ORIGINAL RESEARCH

Women Weigh In: Obese African American and White Women's Perspectives on Physicians' Roles in Weight Management

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Background: **There is little qualitative research on the type of weight loss counseling patients prefer from their physicians and whether preferences differ by race.**

Methods: **This qualitative study used semistructured, in-depth interviews of 33 moderately to severely obese white and African American women to elucidate and compare their perceptions regarding their primary care physician's approach to weight loss counseling. Data were analyzed using a grounded theory approach and a series of immersion/crystallization cycles.**

Results: **White and African American women seemed to internalize weight stigma differently. African American participants spoke about their pride and positive body image, whereas white women more frequently expressed self-deprecation and feelings of depression. Despite these differences, both groups of women desired similar physician interactions and weight management counseling, including (1) giving specific weight loss advice and individualized plans for weight management; (2) addressing weight in an empathetic, compassionate, nonjudgmental, and respectful manner; and (3) providing encouragement to foster self-motivation for weight loss.**

Conclusion: **While both African American and white women desired specific strategies from physicians in weight management, some white women may first need assistance in overcoming their stigma, depression, and low self-esteem before attempting weight loss. (J Am Board Fam Med 2013;26: 421–428.)**

Keywords: **Obesity, Physician-Patient Relations, Primary Health Care**

Obesity, defined as a body mass index [BMI] ≥30 kg/m^2, affects 36% of the US adult population, with the highest prevalence in African American (AA) women (58.6%).[1] Obesity increases the risk of many chronic illnesses, including heart disease, hypertension, diabetes, stroke, arthritis, and cancer.[2]

The US Preventive Services Task Force recommends that physicians screen all patients for obesity and offer or refer obese patients to intensive multicomponent behavioral interventions.[3,4] However, many obese patients do not receive an obesity diagnosis or weight-related counseling from their

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physician.[5–8] Previous research has identified inadequate physician training, negative attitudes toward obese patients, inadequate reimbursement, and perceived futility of potential conversations as reasons for physicians failing to provide weight-related counseling to their patients.[5,6,9] Little research has explored patient perceptions of physician efforts at addressing weight management.

Cultural differences in attitudes toward obesity among white and AA women may affect their desires and expectations regarding physician interactions and counseling strategies in the management of weight loss. Compared with obese white women, obese AA women tend to perceive their weight as lower than it actually is[10–13] and have more satisfaction with and acceptance of a larger body size.[10,14,15] While AA women are more likely than white women to use medically supervised programs[16] and to desire one-on-one counseling with their primary care physician,[17] little is known about whether desires for specific physician interactions and counseling differ by race. We sought to elucidate and compare the desires and expectations of moderately to severely obese white and AA female patients' regarding their physician's role in the management of weight loss. An enhanced understanding of the patient's view will help to foster improved patient-physician interactions regarding weight management.

Methods and Procedures

Study Sample

Data came from semistructured in-depth interviews, conducted between March 2009 and August 2010 in New Jersey, of 33 white and AA women, all of whom were enrolled in a parent qualitative study focusing on barriers to breast and cervical cancer screening among obese women.[18] Participants were recruited through flyers placed in community-based organizations, health clinics, and retail establishments. The parent study purposively recruited women between 40 and 74 years old and moderately to severely obese (BMI >35). To simplify recruitment procedures, a cutoff weight of 220 pounds was used to establish eligibility. This weight corresponded to the lower limit of moderate obesity (BMI at least 35) for a height of 67 inches (90th percentile of height among women in a similar sample).[19] We excluded women who did not speak English, were pregnant, had a history of breast or cervical cancer, and who did not have an established source of care. All participants received $30 as cash or a gift card after completing the interview. The institutional review board of the University of Medicine and Dentistry of New Jersey approved the study protocol, and all women provided informed consent.

Data Collection

Two trained qualitative interviewers conducted interviews by telephone or in person. Questions for the parent study followed an interview guide that was informed by the theory of care-seeking behavior[20,21] and modified after pretesting with 3 focus groups of obese women (n = 18). While the parent study focused on barriers to breast and cervical cancer screening, we also asked questions regarding participants' health care experiences related to weight and their perceptions of physicians' roles in weight management. These included the following: How do you feel about your weight? What has your doctor advised you about your weight? What have you done to try to lose weight? How can doctors better help you to lose weight? How has your weight affected your interactions with doctors, nurses, and other staff? and What can be done to make getting health care more pleasant for overweight women? The analytic process included these issues while the study was ongoing.

Interviews lasted 60 to 90 minutes and were digitally recorded, transcribed verbatim, and deidentified. Recruitment and interviews continued until data saturation was achieved, that is, when no new information was emerging. Transcripts were imported into ATLAS.ti (Atlas.ti Scientific Software Development GmbH, Berlin, Germany) for coding and analysis.

Data Analysis

We used a grounded theory approach with a series of immersion/crystallization cycles to qualitatively analyze our data.[22] In this iterative process, we immersed ourselves in the data through cycles of reading and reflection, recording insights and emerging themes, until interpretations became evident and crystallized. We initially read transcripts together to understand the subject matter and to develop a set of preliminary codes. Joint analysis continued until we agreed on coding schemes. The remaining data then were analyzed individually, with research team members meeting regularly to resolve

coding differences and refine coding schemes as needed. All transcripts were independently coded by at least 2 members of the research team, and any coding differences were resolved through group consensus. Next, quotes within codes were re-read and analyzed in a second immersion/crystallization cycle, and emerging themes and interpretations were compared and contrasted within and between white and AA women. A third immersion/crystallization cycle was used to refine themes and identify negative or disconfirming evidence for emerging themes. The quotations presented here best depict and exemplify our key findings.

Results

Table 1 describes our study population of 18 white and 15 AA women. The presentation of our results is organized around 4 themes that emerged from our analysis.

Theme 1: Differences in Self-Esteem and Body Image

Cultural differences regarding body image and self-esteem were confirmed in our results. AA women we interviewed spoke more about pride and a positive body image.

Table 1. Characteristics of Participants*

Characteristics	Total (N = 33)	White (n = 18)	African American (n = 15)
Age (years)			
40–50	10	3	7
51–60	11	7	4
≥61	12	6	6
Weight (pounds)			
200–249	15	7	8
250–299	11	5	6
≥300	7	4	3
Employment			
Employed	11	5	6
Unemployed	10	7	3
Retired/disabled	12	6	6
Marital status			
Married	8	6	2
Single	9	4	5
Divorced/widowed	12	6	6
Education			
High school or less	10	6	4
College	12	7	5
Postgraduate	6	4	2

*Numbers may not add to total because of missing data.

"I dress nice. I smell good. And that's the main thing. But you know it's your appearance. You know because you a big person–some full-figured women, they don't care how they look when they walk out. You know when I step out, I want to look good when I step out. Because I am a full-figured woman, so you want to take a little bit of extra care than maybe a skinny person. Because people [are] going to notice you; they going to look at you and something. You don't have confidence and you don't love you, then you don't care. But when you love you, you know you going to do what you have to do." (Age 45, AA, 350 lb)

These participants sometimes attributed their personal self-respect to their family values and upbringing.

"My mother was 5′ 5″, and when she died she weighed 250 . . . . But Mom always felt that you know what? If I'm not doing nothing to help myself, why get mad if somebody talks about me? And I've felt that way. If I'm not trying to lose this weight, why get mad if somebody says something about it?" (Age 64, AA, 360 lb)

"You know I come from a family of full-figured women . . . my aunties and stuff, they were well-dressed, church-going ladies. And no matter where they go, they could go to the corner store, they always be dressed." (Age 45, AA, 350 lb)

Conversely, white participants often described low self-esteem and poor body image concerning their weight.

"How do I feel? Depressed, angry, sad, very ashamed. Um . . . I crack jokes about it, you know, and I say to my friend, 'Well, because I'm a fatty, I don't know if they're gonna let me on the rides,' or 'Because I'm a fatty . . . '" (Age 47, white, 290 lb)

"I'd like to be able to fit into something. When you get dressed up and you're a big cow . . . . When I looked at those pictures after the wedding, I looked like a big whale in a mauve dress." (Age 71, white, 265 lb)

Despite these cultural differences regarding body image and self-esteem, women's desires and expectations regarding physician interactions and counseling strategies in the management of weight loss were similar among white and AA participants, as described by our other themes.

Theme 2: Patients Desired Specific Weight Loss Advice and Individualized Plans for Weight Management

Both AA and white participants expressed a desire for specific advice and personalized weight management plans. When women received generalized

and nonspecific weight loss advice from their physician, they equated this with lack of concern, attention, and support.

"[They just say] you need to lose weight and you should do it in a healthy way—duh! . . . They did say something about seeing a nutritionist, but then if you are, as I am, unemployed and I don't have money coming in to see a nutritionist . . . I'm on my own." (Age 57, white, 220 lb)

Subjects mentioned frequent weight monitoring, graphic charting, specific dietary inquiry and recommendations, and providing reference materials and resources as forms of individualized plans that they wanted from their physician.

"Have your chart where they're graphing your weight . . . . I could go there 3 times a [week] and get weighed and have my weight on a chart because that will force me to deal with it . . . . It's drawing your attention to it. If you're losing, it's an immediate positive feedback and that gives you the energy to get past the hunger . . . . You do a diet history . . . you have a doctor checking what you eat all the time so that they can make specific recommendations about your food, that would help." (Age 59, AA, 240 lb)

"But there's never been any kind of handout that they could say—which might be helpful thing for a doctor's office to say, 'You can look at . . . XYZ online.' Or there may be, iVillage or whatever, to give you . . . a guideline that you could follow. And that, I think would be something that would be helpful for a doctor to have. It would be less threatening . . . . A doctor could say, 'I have this information, and you can access it when you're at home or at the library, and these are some sources which could be really supportive.' Right, a guideline, reference materials, resources . . . there's a lot of people who just don't know how to do it or don't have the handout. And it would be nice if, ideally there was a way to have that handout." (Age 56, white, 228 lb)

Theme 3: Physician Qualities That Patients View as Promoting a Positive Patient-Physician Interaction When Discussing Weight

Both AA and white participants indicated that they were more likely to have favorable weight-related interactions with physicians who possessed certain qualities, such as being empathetic, sensitive, respectful, trustworthy, compassionate, nonjudgmental, encouraging, honest, and comforting.

"I think just to be caring and understanding because being overweight is a disease also and I just think that if they care, show some compassion for people and really go out of their way to try to make them comfortable 'cause they're already uncomfortable with the way that they're, you know, that they feel, they're already uncomfortable about it. So if they were to show some compassion and caring toward people that are overweight, I think that might be a good thing. That would be helpful." (Age 55, AA, 300 lb)

"I think that what would be important is that they listen, because you feel like they don't listen. And I think instead of grouping us all together, I think if they listened and respected you as an individual instead of lumping fat women together . . . . You should be more interested in hearing me say, 'I've tried A, B, C, and D. How do we get to G, F, H, I, J?' So I think they could be more suggestive, more positive in attitude, more patient, more attentive." (Age 47, white, 290 lb)

In addition to tactful communication, participants described the importance of having a positive bedside manner.

"Just the tone of their voice. Just have that caring attitude, the approach that they use toward you, you know, that you're not someone with a plague or something. Just, you know, just to see a caring smiling face sometimes is, you know, is good enough when it comes down to how you approach people so it doesn't have to be, you know, with an attitude or just being nasty for no reason. People have all kinds of illnesses. Obesity is one of them." (Age 55, AA, 300 lb)

"So, you're on the receiving end of factual comments that are—the intonation is disapproving . . . . It's, in most of the cases, it's not what you say, it's how you say it." (Age 56, white, 220 lb)

Furthermore, many participants suggested that "sensitivity training" would improve physician and staff interactions with patients, not only during a discussion about weight, but across all interactions.

"Specifically, [they] really need training on how to be polite to their patients. You really need to be educated." (Age 58, white, 228 lb)

"Educating the doctors . . . . Education, educate the doctors how we feel. Do a video letting them—look, this is the way that we feel. I'm a full-figured woman, but I have feelings. I care. I want you to care. I want you to use common sense, you know and don't always put it on our weight." (Age 45, AA, 350 lb)

Theme 4: Self-Motivation for Weight Loss and Role of Physician in Fostering Motivation

AA and white participants agreed that the desire and willingness to lose weight largely depended on self-motivation.

"You need to tell yourself. A person who wants to lose weight has to be the one to lose the weight." (Age 66, AA, 250 lb)

"No, they can't do it. I have to do it. I have to want to do it. They can't help me. Nobody can help me. The same thing with smoking. Nobody can stop me until I want to stop." (Age 67, white, 240 lb)

However, they noted the need for added encouragement from their physician to help foster their own self-motivation.

"At least bring it up once in a while. 'How are you doing with it?' I mean, they obviously have me—they weigh the patients every time you go in, and so they've got that number. You could comment about it, and even if you had lost a few pounds, say something about it. Try to be encouraging. But at least ask if you need help or if you want help. That in itself would be a big opening." (Age 49, white, 220 lb)

Discussion

This is the first qualitative study to examine whether cultural differences in perceptions of weight between obese white and AA women affect their desires and expectations regarding specific physician interactions and counseling strategies in the management of weight loss. While we found cultural differences regarding body image and self-esteem, both white and AA women desired similar physician interactions and weight loss counseling techniques.

Both obese white and AA women recognized that the willingness to lose weight was largely dependent on self-motivation, but they also wanted their physician to foster this motivation by providing encouragement. It has been found that patients with increased levels of self-motivation are more likely to receive higher levels of physician counseling.[23,24] Unfortunately, when compared with the patients themselves, physicians tend to perceive a lower motivation level relating to patients' desire to lose weight.[25] These mismatched patient and physician perceptions may hinder the supportive interaction our respondents desire. Physicians should be encouraged to provide support to all obese patients and use strategies such as the 5 As framework (**A**ssess risk/current behavior/readiness to change, **A**dvise change of specific behaviors, **A**gree and collaboratively set goals, **A**ssist in addressing barriers and securing support, **A**rrange for follow up) because it is associated with higher patient motivation and higher amount of weight loss.[23,24] Recent changes in Medicare reimbursement guidelines now allow payment for physicians doing intensive weight loss counseling if they document the use of the 5 As approach.[26] This policy change has the potential to increase both the willingness of physicians to raise weight issues with their patients and the effectiveness of their efforts using an evidence-based approach to counseling.

Both obese AA and white women desired specific and personalized plans from their physician when addressing weight. Moreover, our study found that when women equated generic weight loss advice from their physician with lack of concern, attention, and support. Past studies also found that patients prefer an individualized approach rather than having a discussion on the health consequences of obesity.[7,27] Overweight and obese patients who were told of their current weight status and were provided with direct weight loss advice by their physician had more realistic perceptions of their own weight, a desire to lose weight, and a higher likelihood of consuming fewer calories and using exercise to lose weight.[6,28] In an attempt to provide physicians with strategies for the office-based management of obesity, it has been suggested that the physician and patient agree on a plan, come up with reasonable goals to change behaviors, and arrange for follow-up of progress.[29] Integrating individual patient opinions and desires into recommendations are beneficial; for example, individuals are more likely to adhere to exercise activities when they self-select the activity.[30] These approaches are essential elements of counseling incorporating motivational interviewing techniques, which can make weight loss counseling more effective.[31] Motivational interviewing techniques, which are compatible with a 5 As counseling format, emphasize affirming patients' efforts by eliciting their own personal motivations for losing weight and tailoring the goal-setting and plans to the patients' preferences.

Both groups of women also indicated that they were more likely to have favorable interactions when discussing weight with physicians who were empathetic, sensitive, respectful, trustworthy, compassionate, nonjudgmental, encouraging, honest, and comforting. Furthermore, many participants in our study directly suggested that "sensitivity training" would improve physicians' interactions with patients, not only during a discussion about weight,

but across all interactions. Past studies have demonstrated that many health professionals hold negative views toward obese patients, characterizing them as lacking self-control, discipline, willpower, motivation to lose weight, or all of these.[9,32,33] In addition, a higher BMI in patients has been associated with lower respect from the physician toward the patient.[34] These negative attitudes affect health care delivery, as evidenced by health care providers spending less time in appointments and providing less health education to obese patients compared with thinner patients.[35,36] A resource for sensitivity training is "Weight Bias in Health Care," a 17-minute video produced by the Yale Rudd Center for Food Policy and Obesity (available at http://www.yaleruddcenter.org/what_we_do.aspx?id=10). The video challenges existing weight-based stereotypes, attempts to induce empathy toward obese patients, and provides strategies for bias-free health care practices. Improving physicians' attitudes and behaviors toward obese patients may help to enhance patient-provider interactions and foster obese patients' motivation to lose weight.

It seems that white women in our study internalized weight stigma more than AA women. AA women displayed more self-confidence and a more positive body image, whereas white participants often expressed low self-esteem and depression concerning their weight. Most participants didn't use the term *obesity* when describing themselves. AA women more often used adjectives such as *thick*, *heavy*, *big boned*, *big*, and *full-figured*, while some white women referred to themselves as *fatty* and identified themselves using derogatory terms such as *cow*, *whale*, and *elephant*. Our study identified a possible reason for the difference in self-esteem and body image among obese white and AA women. AA participants mostly attributed their personal self-respect to their family values and identification with other female family members who were overweight or obese. To our knowledge, no research has reported racial differences in the internalization of weight stigma. This exploratory study raises this issue as a potential area for further study. While both AA and white women desired specific strategies from physicians in weight management, some white women may first need assistance in overcoming their stigma, depression, and low self-esteem before attempting weight loss. For example, teaching mindfulness and acceptance targeting obesity-related stigma and psychological distress has been shown to improve quality of life and weight loss efforts among white women.[37] More research is needed to elaborate the differences in perception of weight stigma among white versus AA women and the role this may play when providing weight loss counseling.

This study has limited generalizability. As a qualitative study it was not designed to produce generalizable findings but to probe in depth into participants' feelings and perspectives. Although geographically limited to the state of New Jersey, participants were recruited from the community and from diverse backgrounds. In addition, the age of the subjects was limited to 40 to 74 years old, but the prevalence of obesity is highest among middle-aged women.[1] In addition, this study included only moderate to severely obese women, and women with a BMI of 25 to 35 may be more likely to be missed by physicians as needing weight loss counseling.

Conclusion

We found that both white and AA women desire specific weight loss advice and individualized plans for weight management given by physicians in an empathetic, compassionate, respectful, and nonjudgmental manner. While white and AA women seemed to internalize weight stigma differently, both groups recognized the need for self-motivation and encouragement from their physician to successfully lose weight. Understanding these themes will help to foster improved patient-physician interactions regarding weight management.

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