving weight? What elements (if any) of physiotherapy interactions do patients perceive as weight stigmatising?

2. Methods and materials

2.1. Design

Physiotherapy patients' experiences were explored using a qualitative semi-structured interview design. Two in-depth, semi-structured interviews were conducted with each participant. A second interview is thought to provoke a reflective or analytical perspective from the participant, while the first focuses more on experiences (Flowers, 2008). Participants responded to open-ended questions about their experience of interactions with physiotherapists involving body weight (Appendix 1). Questions were developed from the findings of Setchell et al.'s (2014) study on weight stigma in physiotherapists and from available literature on weight stigma. However, the presence of weight stigma was not assumed. Interviews were piloted on two participants resulting in minor alterations to the question guide. Two experts in the field of weight, whose professional roles include investigating implications of negative judgements about weight from health professionals, were engaged as consultants. They provided feedback on design and analysis from the perspective of those who have been stigmatised for their weight (Louis and Bartunek, 1992). *A priori* rigour and quality procedures were established based on consolidated criteria for reporting qualitative research (COREQ: Tong et al., 2007). Ethics approval was obtained from the institutional ethics committee and all participants provided informed consent.

2.2. Participants

Participants were current Brisbane, Australia residents who had been patients of physiotherapists. Recruitment was via posting on 'community noticeboards', including Facebook and Twitter, and notices at shopping areas or workplaces within a 10 km radius of the first interview location. Although the sampling strategy was a convenience sample, the researchers intentionally recruited in environments with potential participants who varied in socio-economic status, ethnicity, gender and age. The number of participants was determined as the study progressed, when saturation was reached (i.e., when few new topics were being discussed, and themes had sufficient data for analysis). Data were analysed following each interview in an iterative process during recruitment.

Data saturation was reached with 15 participants (30 interviews). Forty-one people responded to broad recruitment strategies inviting participants to discuss their experiences as a physiotherapy patient. All were contacted by telephone and asked whether they had experienced interactions involving weight in a physiotherapy context. The researcher clarified, if needed, that weight experiences could be neutral, positive or negative, could be about being any body size, and about the patient's body, the physiotherapist's body or someone else's. There was no restriction on when this experience occurred as patient perceptions, rather than actual experiences, were the research focus. For ethical reasons persons were not considered if they had been a patient of the first author or had attended the physiotherapy practice used to conduct interviews. Twenty six people were excluded because they had either not had experiences involving weight in a physiotherapy context (19), attended the practice where the interviews were being conducted (2), were unable to attend interviews (1), had never attended physiotherapy (2), or did not respond to follow up contact (2).

2.3. Procedure

The first author who conducted the interviews was trained in qualitative interviewing. The first interview was face-to-face and 'situated' in a private physiotherapy clinic. A 'situated' interview (conducted in an environment that is similar to where the experiences being discussed had occurred) was chosen to facilitate access to memories of previous physiotherapy experiences (Carpiano, 2009). Demographic information was gathered and a debrief sheet provided after the first interview. The interviewer took field notes in a reflexive diary following each interview. Participants received a diary after the first interview to facilitate reflection on the topics