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**Nursing Students' and Recent Graduates' Observations of Fatphobia in the Clinical
Setting**

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Honors Thesis

Abstract

Objectives: To investigate the incidence of fatphobic behaviors among the healthcare team and how nursing students' and recent graduates' observations of fatphobic behaviors impact the provision of affirming care.

Background: Weight stigma among healthcare providers can lead to fatphobia (e.g., hurtful or stigmatizing language, dismissal of symptoms). These experiences can negatively impact patients' health and experiences with healthcare, leading some patients to avoid or delay seeking healthcare services. Fatphobia can also cause increased stress levels among patients, which places them at a higher risk of several diseases. The short-term and long-term effects of fatphobia lead overall worse health outcomes.

Methods: A mixed-methods approach was used to develop a survey and distribute among undergraduate nursing students and recent graduates. Data collected included demographics, a Fat Phobia Scale, and both quantitative and qualitative questions about instances of observed fatphobia.

Results: Participants ($N=67$) reported engaging in fatphobic behaviors themselves ($n=20$, 30%) and observing fatphobic behavior by their clinical instructor ($n=14$, 21%), nurse ($n=23$, 34%), and provider ($n=20$, 30%) engage in at least one fatphobic behavior. Participants also reported that others' engagement in these behaviors makes it more difficult for them to provide affirming care ($n=21$, 31%).

Conclusions: Nursing students and new graduates are observing multiple roles engage in multiple types of fatphobic behavior, which is making it more challenging for them to provide affirming care. Further research is needed on methods of reducing weight bias in healthcare.

Introduction

Fatphobia Among Healthcare Providers

In the United States, 41.9% of adults are considered obese (CDC, 2022). Many of these individuals receive healthcare from providers who hold weight bias. Literature has shown that healthcare workers of multiple professions possess weight bias, including nurses, physicians, dietitians, and occupational therapists (Lawrence et al., 2021). Nursing students, in particular, may be unaware of the bias they hold. A study conducted on unconscious weight bias among nursing students surveyed students' predictions about whether they would have weight bias before taking an implicit association test, a test that examines negative attitudes one has in association with images of people in larger bodies (George et al., 2019). When asked, 81% of nursing students predicted they would have no weight bias at all, however, the results of the test showed 91% of the students in the study had weight bias. This indicates a huge gap in awareness about personal bias towards people of a larger size among nursing students.

Impacts of Fatphobia on Patients

Studies have shown that fatphobia, as well as “felt stigma” (experienced fatphobia) are associated with negative patient outcomes (Phelan et al., 2015; Udo et al., 2016). Because the patient is in a larger body, the health care provider who carries weight bias may assign stereotypes to the patient which in turn affects the provider's decision-making. One example of weight bias is a provider assuming a patient's presenting symptoms are a direct result of their weight and not investigating further to find other underlying causes. These experiences also impact patients' decision-making and internalization of fatphobia. When the patient enters the room, for instance, and sees only blood pressure cuffs which are too small to fit, they may experience stress in anticipation of an uncomfortable interaction. They may also have previous

experiences of symptoms being dismissed or not believed, leading to mistrust of their provider. In the short-term, this can interfere with their ability to retain and recall information from the visit, leading to decreased treatment compliance when they leave. In the long-term, the cumulative stress exposure associated with felt stigma and avoidance of care due to fear of poor treatment in healthcare can lead to long-term physiological effects. These include heart disease, arteriosclerosis, stroke, diabetes, depression, and anxiety (Udo et al., 2016).

Social Learning Theory

Bandura's Social Learning Theory provides some insight into how these fatphobic behaviors are being perpetuated in healthcare (Mcleod, 2023). This theory explains that an individual's cognitive factors (e.g., personal experiences, education) and situational factors (e.g., peers' and coworkers' behaviors and the consequences of those behaviors) influence the individual's behavior. Nursing students come primed by cognitive factors when they arrive at their clinical experiences. However, even if they are educated on evidence-based practice recommendations related to caring for people in larger bodies, their behavior can still be influenced by situational factors. For instance, if a nurse on the unit engages in a fatphobic behavior and that behavior is not rejected by those around them, the student is receiving social signals that this behavior is normal and tolerated, which may increase the student's engagement in this behavior. With time and repetition, this social influence can overpower the student's cognitive factors and become the student's normal behavior. On a larger scale among healthcare professionals, social influence can contribute to the negative patient outcomes being documented.

Objectives

The aim of this study is to investigate the incidence of fatphobic behaviors among the healthcare team and how nursing students' and recent graduates' observations of fatphobic behaviors impact the provision of affirming care.

Methods

Study Methodology

This cross-sectional study was distributed via Qualtrics online survey, between February and March of 2023. The study was approved by the institutional review board (IRB) of a public university in the northeast United States (IRB Number IRB-FY2023-104). Inclusion criteria for participants in the study included being: currently enrolled in a pre-licensure nursing program who have completed at least one semester of clinical experience or a recent graduate having been a registered nurse (RN) for less than two years, over the age of 18, and able to read and respond to questions in English. Consent was obtained at the beginning of the survey where participants were provided the document and could indicate whether they consent to participate. Individuals who answered "yes" were directed to the rest of the survey while "no" answers closed out of the survey. Participants were incentivized to complete the survey by entering a raffle for a \$50 gift-card.

Instruments

Quantitative Data Collection

The data collection tool was a 45-question mixed-methods survey which was distributed via social media. Demographics questions included age category, gender, race, ethnicity, household income, self-perception of body size, and possessing a friend or family member of a

larger size. Participants were given a list of fatphobic behaviors and asked to select which behaviors had been done by themselves, their clinical instructor, a nurse or nursing assistant, and a provider. Answer choices were: sharing a patient's weight with others to whom it was not directly relevant, using derogatory terms or slurs to describe a patient, making judgmental comments about a patient's habits, blaming a patient's medical or psychological condition on their weight, assigning personal blame to a patient for their body size, laughing about a patient's weight or ability, making comments about a patient's appearance to or in front of a patient, making excessive comments about difficulty transferring or moving patients, blaming a patient for difficulty moving or transferring, and suggesting weight loss as a solution for an unrelated medical problem. Participants were also asked whether they felt the fatphobic events they observed or clinical in general had an impact on their ability to provide affirming care or their feelings about caring for people of a larger size using a 5-point Likert scale ranging from "strongly disagree" to "strongly agree."

Fat Phobia Scale

The Fat Phobia Scale was utilized to measure participants' fatphobic attitudes and beliefs. The original form of this scale, which had 50 items, has been shortened to a 14-item scale (Bacon et al., 2001). The short form was found to demonstrate "excellent reliability" and strongly correlated with its 50-item counterpart. The short form was utilized in the survey and consisted of 14 pairs of terms used to describe fat individuals. The participants were asked to score fat individuals on a scale of 1 to 5 based on pairs of adjectives with opposite meaning. For instance, 1 meant "fast," and 5 meant "slow." Some items require reverse scoring so that a higher average score indicates more stigma. Once the necessary scores have been reversed, the total score is added and divided by 14, or the total number of items, to give a mean score. If the score

is less than 2.5, then the individual is considered to have positive attitudes towards fat individuals, but if the score is greater than 2.5, the individual is considered to possess negative attitudes towards fat individuals.

Qualitative Data Collection

Qualitative questions asked participants to expand on any of the fatphobic behaviors they observed. Prompts included, “Please describe one or more scenarios that describe an experience you checked off above,” in reference to the fatphobia observations, “Please describe why or provide a story about an experience that represents your discomfort caring for patients of a larger size,” and “Please elaborate on how clinical has impacted your feelings about caring for patients of a larger size.” Open text response boxes were provided for each question

Analysis

Descriptive statistics of the quantitative findings were analyzed for preliminary findings of this study. Thematic analysis was conducted on the qualitative responses. Participant responses were analyzed and categorized based on common themes using inductive coding methods. Two authors collaborated on coding of qualitative themes. Representative quotes were selected to illustrate the critical themes for each prompt.

Results

Demographics

67 participants were included in this study. The demographic information of those who responded is included in Table 1. The majority of respondents were female ($n=62$, 94%), white ($n=***$, ***%), non-Hispanic ($n=***$, ***%), students ($n=57$, 86%), and self-identify as an average weight ($n=49$, 78%).

Table 1. Participant demographic results

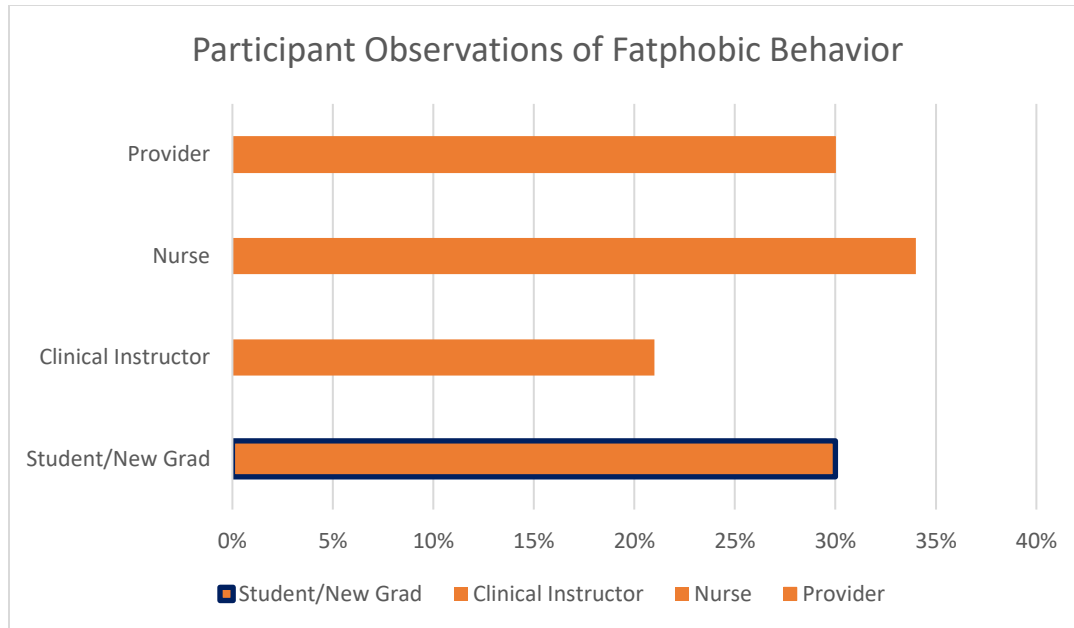
Demographic Variable	Answer Options	Frequency	Percent
Total Sample		67	
Gender Identity	Man	3	4.55
	Woman	62	93.94
	Not Listed	1	1.52
Race	White	65	97.01
	Other Races	2	2.99
Status	Student	57	86.36
	New Graduate	9	13.64
State	New Hampshire	57	85.07
	Other States	10	14.93
Body Size	Underweight	1	1.59
	Average	49	77.78
	Overweight	12	19.05
	Significantly Overweight	1	1.59

Quantitative Findings

Figure 1 represents the quantitative findings of observed fatphobia. The bottom bar shows that of the participants, 30% ($n=20$) self-reported engaging in at least one of the fatphobic behaviors listed. The top three bars show the percentage of participants who reported observing that type of person engage in at least one fatphobic behavior. For instance, 21% ($n=14$) observed their clinical instructor, 34% ($n=23$) observed a nurse or nursing assistant, and 30% ($n=20$)

observed a provider on the unit. Additionally, 31% ($n=21$) of participants either “agree” or “strongly agree” that these events have made it considerably more difficult for them to provide affirming care.

Figure 1. Percentage of participants who observed certain roles engage in fatphobic behavior



From the list of fatphobic events in the quantitative section of the survey, the most prolific was blaming a patient’s medical or psychological condition on their body size ($n=15$, 22%). Following this was making judgmental comments about a patient’s habits ($n=12$, 18%), making excessive comments about difficulty transferring or moving patients ($n=12$, 18%), sharing a patient’s weight with others to whom it was not directly relevant ($n=11$, 16%), assigning personal blame to a patient for their body size ($n=7$, 11%), blaming a patient for difficulty moving or transferring ($n=6$, 9%), and using derogatory terms or slurs to describe a patient ($n=3$, 4%). Laughing about a patient’s weight or ability, making comments about a

patient's appearance to or in front of the patient, and suggesting weight loss as a solution for an unrelated medical problem were not reported by participants.

Qualitative Themes

Observations of Fatphobia

In responses asking participants to elaborate on the fatphobic events they reported in the qualitative questions, themes were identified. These include disrespectful language and actions ($n=8$) and weight loss suggestions ($n=5$).

Disrespectful Language and Actions. Several responses reported observing derogatory language being used towards patients in larger bodies, both in front of the patient and in conversations with coworkers. A response reporting derogatory language states, "One nurse said a patient was better off dead because of her weight," while another observed,

"I have heard people make derogatory terms toward larger patients. These conversations are often not shut down from the surrounding people."

Both responses illustrate that staff are making derogatory comments about the patient's weight in front of students, though the second also reports that bystanders often do not intervene when these comments are made.

This theme also encompasses actions done to the patient which violate ethical principles such as autonomy and dignity, including, "One of the nurses complained openly and in front of the [patient] that the [patient] was difficult to move/turn, ripped open their briefs and provided no privacy." This theme included responses with reports of more overt fatphobia, compared to others which were more subtle.

Weight Loss Suggestions. Another identified theme was weight loss suggestions made to the patient when they were not directly relevant. One response illustrating this was, "A

behavioral health nurse suggested a patient should ‘just lose weight’ if she no longer wanted to be depressed.” Other responses reported staff suggesting patients should “try harder” or “just [...] go to the gym.” The responses illustrate a sense of perceived ease by the person making the comment, as though the patient could lose weight if they tried to.

Discomfort Caring for Larger Patients

In response to the statement, “Please describe why or provide a story about an experience that represents your discomfort caring for patients of a larger size,” several themes were identified. The three critical themes include emotional distress ($n=7$), fear of injury ($n=4$), and lack of support ($n=4$).

Emotional Distress. Several participants identified that caring for patients in larger bodies causes them emotional distress. This ranged from added stress to discomfort in interactions with patients. One response in particular states, “I get uncomfortable when the patient makes derogatory comments about themselves or makes a reference to my own size.” This participant is expressing discomfort related to the patient’s self-deprecating comments, which are likely a result of internalized fatphobia, as well as comments related to the participant’s body, which they feel adds to their discomfort caring for people in larger bodies.

Fear of Injury & Lack of Support. Several responses identified that their discomfort caring for people in larger bodies is rooted in a fear of injuring themselves, including,

“Sometimes I feel uncomfortable because I am afraid I will hurt my back assisting patients with [activities of daily living]. I know I should seek assistance from other [co-workers], but we are often too short-staffed.”

Most pointed to concerns of injury transferring patients and lacking knowledge and training on proper body mechanics to avoid injury. Of these responses, 75% also indicated a lack of support such as staff, safe protocols, and equipment.

Impact of Clinical Experiences

The third qualitative question asks participants to elaborate on how clinical has impacted feelings about caring for patients of a larger size. Of these responses, ten report clinical having no impact, eight report it having a negative impact, and one reports having a positive impact.

Negative Impact. One participant who feels clinical experiences have had a negative impact on their feelings about caring for patients of a larger size reports,

“I feel that others’ negativity about caring for patients makes me have feelings of dread for also caring for them. They describe it as being such a negative experience, so I also start to view it that way.”

Other responses indicated negative experiences with the patients themselves, including feeling as though certain patients were not putting in effort to help with transfers, making the participant less inclined to want to help them.

Discussion

These findings are consistent with previous literature that nursing students both possess bias (Gormley & Melby, 2020; George et al., 2019) and are observing fatphobia (Oliver, 2020). However, this is the first study to explore which roles on the healthcare team are engaging in which kinds of fatphobic behaviors and how nursing students’ and new graduates’ observations of these behaviors are impacting their ability to provide affirming care.

These results illustrate that both educators and experts are engaging in multiple types of fatphobic behaviors in front of students who are at clinical to learn how to act as a nurse. Both the quantitative data and qualitative themes demonstrate numerous members of the healthcare team engaging in various types of fatphobic behaviors. This reinforces the idea that these behaviors are a social norm in healthcare settings. As discussed, these situational factors can override education students may have received on evidence-based care and influence students to engage in these behaviors themselves, which nearly a third self-reported doing.

The qualitative themes identified illustrate that students are experiencing emotional distress, fear of injury, and lack of support caring for people in larger bodies. Overall, a significant proportion of participants report that clinical experiences, which should be preparing them for caring for patients as nurses, are having a negative impact on their feelings caring for people in larger bodies and their abilities to provide affirming care. Participants report that others' engagement in fatphobic behaviors makes them less capable of providing evidence-based care to this population. This suggests that a portion of those who self-reported engaging in fatphobic behaviors as students and new graduates may not have engaged in those behaviors without observing others engage in them.

Limitations

This study was limited by the small convenience sample primarily in the New Hampshire area. The demographics results of this study show that the sample was not representative of the general population of the United States. Further studies are necessary to identify results in different geographical locations, as well as with more variation in demographics information such as gender identity, race, ethnicity, and body size. Participants were also not required to fill

out each question of the survey, which may have led to under-reporting of certain measures. For instance, those who chose not to answer the question asking them to report which type of individual they witnessed engaging in fatphobic behaviors were included in the results as reporting that they had not observed that type of behavior. This was evident in that none of the participants selected the box indicating they had observed weight loss suggestions to patients, though five of the qualitative responses reported this behavior. Areas for future study could include a longitudinal which measures nursing students' weight bias when they begin their clinical training and after they complete it to more accurately determine whether students are being negatively impacted by their observations in clinical. Additionally, more research is needed on ways to reduce weight bias in healthcare in order to address the underlying issue.

Conclusions

Nursing students report both observing fatphobic behaviors in clinical and feeling that clinical has had a negative impact on their ability to provide affirming care. Nursing students comprise the next generation of nurses, and as long as healthcare providers continue engaging in fatphobic behaviors and the healthcare system continues allowing those behaviors, nursing students will continue being influenced by them.

Solutions to this problem would not be successful if they only targeted one profession. Additionally, they must address both the lack of awareness and education on affirming care and the structural healthcare issues, such as staffing shortages and lack of transfer equipment. Interventions are imperative in reducing weight bias among healthcare workers in order to improve patient outcomes.

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