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Weight bias and identity characteristics among students at a public university in Southern Brazil

Discriminação relacionada ao peso e suas vinculações com características identitárias entre estudantes de uma universidade pública no sul do Brasil

Jessica Rasquim Araujo[1], Maurício Soares Leite[2], João Luiz Bastos[3]

[1] Universidade Federal de Minas Gerais, Programa de Pós-Graduação em Saúde Pública. Belo Horizonte, MG, Brasil. Correspondence to: JR ARAUJO. E-mail: <araujojr@ufmg.br>.
[2] Universidade Federal de Santa Catarina, Centro de Ciências da Saúde, Departamento de Nutrição. Florianópolis, SC, Brasil.
[3] Simon Fraser University. Burnaby, Canada.

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ABSTRACT

Objective
Despite the consequences of weight discrimination for health inequities, its relationship with identity characteristics remains poorly understood. We investigated whether and to what extent discrimination attributed to body weight is linked to sociodemographic and identity factors.

Methods
This cross-sectional study is based on a representative sample of undergraduate students from the Federal University of Santa Catarina. Information on perceived discrimination was collected using the brief version of the Explicit Discrimination Scale. Socioeconomic and demographic data were also collected.

Results
The results showed that 22.8% of the sample reported experiencing discrimination for being "fat or thin" throughout their lives. Perceived weight discrimination was higher among respondents whose household heads had completed up to high school education, and among those who were overweight and rated their health as "poor."

Conclusion
Perceived weight discrimination was associated with significant factors linked to the stigmatization and pathologization of body weight. These findings should be considered in more inclusive approaches aimed at counteracting the embodiment of social inequalities.

Keywords: Health inequality monitoring. Intersectional framework. Weight prejudice. Weight bias. Weight stigma.

RESUMO

Objetivo

Apesar das repercussões da discriminação pelo peso serem reconhecias nas iniquidades em saúde, sua relação com outras características identitárias ainda é pouco compreendida. Investigamos o quanto a experiência de discriminação relacionada ao peso corporal está vinculada a fatores sociodemográficos e aspectos identitários.

Métodos

Trata-se de um estudo transversal, baseado em amostra representativa dos graduandos da Universidade Federal de Santa Catarina. As informações sobre percepção de discriminação foram obtidas com a Escala de Discriminação Explícita, em sua versão reduzida. Dados socioeconômicos e demográficos também foram coletados.

Resultados

Os resultados demonstraram que 22,8% dos respondentes perceberam ter sido discriminados por "ser gordo ou magro" ao longo da vida. Esse tratamento diferencial esteve mais fortemente vinculado à percepção de discriminação por "apresentar determinado comportamento" ou "modo de se vestir". No modelo de regressão ajustado, a discriminação percebida por "ser gordo ou magro" foi maior para a faixa etária de 23 a 27 anos; para os respondentes cujos chefes do domicílio tinham até o ensino médio completo; e para aqueles com excesso de peso e autoavaliação de saúde "ruim".

Conclusão

A discriminação percebida por "ser gordo ou magro" esteve relacionada a importantes características e condições que se associam com o estigma e a patologização da gordura corporal. Tais achados devem ser considerados em abordagens mais inclusivas de combate à incorporação de injustiças sociais.

Palavras-chave: *Mensuração das desigualdades em saúde. Enquadramento interseccional. Preconceito de peso. Viés de peso. Estigma do peso.*

INTRODUCTION

Discrimination refers to the manifestation of prejudices directed at population groups with historically stigmatized characteristics, defined by race, gender, sexual orientation, disability, and class. Unfair and unpredictable, discrimination can have an impact on mental health and may cause depression, low self-esteem, and self-image disorders. Furthermore, discriminatory experiences can lead to variations in heart rate and hormonal responses that can cause deleterious health effects in the long term [1,2].

Prejudice due to body weight is common and targets especially fat individuals attributing to them a set of negative moral characteristics, such as lack of willpower, lack of self-discipline, laziness, or poor competence [3-6]. Weight discrimination in turn reduces demand for physical activity and causes dysfunctional eating behaviors among the respective target population groups [7]. In the realm of health care, shorter doctor's visits, incomplete anamnesis, requests for exams or erroneous diagnoses are associated with weight-based discrimination, and are often perpetrated by health professionals, including nutritionists [8-10].

Weight discrimination is a topic of growing interest in the health inequities literature, given its negative effects on the well-being of the population. However, the topic is not often from the perspective of those who experience injustice, which, according to Rubino et al. [5], is a necessary perspective to better understand this issue and its consequences. Furthermore, since body weight discrimination is common in our daily lives and individuals can experience their corporeality alongside other characteristics of their social identity – such as race, gender, class, and disability –, we assume that intersections between weight-based discrimination and other forms of mistreatment should be further investigated [11-15].

It is crucial to deepen the understanding around the relationships between weight-based discrimination and other identity characteristics. This research endeavor has the potential to support policies aimed at counteracting discrimination and its myriad effects. Thus, the objective of the present study was to investigate the relationships between discrimination, sociodemographic and identity factors, such as gender, race, and age. To this end, the present study described the frequency, intensity and life domains in which weight discrimination was perceived by a representative sample of undergraduate students from southern Brazil. We also examined the relationships between discrimination and the students' sociodemographic characteristics, Body Mass Index (BMI), and self-rated health.

METHODS

This is a cross-sectional study based on data from a previous survey carried out with undergraduate students at Universidade Federal de Santa Catarina (UFSC, Federal University of Santa Catarina), in the first semester of 2012 [16]. The exclusion criteria were: students attending newly established undergraduate courses, and students who had not completed their registration process by the time the survey took place. Sample size estimation was based on the associations between discriminatory experiences and self-rated poor health (i.e., 4.5% among respondents that did not report discrimination and 13.7% among those who did), and 73.0% overall prevalence of discrimination with 0.05 β error and 0.01 α error. The final sample size estimate, after correcting for the complex sampling and adding 10% due to losses or withdrawals, was 1,341 [16].

The survey involved 1,264 eligible students, with 1,023 respondents (i.e., 80.9% response rate). Out of these, 765 students had complete information for all variables analyzed in the present study. This analytical sample, which was similar to the original 1,023 respondents provided statistical power between 51.0% and 99.0% to examine the study relationships, except for discrimination by body weight and sex (7.0%), race/skin color (6.7 %) and age (16.0%). The complex sampling scheme included the selection of courses and, within them, classes from the three training phases (beginner, intermediate and final). Prior to the fieldwork, a pre-test was carried out with 17 students who had similar socioeconomic and demographic characteristics, and a pilot study that included 43 students, who were not part of the final sample. Data collection took place between March and May 2012. The questionnaires were administered in the classrooms and were handed out for self-completion by students. Information collected included, among others, items on sociodemographic and economic characteristics, self-perceived health, self-reported weight and height, in addition to the Explicit Discrimination Scale (EDE), developed by Bastos et al. [16].

In the present study, an abridged version of the EDE was used, which includes eight items (Chart 1) [17]. Perceived differential treatment, and their reported reasons were recorded, including "being fat or thin.". Respondents could indicate more than one reason. An additional item asked the level of discomfort associated attributed to experiences with differential treatment, with response options ranging from "no"; "yes, to some extent"; "yes, reasonably" and "yes, very much". One final item asked whether differential treatment was considered as discriminatory or not by the respondent.

The frequencies of the dependent variable – perceived weight-based discrimination" – as well as the degree of discomfort were calculated. Perceived discrimination was a count variable, calculated by adding up all 8 items in which differential treatment was interpreted as discriminatory; hence higher scores indicated more intense levels of perceived discrimination. Categorization of independent variables is shown in Table 1. To investigate the relationship between reasons attributed to differential treatment and perceived discrimination, two ordinal variables were constructed.

Chart 1 – Explicit discrimination scale items.

Item	Situation
1	Have you ever been mistaken for an employee at an establishment, when in fact, you were a customer? For example, confused with a salesperson, clerk or waiter?
2	When visiting stores, restaurants or cafeterias, have you ever been treated in an inferior manner compared to other customers?
3	When visiting public offices, such as the federal revenue, notary offices, traffic departments, water, electricity, sewage companies or others, have you ever been treated in an inferior manner compared to other people attended there?
4	Have you ever been treated as if you were unintelligent or incapable of carrying out any curricular activity at school or university? Consider current (university) and past (school) situations in which you were treated this way by teachers or colleagues, even though you thought you had all the conditions to carry out the activities.
5	When trying to hook up or date someone, have you ever been treated with contempt by the other person, without giving reasons for it? Just consider situations in which you were treated worse compared to others who also tried to hook up or date this person or another person.
6	Have you ever been treated in an inferior manner by any of your parents, uncles, cousins or grandparents compared to other family members?
7	Have you ever been called names, heard words you didn't like, or derogatory terms? Consider that this could have happened on streets, buses, shopping malls, banks, stores, parties, schools, workplaces or other public places.
8	Have you ever been excluded or left aside by a group of neighborhood friends, people in your neighborhood or in your condominium? Consider that this could have happened at neighborhood gatherings, condominium meetings, parties and other celebrations.

Source: Author's adaptation from the article Scaling up research on discrimination and health: The abridged Explicit Discrimination Scale [17].

Table 1 – Regression coefficients for "being fat or thin", predicted by a negative binomial regression model (n=765). Florianópolis (Brazil), 2012.

Variables	Final Model		
	Regression coefficient	95% CI	*p*-value
Level of education of the head of the family			
Incomplete high school or more	1.00(ref)	1.00(ref)	1.00(ref)
Up to complete college education	1.74	1.23-2.46	0.005
Body mass index (kg/m^2)			
18.5-24	1.00(ref)	1.00(ref)	1.00(ref)
<=18.4	2.17	0.95-4.95	0.061
>=25.0	2.43	1.47-4.01	0.002
Self-rated health			
Good	1.00(ref)	1.00(ref)	1.00(ref)
Bad	1.98	0.13-0.24	0.003

Note: CI: Confidence Interval.

The first considered the exposure of interviewees to differential treatment, based on each of the eight EDS items, multiplied by the corresponding frequencies – 0, 1, 2 or 3 – with which they occurred. The second evaluated the number of reasons that respondents attributed to their experiences with different treatments, both serially and simultaneously. We then examined the frequencies with which all the reasons for differential treatment were reported; pairwise correlations were then assessed using the Spearman correlation test.

Negative binomial regression analyses were conducted to assess the association of the independent variables – gender; age group; skin color/race; level of education of the head of the household; BMI and self-rated health – with the dependent variable, which was the discrimination score associated with the reason "being fat or thin". The choice for negative binomial regression took into account the nature of the dependent variable – a count – and the overdispersion of the data. The selection of variables to compose the final model followed the backward elimination process, using the *p*-value of 0.20 as a criterion to keep independent variables in the model.

Statistical analyses were conducted using Stata, version 14.1, considering the complex sampling structure and the sample weights. The study protocols were approved by the Human Research Ethics Committee of the Federal University of Santa Catarina, under registration number 459,965. Participants signed the Free and Informed Consent Form.

RESULTS

The study sample included 765 students, mostly men (54.5%), aged between 16 and 22 years (63.3%) and self-declared as white (86.0%). More than half of the sample (71.2%) reported that the level of education of the head of the household was equivalent to incomplete higher education or more (Table 2).

Table 2 – Sample distribution according to sociodemographic characteristics and perceived differential treatment for being fat or thin. Universidade Federal de Santa Catarina. Florianópolis (Brazil), 2012.

Characteristics	Sample distribution		Analytical sample distribution		Differential treatment for being fat or thin		Classification of differential treatment as discrimination	
	n	%[a]	n	%[a]	n	%[a]	n	%[a]
Gender[b]								
Man	553	55.7	408	54.5	91	22.3	63	15.4
Woman	455	44.3	357	45.5	71	19.9	63	17.6
Age group (years)[b]								
16-22	558	60.8	499	63.3	100	20	78	15.6
23-27	240	27.1	205	27.9	50	24.4	41	20
28-52	101	12.2	61	8.8	12	19.7	7	11.5
/race[b]								
White	827	84.4	656	86	139	21.2	110	16.8
Black	152	15.6	109	14	23	21.1	16	14.7
Level of education of the head of the household								
Up to complete secondary education	287	28.6	218	28.8	55	25.2	46	21.1
Incomplete higher education or more	736	71.4	547	71.2	107	19.6	80	14.6
Body mass index[b]								
<=18.4	66	6.4	58	7.4	16	27.6	14	24.1
18.5-24	730	71.4	550	70	89	16.2	70	12.7
>=25.0	227	22.2	157	22.6	57	36.3	42	26.8
Self-rated health[b]								
Good	853	83.6	646	83.2	118	18.3	90	13.9
Bad	167	16.4	119	16.8	44	37	36	30.3

Note: [a] Estimates are corrected by sampling design and sample weights. [b] These variables presented missing observations: gender, 15; age group, 124; skin color/race, 44; self-rated health self, 3.

The frequency of perceived differential treatment and discrimination in one or more life domains, as assessed by the EDE, was 83.0% and 62.3%, respectively. We also observed that 162 respondents (27.5%) attributed differential treatment to "being fat or thin" (Table 2). The three life domains with the highest frequencies were those referred to by item 7 ("Have you ever been called names, heard things you didn't like or derogative terms?") (90%); item 2 ("When going to stores, restaurants or cafeterias, have you ever been treated in an inferior way compared to other customers?") (50.0%) and item 5 ("When trying to date someone, have you ever been treated with contempt by the other person?") (48.8%) (Figure 1).

Among the 162 students who reported differential treatment for "being fat or thin", 126 (80.4%) considered the situation as a discriminatory event. The life domains in which students most frequently perceived discrimination for "being fat or thin" were those of addressed by item 4 ("Have you ever been treated as if you were unintelligent or incapable of carrying out any curricular activity at school or university?") (78.0%); item 2 ("When visiting stores, restaurants or cafeterias, have you ever been treated in an inferior way compared to other customers?") (73.3%) and item 7 ("Have you ever been called names, heard things you didn't like or derogative terms?") (69.1%) (Figure 1).

Figure 1 – Frequency of perceived differential and discriminatory treatment for "being fat or thin" in each of the eight life domains. Florianópolis (Brazil), 2012.

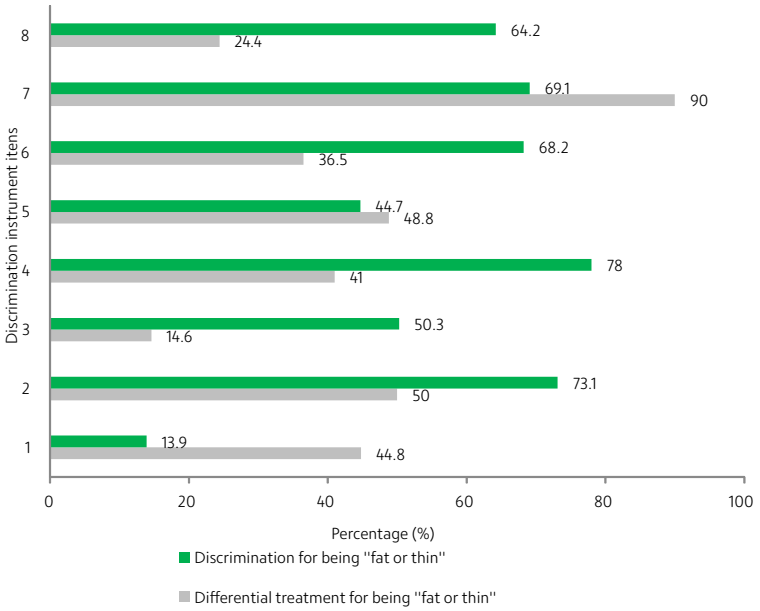
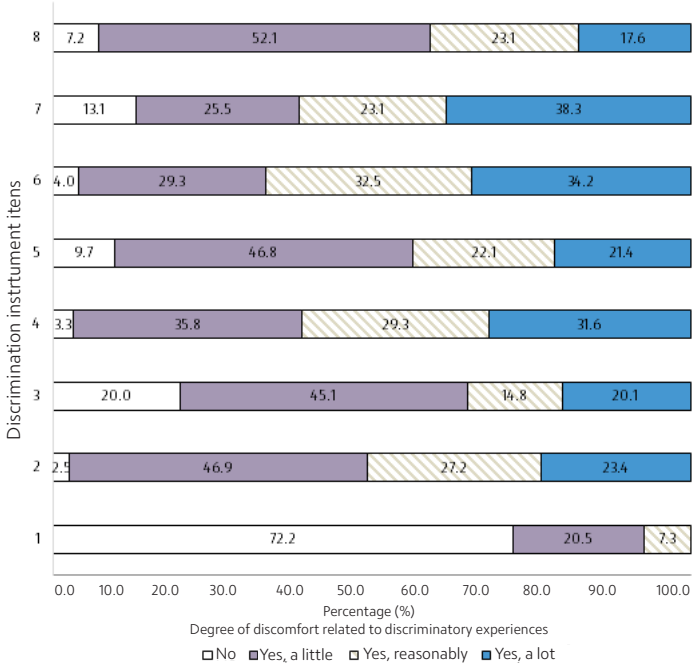


Figure 2 shows the degree of discomfort related to differential treatment when the perceived reason was "being fat or thin". Item 7 ("Have you ever been called names, heard things you didn't like or derogatory terms") was associated with the greatest degree of discomfort – 34.2% of students who had gone through this experience considered it very uncomfortable. The magnitude of the Spearman correlations (r) between differential treatment attributed to "being fat or thin" and other reasons varied between 0.0040 and 0.2351. The largest coefficients were observed between the following pairs of reasons: being fat or thin and behavior (r=0.2271) and being fat or thin and way of dressing (r=0.2351).

Figure 2 – Degree of discomfort related to differential treatment attributed to "being fat or thin" for each life domain. Florianópolis (Brazil), 2012.



According to Table 1, the average discrimination score for "being fat or thin" was higher among students whose head of household's level of education was up to high school; the average discrimination score was also higher among respondents whose BMI indicated overweight, and those with self-rated "poor" health. Age, gender, and skin color/race were excluded from the final model as they presented a p-value greater than 0.20.

DISCUSSION

In this study, we sought to investigate the relationships between discrimination based on body weight, sociodemographic, and identity characteristics that reflect social injustices, such as gender, race, and age. The student population at UFSC is socially and economically privileged in comparison to the general population of the state of Santa Catarina and that of the rest of the country. Although their characteristics could suggested that the majority would not be discriminated against, perceived differential treatment and discrimination were frequently reported by the sample [16].

Our results highlight the prevalence of weight-related discrimination, especially in two specific life domains: the case of individuals who are called derogatory names and those who are treated in an inferior manner in stores or shops, as well as in close relationships. Among adults with obesity in the USA, the prevalence of weight discrimination ranges from 19% to 42% and is higher in people with high BMI and women. Perpetrators are most often educators, employers, healthcare professionals, the media, and even friends and family [5]. In Brazil, body stigma and discrimination have been studied from the perspective of the targeted subjects, and these studies clearly indicate the pathologization of fatness [18-20]. However, we have not yet found data in the literature on the prevalence of weight discrimination in the Brazilian population or specific groups, which limits our ability to compare results.

Furthermore, correlations between the perception of differential treatment due to weight and other reasons, such as gender, age and race/skin color, were less significant compared to other combinations between these reasons. The wording of the questionnaire indicated the possibility of entering more than one reason, but required the student to indicate the main reason. However, in addition to the way it was questioned, the dynamics of social markers per se, with the possibility of underinclusion or overinclusion [12,14] and the way they interact in an individual's experience need to be better explored in future studies, with the inclusion of absent social groups in EDE and with complementary methodologies. Furthermore, we can point out as a limitation of our study the small sampling power for some of the relationships examined, which may have contributed to the fact that we did not find an association between discrimination and gender, age and race/skin color.

Individual weight responsibility reflects historical structural inequalities, such as weight control among women [21-23], the racialization of weight stigma [24] and the investments required to adhere to certain body standards [25]. Considering the results of our investigation, we believe that discussions will provide a baseline for potential future comparisons. Furthermore, our results point to a scenario of hostility in the social relations that not only remains current, but has worsened over the last few years. Several social organizations have denounced the intensification of violence against minority groups, indicating that discrimination has not only been tolerated, but advocated and demonstrated in different instances, including official ones [26-28].

Thus, criticism of the focus on individual responsibility and blame in approaches that involve the body, in the health field, needs to include the recognition of other conditions and identity characteristics that may be involved, besides weight, in this relationship of oppression. The results

they provide are current and should be present in teaching-service interactions, with a view at a development of professional training and health care practices.

CONCLUSION

We hope that our findings contribute to the academic community's recognition of the importance and potential consequences of discrimination experiences and the relevance of considering them in pedagogical practices in university education and extension. Furthermore, we point out the need for health professionals to reflect and transform their practices based on the recognition of perceptions and experiences of the body and its influence on the social relationships and, consequently, on health. We aim to join efforts towards building policies and actions to curb health inequities, inside and outside the university.

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CONTRIBUTORS

Conceptualization, Methodology, Data curation, Formal analysis, Investigation: JR ARAUJO, MS LEITE, and JL BASTOS. Supervision: MS LEITE and JL BASTOS. Writing – original draft: JR ARAUJO. Writing – review & editing: JR ARAUJO, MS LEITE, and JL BASTOS.