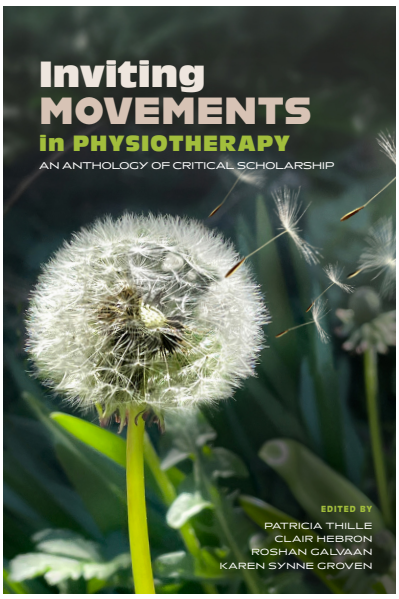

Inviting movements in physiotherapy: An anthology of critical scholarship

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Chapter 6

Disrupting the ongoing flow of weight stigma in physiotherapy: The value of critical reflection

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ABSTRACT:

Multiple studies have found physiotherapists hold weight stigmatizing attitudes, but few explore weight stigmatization in physiotherapy practice or movement toward anti-stigmatizing practices. Doing so involves re-evaluation of worldviews and daily practices which reproduce injustice, involving cognitive and emotional forms of movement. We aimed to (a) explore physiotherapists' understandings about the existence of, and ways to disrupt, weight stigmatization in practice, and (b) evaluate the workshop that aimed to spur movement toward anti-stigmatizing practice. We generated qualitative data before, during, and after a workshop informed by critical theory about weight stigma in clinical practice for physiotherapists and trainees. Critical reflection was the primary pedagogical guide, which we attempted to spur through activities to make the familiar strange, and support dialogical engagement. Evaluation involved exploring cognitive and emotional movements over time. The workshop's pedagogy successfully fostered critical reflection for most, spurring challenging emotions wherein participants grappled with complicity in reproducing weight stigma. Few knew practice-based strategies to disrupt weight stigma. Most moved through difficulties, demonstrating openness to learning. Based on our and other justice-oriented studies, we argue for the use of critical pedagogical strategies to unsettle the ongoing flow of injustice and to support movement toward justice in physiotherapy.

CHAPTER 6

Disrupting the ongoing flow of weight stigma in physiotherapy

THE VALUE OF CRITICAL REFLECTION

PATRICIA THILLE, ZOE A. LEYLAND, AND LIZ HARVEY

Dear physiotherapists

We often move through our days, our patients, our careers, doing things as we have always done them, as we were taught. We flow ever onwards, accepting the status quo, like a river running smoothly over rocks. We often want to ignore the push and pull of the current underneath, hoping for calm waters. But how can one really understand the river if one just appreciates its flow? Interrupting the movement of this metaphorical river, churning it, disturbing that which has long been done, is how we frame this chapter. We argue this is necessary to deal with injustices created by the established flows in our profession.

The need to disrupt stigma in physiotherapy: Weight stigma as examplar

High quality clinical practice requires attention to the human dimensions of health care (Wieringa et al., 2017). Nicholls & Gibson (2010) suggest that "physiotherapists . . . are perfectly placed to take advantage of people's growing need for more person- and-community-centred approaches to rehabilitation" (p. 504) but are limited in doing so due to a restricted

worldview, focused more on bodies than people. We agree, adding that person- and community-centered approaches require therapists disrupt the ongoing flow of societal stigmas that can be reproduced through clinical activities. There are signs that physiotherapists hold weight-stigmatizing beliefs (Awotidebe & Phillips, 2009; Jones & Forhan, 2021; Setchell et al., 2014; Elboim-Gabyzon et al., 2020; Wise et al., 2014; Sack et al., 2009; Setchell et al., 2016; Groven & Heggen, 2016), which we seek to disrupt. In this chapter, we will introduce weight stigma and theoretical assumptions shaping our work to disrupt it, before sharing our approach and findings from our attempt to do so with practising physiotherapists in 2020.

Stigma starts from a societal belief that a particular characteristic or history discredits or taints a person (Link & Phelan, 2001). This is because "the stigma or mark is seen as something in the person rather than a designation or tag those others affix to the person" (Link & Phelan, 2001, p. 366). Link and Phelan (2001) theorise stigma as the result of a co-occurrence of the following: labelling of people into groups based on some form of difference; attaching negative personality stereotypes to certain groups with a shared characteristic; constructing the group as Other, as separate from "us," and as a threat to society; generating widespread status loss and discrimination. For this to occur, powerful institutions (e.g., media, health care, education, justice system) reproduce the stigmatizing stereotypes and Othering through policies, architecture, media representations, and more (Link & Phelan, 2001). What is stigmatised in a given society reflects cultural norms and values (Phelan et al., 2008). Thus, we should understand stigmatization as a social process that plays out in everyday activities, including in institutions like health care (Meisenbach, 2010).

In Western societies, bodily fatness and thinness are interpreted as reflecting personality characteristics of willpower, motivation, and knowledge (Lupton, 2018). Pro-thin and anti-fat stereotypes are reinforced in media, in education, and in health care (Puhl & Heuer, 2009; Lupton, 2018). These stereotypes are based on long-standing but scientifically falsified ideas about body weight and composition that overemphasise the impact of "lifestyle" factors (Brown et al., 2016), focus on diet and physical activity to the exclusion of other determinants of both weight and health (Thille et al., 2017; Medvedyuk et al., 2018), and imply that all bodies can be made thin by "healthy lifestyles" and "taking personal responsibility" (Mayes, 2016). This

collection of persistent cultural beliefs underpin fat stigma and create harms (Mayes, 2016), which are increasingly recognised as a problem (Tomiyama et al., 2018). For example, a Public Health Agency of Canada (2019) report highlights how stigma changes life trajectories and is a fundamental cause of population health inequities. Health professionals are often called upon to provide care to prevent or reduce bodily fatness, and in doing so they may stigmatise patients and reproduce inaccurate beliefs about weight, resulting in a poorer quality of health care (Phelan et al., 2015). To date, the minimal research about weight stigma in physiotherapy establishes that pro-thin/anti-fat biases are common (Awotidebe & Phillips, 2009; Jones & Forhan, 2021; Setchell et al., 2014; Elboim-Gabyzon et al., 2020; Wise et al., 2014; Sack et al., 2009; Setchell et al., 2016; Groven & Heggen, 2016). Our team's (Webber et al., 2022) recent study found mainly neutral to positive fat acceptance attitudes in a 2019 Canadian sample of physiotherapists. Regardless, measures of attitudes do not directly predict skill or knowledge about how to interrupt stigmatizing language, interactions, and structural manifestations of anti-fatness and pro-thinness in the "real world"—in this case, in the practice of physiotherapy.

Currently, there is little published that explores how weight stigma occurs in physiotherapy practice, and only two studies attempting to disrupt it. One pilot had promising but minimally described outcomes (Setchell et al., 2017); the second was a workshop intervention study that did not work well (Jones & Forhan, 2021) and thus offers little guidance to design interventions to disrupt weight stigma in physiotherapy. The first of two reviews of "weight bias reduction" interventions—a frame which considers only psychological outcomes—found limited evidence of effect on health care professionals' biases across the range of studies (Alberga et al, 2016). The second, more recent review found weight-neutral and human-rights affirming strategies were most promising (Talumaa et al, 2022). Note the emphasis of these reviews on the intrapersonal—meaning, working at the individual level on beliefs or attitudes. In clinical practice, however, the interpersonal and structural enactments of stigma also worsen outcomes (Phelan et al, 2015). Interpersonal enactments involve two or more people, such as in a clinical appointment, while structural enactments of stigma occur through institutions and in some way target stigmatized groups (Cook et al, 2014).

To improve care, we need to develop better methods to support clinicians to detect and disrupt weight stigma. This requires exploring how anti-fatness and pro-thinness are embedded in everyday clinical activities and clinical environments. To return to the river metaphor, these everyday activities are the flow, the status quo, that moves ever forward. While manifestations of weight stigma overlap among health professions, future strategies to unsettle anti-fatness/pro-thinness can also address profession-specific forms of thinking and acting that are barriers.

We designed a qualitative follow-up study to our earlier quantitative one (Webber et al., 2022), aiming to explore physiotherapists' understandings about the existence of, and ways to disrupt, weight-stigmatizing actions in professional practice. We wished to see how and if physiotherapists were prepared to interrupt the metaphorical flow. We sought to learn what might make disrupting weight stigma challenging in physiotherapy practice. In parallel, we evaluated how well our chosen presentation method facilitated reflective or defensive responses from physiotherapists and physiotherapy trainees, as both are possible in social justice-oriented education (Boler & Zembylas, 2003). We did this via data collection before, during, and after virtual workshops for physiotherapists and trainees. The workshop aimed to foster critical reflection to help the participants explore weight stigma and physiotherapy practice. Critical reflection involves confronting power dynamics and critically questioning taken-for-granted "truths" and attitudes (Kinsella et al., 2012) "that may distort and dehumanise relationships and interaction in medical care" (Kumagai & Wear, 2014, p. 974).

Break the rhythm that excludes thinking[1]

Physiotherapy often proposes that clinical knowledge is objective and neutral. Thinking with Haraway (1988) among others, we understand neutrality and objectivity as impossibilities. Haraway argues there is no "view from nowhere" or god-like knowledge held by humans which the terms objectivity or neutrality imply. There is no escaping or transcending our cultures. Instead, we should understand all knowledge as *situated knowledge* (Haraway, 1988), reflecting the cultural communities in which it is constructed. For example, evidence-based practice, based on statistical ways of knowing, carries with it a whole host of culturally based assumptions about what constitutes a good outcome. But the idea of a "good outcome" must be decided

by someone, by some chosen criteria; there is no neutrality here. In practice, treatments can create both goods and bads, in terms of new demands or difficulties (Mol, 2008).

One aspect of the *situated knowledge* of physiotherapy is that it "privilege[s] a mechanistic view of the body at the expense of 'other' views" (Nicholls & Gibson, 2010, p. 503). This, Nicholls and Gibson (2010) argue, limits physiotherapists' ability to account for other facets of embodiment, which would instead orient clinicians toward the whole person rather than a reductionist and singular view of the body. We extend their argument to include stigma. Consistent with other normalizing and disciplinary practices in rehabilitation (Gibson, 2016; Praestegaard et al, 2015), physiotherapists have been trained in biomedical framings of body size which "prescribe the 'proper' weight and size of bodies and define certain bodies—including fat bodies—as pathological and others as normal" (Lupton, 2018, p. 21). Interrupting the normalizing ongoing flow and drawing attention to injustices that create different embodied experiences might both help disrupt weight stigma.

Learning about social injustices can elicit a range of emotions, including frustration and defensiveness, and create resistance (Boler & Zembylas, 2003). Discomfort is to be expected through activities where "educators and students . . . engage in critical thinking and explore the multitude of habits, relations of power, knowledge, and ethics" (Boler & Zembylas, 2003, p. 106). This discomfort churns the metaphorical waters, causing turmoil in the flow of the status quo that is pro-thinness and anti-fatness. Given our interest, we turned to the concept of *critical reflection* to inform workshop pedagogy (Kinsella et al, 2012; Kumagia & Wear, 2014; Ng et al, 2019). Critical reflection educational activities can help learners connect new ideas to their prior experience and knowledge, as well as reinterpret past events and beliefs.

We relied on two pedagogical strategies to foster critical re-examination of everyday practices. The first is to *make the familiar strange*. As Kumagai and Wear write, "By forcing us to reconsider familiar ideas, situations, and relationships in new and different ways, this process of alienation and estrangement frees thought and reflection to pursue entirely new avenues of questioning and discovery" (Kumagai & Wear, 2014, p. 976). This creates a distance that can reduce defensiveness. The second strategy we mobilised is *dialogical engagement*. Theorist Mikhail Bakhtin (1984) describes "the dialogical as that which resists closure or finalization—that is, not monological"

(Thille et al., 2018, p. 870). Like Haraway's refusal of the "god trick," dialogical forms of engagement disrupt voices that claim authoritative knowledge. Instead, when engaging dialogically, a person recognises the limits of their perception and knowledge, fostering uncertainty and humility. When a person does not believe they know the truth in any complete sense, they can resist the idea that their perspective is right or complete:

A dialogue taps into each individual's affective, experiential, and identity reserves in an exploration of the thoughts, feelings, and lived experiences of the participants. The intention of this dialogue is the very act of exploration itself, as well as the discovery of new ways of seeing and understanding oneself, others, and the world (Kumagai & Naidu, 2015, p. 284).

How we sought to learn about physiotherapists' understandings of weight stigma

We aimed to (a) explore physiotherapists' understandings about the existence of, and ways to disrupt, weight stigmatization in practice, and (b) evaluate the workshop design that aimed to spur movement toward anti-oppressive practice. We generated qualitative data before, during, and after a virtual workshop about weight stigma in clinical practice for physiotherapists and physiotherapy trainees. Critical reflection was the primary pedagogical guide, which we sought to foster using activities to "make the familiar strange," and support "dialogical engagement." Analytically, we explored cognitive and emotional movements over time.

Virtual workshop

After very brief introductions, we shared a nine-minute video titled "The Gallery." We created the video in 2020 with a public advisory board critical of weight stigma in health care and familiar with physiotherapy as patients. "The Gallery" was the result of eight hours the group spent together. The video layers auditory stories and comments over purposefully chosen images to share the group's key messages about weight stigma, with the aim of "enhanc[ing] understanding through the communication of subjective realities or personal truths that can occur only through works of art" (Barone, 2008, p. 2). Arts-informed approaches are not geared towards finding an objective truth. Instead, they "promote profound reconsideration of the commonsensical, the orthodox, the clichéd, and the stereotypical" (Barone,

2008, p. 3)—or what we in this study have called the metaphorical flow. Starting with this video introduced former patients' points of views without the usual power dynamics of clinician-patient. We anticipated the video would help make the familiar strange for those unfamiliar with such perspectives and initiate dialogical engagement in the workshop by introducing voices counter to physiotherapists' perspectives.

Following the video, participants reflected silently about their emotions and thoughts. To help physiotherapists name their emotions, we shared the Feelings Wheel, an adaptation of Wilcox's (1982) earlier version (Calm, n.d.). This image organises emotions around a circle, clustering together different emotions around one of seven core emotions (happy, surprised, sad, angry, disgusted, bad, or fearful). We expected "The Gallery" would unsettle participants and hoped this early moment of pause would help them engage. If they wished, participants shared their responses anonymously via an online whiteboard that did not show answers to other workshop attendees.

We then shared two brief presentations. The first shared a conceptual introduction to stigma and weight stigma. The second shared results from our recent study of fat acceptance attitudes held by local physiotherapists and trainees (Webber et al., 2022). The brief presentations were purposefully didactic, introducing content before opening discussion, allowing people to react to content without being visible to others. We did so in hopes to reduce defensiveness, as well as to focus a brief discussion facilitated by the workshop lead, inviting questions and comments of what they found meaningful, confusing, or challenging.

The final segment shared strategies to disrupt anti-fatness and pro-thinness in clinical practice, focusing on the interpersonal and structural levels. Assessment, advising, goal setting, and treatment were each addressed in turn, as well as physical and visual environment changes for the setting, and strategies to identify and address self-stigmatization by patients. We closed the workshop with another reflection round, including the Feelings Wheel prompt and a series of questions that invited feedback on the workshop and asked what participants were committing to change in their own practice.

The physiotherapists who joined workshops

Recruitment occurred via multiple channels in November 2020, including emails circulated by the professional licensure body to all licensed student and practicing physiotherapists within the province and a listserv reaching all registered master of physiotherapy (MPT) students at the University of

Manitoba. A provincial physiotherapy advocacy organization shared the invitation via their newsletter and social media. Patricia and Liz shared the invitation via social media.

Nineteen participants attended the virtual workshop at one of four different sessions. Twelve completed the additional pre- and post-workshop reflection process (KWL). One physiotherapy student attended; the rest were practicing physiotherapists working in health care and education sectors. All but one were women. We did not collect cultural background or other demographics from participants.

Ethics/consent

The University of Manitoba's Health Research Ethics Board approved the study. Recruitment materials explicitly noted the research aspect of the workshop, including audio-recording of discussions and anonymous digital whiteboard comments. We gave a twenty-five dollar honorarium to those who completed additional pre- and post-workshop reflections.

The data we created via the virtual workshops

We used multiple methods to generate data to create a longitudinal dataset and enhance privacy: (1) pre- and post-workshop reflections, structured in the Know/Want to Know/Learned format (Ogle, 1986); (2) anonymous reflections and feedback, collected via a digital whiteboard (Mural™) during and immediately after the workshop; and (3) short discussions within the workshops.

First, the Know/Want to Know/Learned (KWL) reflection asked physiotherapists and trainees to participate in an optional written reflection activity. KWLs ask learners to share what they *already know* (K) and what they *want to know* (W) about the topic prior to an educational event, initiating reflection (Ogle, 1986). These were written as part of registration. Upon completion of the workshop, we emailed questions inviting attendees to share what they *learned* (L) through the workshop, which were then added to their earlier KW answers. Second, twice during the workshop, we invited anonymous reflections and feedback via a digital whiteboard, described above. Finally, we timed the group discussion to follow most, but not all, of the workshop content. Structured as a learning activity, the workshop attendees had approximately fifteen minutes to discuss the content of the workshop to that point. We audio-recorded, then transcribed the discussions.

How we analyzed the data generated

If successful, our workshop data would show signs of critical reflection in the form of recognizing new uncertainties and imagined possibilities for practice, as well as showing points that create resistance, tension, or defensiveness. Both have the potential to highlight profession-specific possibilities and concerns that could be addressed in future anti–weight stigma education. During analysis, Patricia and Zoe utilized multiple and iterative methods to enhance our interpretation, including immersive data readings, iterations of coding, summarizing KWL content by participant, analytic writing, and analytic conversations. We considered each KWL as showing the trajectory of different participants, which allowed comparison both within and across participants. Coding iterations included:

1. Organizing the data chronologically (pre-workshop; early workshop; late workshop; after the workshop).
2. Generative coding, which helps researchers open up ideas by interacting with the data iteratively, exploring potential lines of abstraction and conceptualization via coding and writing analytic memos in parallel (Eakin & Gladstone, 2020).
3. Some theoretically informed codes, particularly to identify defensive or other monological engagements in the workshop, characterised by Boler & Zembylas (2003) as alternative arguments to defend status quo.

As we worked with the data, we considered common patterns, outliers, and data that was personally striking, treating each as starting points for interpretation and reflexivity (Eakin & Gladstone, 2020).

Who we are

Qualitative research recognises that the researchers shape the results, and so, reflexivity is valued (Tracy, 2010). Patricia is a physiotherapist with a PhD in sociology. She is a straight-sized, white Canadian settler woman. Her interest in weight stigma in health care spans over two decades, first sparked when working as a physiotherapist and learning about feminist approaches to health and the body. Zoe is a health professions education scholar who is a white, cis-gender woman and settler of Canada. She takes an embodied approach to weight stigma given her own size and the health care inequities

she has endured. Liz is a physiotherapist, physiotherapy educator, and PhD candidate. She is a white, cis-gender woman who lives in a bigger body. Both Patricia and Liz approach their work with the goal of critical allyship (Nixon, 2019).

Patricia was the lead investigator on the project. Liz designed and led the public advisory group and co-developed the workshop and data collection design, with Patricia's support. Zoe joined the project after data collection, analysing the data generated with Patricia, which Liz reviewed.

How to provide good care that recognizes and disrupts weight stigma?

How to provide good care that recognises and disrupts weight stigma? This was the focus of the workshop, but also an animating question of participants throughout. Most entered the workshop recognizing that weight stigma is a problem to be addressed. Opening it up for deeper exploration also created new problems for them to navigate. Throughout the ninety-minute workshop, we found participants grappled with this question and these problems from two perspectives: how it applies to their practice, and to their own personal experiences, including with family and friends.

We start our findings where they did: sharing the problems participants recognised prior to the workshop. We then show the evolution of their understandings during and after the workshop, before highlighting particular topics that arose that may have relevance for the field of physiotherapy as it works to disrupt weight stigma in practice.

Quotes from participants are italicized. We mark direct quotes by the source of data they came from. K, W, or L refer to the pre- and post-workshop reflections, with participant number included. Mid-workshop discussion (D) and anonymous comments on the Mural™ digital whiteboard (M) are followed by a number, representing the workshop they attended.

Pre-workshop: Wanting to learn how to help

Most participants shared general but limited information when asked, "What do you already know about weight stigma?" Many mentioned having no formal knowledge and/or stated merely that they recognise weight stigma exists within physiotherapy. For example:

> *Anecdotally I can speculate that it could include bias assessment of an individuals' health and overall activity engagement as based on a visual inspection of their body and weight status.* (P20–K)

A few participants wrote a more sophisticated understanding that stigma is driven by stereotypes, where personality characteristics are ascribed to people based on their body type. For example:

> *Stereotypes about someone's health and/or character based only on their weight (example: lazy, uninformed) that may or may not lead to discriminatory behaviour against the overweight person (may make us treat them unfairly).* (P23-K)

> *Weight stigma to me, means that there is a perception around what a person should weigh and what they should look like and if they do not fall within that domain that society classifies as "normal" or "ideal" then individuals will tend to scrutinize them and there is also a belief system attached to the stigma such as they are lazy and unmotivated, etc.* (P16–K)

Fewer still were comments showing that a participant understood how anti-fat bias could result in stigmatizing physiotherapy care:

> *There are physiotherapists that have the perception that certain conditions occur because a person is overweight and will discuss that as the "cause" to the patient meanwhile leaving out other viable reasons as to why the condition or injury occurred. An example that I hear often is osteoarthritis in the knees, a lot of physiotherapists will attribute it to the patient being overweight and recommending they try to lose weight, which I feel like there's a lot of other ways around making them feel better and actually getting better rather than bluntly telling a patient they need to lose weight.* (P16–K)

Two participants also suggested physiotherapists themselves are subject to thinness and/or fitness-related expectations, sharing different ideas about why that might matter. One suggested that pro-thin biases are embedded in expectations about physiotherapists:

> *There is a societal expectation that physiotherapists should be of a smaller, more fit body type. 'Practice what you preach' related to physical health and fitness. That by being physically active, you should naturally have less fat.* (P22–K)

The other suggested that the fitness orientation of the profession may result in stronger biases:

> *Physiotherapists are often associated with being active and fit and so may be more likely to have developed negative stereotypes against people who are overweight. Weight stigma is not included as a strong component of physiotherapy education.* (P23-K)

What physiotherapists wanted to know varied from vague to specific, similarly displaying a range of depth of understandings of weight stigma in practice. In their responses, many shared their concern about how to care well for patients. For example:

> *I'm very uncomfortable talking about weight to patients because I truly don't think the weight of a person matters, there's more to health than that, but is that the wrong perspective to have and am I potentially creating a disservice to my patients by not talking about it? If we need to talk about weight, what is the best way to do that?* (P16-W)

> *I would like to learn the extent of weight bias in physiotherapy. I would like to learn strategies to recognize and overcome weight bias for care provision.* (P19–W)

Some responses seemed to highlight a lack of understanding of weight stigma as a societal problem. For example, one participant wanted to know:

> *In a world where obesity rates are rising, are we doing a disservice to patients by not talking about weight as a way to combat the weight stigma? How should we approach this?* (P22–W)

This question implies the solution to weight stigma may be reduced body weight, a strategy that does not disrupt fat stigma at structural or interpersonal levels and implies weight reduction is desirable and possible.

In these pre-workshop questions, two participants spoke to the issue from a more personal perspective, of people experiencing weight stigma. One clearly highlighted how physiotherapists themselves are not a homogenous group, sharing information about her own experience with an eating disorder, and body fat gain during recovery.

Engaging in the workshop: Creating new problems and uncertainties

Confronting patients' experiences in a new way

Entering the workshop, the physiotherapists and students recognised the limits of their knowledge, including how weight stigma might influence care. Then, the workshop itself posed problems for practice that participants had to work through. The Gallery confronted participants with the voices of past physiotherapy clients speaking directly about problems they have faced in clinical care, and the need for change. The private reflections shared anonymously after the video highlighted the emotional aspect to social justice learning predicted by Boler and Zembylas (2003). The most common emotions named were sad (n=5), followed by frustration/frustrated (n=4). Two or three participants added disappointed, embarrassed, guilty, nervous, and vulnerable. These emotions are mostly located in the "sad" and "angry" quadrants of the Feelings Wheel image (Calm, n.d.).

Reflecting on prior fault

In the more open-ended question posed for private reflection after "The Gallery," many shared variations of "Have I done this?" For example:

> *It made me wonder if I have been guilty of treating people differently based on their size.* (M2)

> *After watching the gallery, I am thinking how I as a practicing physiotherapist enter in discussion with patients and how they perceive that discussion. I query about if the patients feel like they are free to express their thoughts, concerns, and fears as these too could all be barriers to their healthcare journey.* (M1)

> *I hope I have never unintentionally made anyone feel the way they explained they feel.* (M4)

The question of prior fault repeated later in the workshop, when participants had a chance to discuss and ask questions in relation to the content presented to that point.

> *I struggle a lot with, like I know I want to help, and I know I don't want to make any inappropriate comments inadvertently 'cause sometimes you know how you say things but then you come across not the way you want them to come across? Um so I guess that was one of my fears, like what if I'm trying to help the situation, but I might actually be hindering the situation?* (D3)

Over the course of the workshop, our data suggests many were actively grappling with their culpability in the reproduction of anti-fatness, and the impact on those they were to help. The exception was a participant who acknowledged having stigmatised prior patients on the basis of weight but took issue with "being judged" by patients:

> *I was a little frustrated and perplexed by the initial video . . . I almost felt frus—, well frustrated and angry 'cause I thought . . . they're judging me as a health professional, whereas my job is to try and make them the best that they could be . . . .., I mean I know I've, I've stigmatised people, but in my professional life I've en— y'know always endeavoured to help people, whatever. But if they aren't willing to help themselves, whether they're fat or thin or whatever the case may be, you can't help them, which gets into the, y'know, health behaviour change type of component. So I think I better shut up there (laugh).* (D4)

Based on this comment, "The Gallery" did not spark a dialogical form of questioning and uncertainty about past action. Instead, this participant dismissed her own stigmatizing actions and deflected attention from the potential impact on others. Instead, she portrayed those who do not take her help, offered on her terms, as those who "aren't willing to help themselves." We interpret this as a defensive action.

Grappling with how best to care: Discomfort and uncertainty

Throughout the workshop, most participants expressed uncertainty about how to address and disrupt weight stigma in practice. They made sense

of these issues in differing ways, and with varying levels of openness or defensiveness.

Many participants continued to explore how best to care for people in the face of weight stigma. Prior to the final presentation that shared possible actions, some predicted strategies that would help lessen stigma, including ensuring equipment used is suitable for a range of body sizes and weight, improving seating options to fit different bodies, ensuring careful and purposeful selection of images, and utilizing better communication approaches.

Two, however, responded more defensively, including the participant who made the earlier comment that she had "always endeavoured to help people." She framed her concern as a challenge to the content, in opposition to the possibility of disrupting weight stigma:

> *I'm gonna just counter and just challenge you with one little thing is that . . . we also have to look at the health care workers health and safety too. And I have seen many therapists um probably in the last five or ten years where you have to look for your own safety while you're trying to get someone moving and y'know where you're looking at three or four therapists trying to help a patient and you know you have to be cognizant of your own health and safety as an employee as well as trying to mobilise someone and those are those are the tougher conversations I think and the tougher things to kind of work around because y'know how do you do that? How do you set a patient up to safely move? How do you do and say okay we've got four people here to try and get you up and I mean, we're doing that to try to be safe for you but also to be safe for ourselves because we don't want to put ourselves in a situation where we're going to hurt ourselves.* (D4)

Her comment implies that occupational safety is somehow counter to disrupting weight stigma. However, this points out a concern that future anti-stigma education could address—physical safety with transfers and similar activities.

The other participant shared a story of an Indigenous woman with a larger body who expressed anger after the participant approached the woman in a public place to share program information. Instead of reflecting on or

questioning what she had done, she spoke in a way that deflected blame onto the other woman:

> *I'm white and I'm thin so I guess I had two strikes against me. I sat down at the table with her and just started chatting with her, I just told her what our program was and you know, would she be interested in coming and joining us for you know to try some exercises or something. And she got so mad at me, she just started yelling at me and she said "what would you know about or something what would you know about being fat or something" she said and "how dare you suggest that I need to exercise? People that are thin like you know nothing of what it's like." . . . I'd never been attacked like that before, um for being thin . . . I wanted to say something helpful but I was really afraid that at that point, whatever I said was not going to be interpreted as helpful.* (D3)

Post-workshop: Evolving understandings of weight stigma

Immediately after the workshop, participants shared anonymous reflections and feedback. This included another question about emotions. The most common emotions, each stated by two or three participants, were optimistic, surprised, and interested. These emotions are mostly located within the "happy" quadrant of the Feelings Wheel, a shift from earlier responses.

While such positive emotions might imply an over-confidence or a form of premature closure for the participants, the responses to the other post-workshop questions showed a growing sophistication of their understanding of weight stigma, with uncertainty still an undercurrent. We interpret this as success, given one important facet of critical reflection is increasing tolerance for uncertainty and fostering humility. Looking to future practice, many participants' reflections after the workshop highlighted an openness to try new things, and more confidence in terms of what to try. Their responses continued to build on the animating question of the workshop: how to care well for people in the face of weight stigma?

> *Curious in exploring the different strategies explained and not being scared or awkward if a patient brings up the "weight talk" with me . . . it has always been a conversation I avoid and don't*

> *feel comfortable in having because I truly don't think weight equals health but explaining how losing weight is not a behaviour and how self-kindness is important reinforced that I'm potentially already on the right track on trying to reduce weight stigma.* (M4)

Others highlighted more conceptual knowledge gained, and a better appreciation for patients' perspectives:

> *I learned about the labels and stereotypes that create the cycle of stigma. I learned about the Health at Every Size™ model and its principles of weight inclusivity, respectful care, and life-enhancing movement (among others). While I am still unclear about the exact nature of the link between elevated body weight and certain health issues, I am more open to the idea that people can be healthy at a wide range of body sizes. I was reminded that in many ways we are not in control of our body weight and that higher body weight is not a reflection of poor health choices or lack of motivation, effort, or health resources.* (P15–L)

> *Weight stigma can have a negative effect on our patients right through their treatment course. It can start from them not even making an appointment because of the fear/anxiety of having these biases affect their care.* (P22–L)

And some displayed a new ability to perceive situations as stigmatizing:

> *The presentation at the beginning with the voice overs made me realise how something as simple as not having a chair big enough for someone to sit in could lead to negative feelings and which could result in an overall negative interaction with physiotherapy and the healthcare system. I know in one of my clinical placements I debated using the parallel bars with a patient, but my CI and I weren't sure if she would fit as they weren't adjustable width wise so to spare her any humiliation or negative feelings, we decided not to use them for her exercises. It made me realise afterwards that this patient was receiving a lower standard of care just because of her size. This presentation reinforced the importance of having appropriate equipment for all shapes and sizes.* (P8–L)

Several engaged with the topic through their personal, non-clinical experiences, or that of their family and friends. Some spoke of their children's experiences as teens and young adults, or their own. The clinical and the personal could entwine, one informing the other:

> *Although I would think that I accept all body sizes, I don't accept mine, so does that make me "authentic" in dealing with patients? I have been working in a 'medical model' and so what I think is maybe that weight is not the risk factor for heart attack, but maybe it is the health behaviour. It makes me question previous studies and wonder if they teased this apart or simply based their conclusions on BMI. What if we teased apart "health behaviour" and "weight" as weight is based on so many aspects, medication, genetics, exercise, how you build muscle (some stay lean whereas others seem to bulk). Is weight due to muscle, or fat? Is weight due to unhealthy eating or not? Do they have any health risks or conditions due to their weight? Is the weight due to factors they can or cannot control? Are any of these correlated? . . . I learned how complex the idea of "weight" is.* (P13-L)

To further exemplify this growth, we looked at each participants' KWL individually. Across the set, we saw longer and much more robust responses in the post-workshop reflections than prior. For example, consider the trajectory of one participant, who had shared only a brief, basic understanding before the workshop about the existence of weight stigma:

> *Nothing concrete. I would assume physiotherapists are not as far removed from the norm in regard to having weight stigma towards others as we would like to think. I would also guess that physiotherapists experience it more than some as we are supposed to be the exercise professions.* (P17–K)

Pre-workshop, they asked,

> *Is it an actual "risk" to not receiving optimal care?* (P17-W)

After the workshop, they shared that some previously held ideas have been disrupted, made strange:

> *I have not thought of "go lose weight" as essentially being as helpful an instruction as "go lower your blood pressure"* (P17–L). [As well, I] *had never thought about the concept of weight stigma being something internal that patients can have towards themselves. I've seen the behaviour of that in real life, so it is helpful to able to recognise it as weight stigma so it can be approached through that knowledge and lens when talking. Bring treatment back to behaviours and remind people that weight is multifactorial.* (P17–L)

This example, like many others, displayed a newer appreciation of the issue as it presents in physiotherapy practice.

What makes disrupting weight stigma hard in physiotherapy: Participants' ideas

In the post-workshop questions, participants shared their ideas about what might make addressing weight stigma difficult within physiotherapy practice. Most common was that disrupting the simplistic "weight = health" belief could be difficult; they thought it is a core belief held by many physiotherapists. Some described how the "weight = health" belief is currently embedded in clinical practice recommendations, that guide physiotherapists to tell people to make their bodies "lose weight," or how uncommon it would be to interpret a person as "healthy" if their body had visible body fat. Next most common: the participants thought that physiotherapists may struggle to shift from weight/outcomes focus to a lifestyle/behaviour change support focus in care.

> Otherwise, there was less consistency. Some comments highlighted a lack of knowledge about health coaching/self-management support strategies, getting enough physiotherapists to be willing to "*face your bias and prejudice*" (P7-L) or "*unlearn what we feel that we know as truth*" (P19-L). Another mentioned the magnitude that disrupting anti-fatness and pro-thinness would involve: "*there is no simple change of one item. Instead, it is a shift of physical environment (equipment, space, uniforms), a shift to technologies, a shift of mindset, a shift of intellectual mindset and practice application*" (P22–L). However

difficult, participants affirmed the importance of the topic to physiotherapy, some emphasizing the need for integration into curriculum.

The cognitive and emotional work of disrupting stigma

We sought to explore physiotherapists' existing understandings of weight stigma and what might make disrupting weight stigma challenging in clinical practice. Given the topic, physiotherapists who attended may be those with more pre-existing awareness of weight stigma or be early adopters on social justice topics. Overall, we found that participants started from varying understandings of weight stigma, but few knew strategies to disrupt weight stigma in practice. In our river metaphor, few knew how exactly to unsettle the waters and interrupt the flow of the status quo. This is notable; our earlier study (Webber et al., 2022) found that, on average, physiotherapists in this same province displayed mainly neutral to positive fat acceptance attitudes. Yet attitudes do not predict action—or, as we found, even an understanding of what actions will help.

After the workshop, participants noted two ideas that they anticipated would make disrupting anti-fatness and pro-thinness difficult. The first, a simple "weight = health" formulation, is a core assumption that underpins weight stigma in our society that treats health as a moral good (Lupton, 2018; Mayes, 2016). In the workshop, we challenged this assumption, pointing to the many problematic assumptions and clinical actions that can follow if bodily thinness is automatically assumed to mark good health, and bodily fatness the reverse. This simplistic formulation ignores that thinness and weight reduction can be signs of eating disorders, depression, or cancer, among other problems. It also reduces health to a single physical measure, and a flawed one: BMI categories are poor proxies for cardiometabolic health (Phillips, 2013; Wang et al., 2015).

The formulation of "Thinness = health" underpinned an unsuccessful, brief educational study with physiotherapists on this topic (Forhan & Jones, 2021). While stating they were attempting to answer a call by Groven and Heggen (2018) and Setchell et al., (2017) to better understand "the interactional, psychological, sociocultural and political aspects of stigma" (Jones & Forhan, 2021, p2), Jones and Forhan focused their workshop on "obesity,"

a medical frame for body size which the authors described to participants as a risk factor for poor health. In Western cultures, where healthiness takes on moral overtones (Lupton, 2018; Mayes, 2016), education that aims to disrupt stigma is likely to fail if it reinforces one of the underpinning drivers of the particular stigma. This is an identified problem with pairing a biomedical obesity frame with weight stigma reduction (Brady & Beausoleil, 2017; Thille, 2018; Bombak et al., 2022; Talumaa et al, 2022).

A second issue physiotherapists identified after the workshop was the switch from focusing on health outcomes to health behaviours. Given physical activity promotion is a core physiotherapy activity, we assumed that physiotherapists had pre-existing knowledge of the clinical skills associated with support of patient behaviour change and self-management. Supporting self-management involves focusing on feasible actions the person values and coaching skill development in goal setting and problem solving (Lorig & Holman, 2003). Our assumption was misguided; this approach was unfamiliar to many. In retrospect, this was perhaps predictable. Several studies have found physiotherapists lack knowledge and skills with self-management support strategies (Espiritu et al., 2020; Kongsted et al., 2019; Button et al., 2018; Brewer et al., 2021). Perhaps even more concerning, Gardner and colleagues (2018) found physiotherapists did not recognise that they lacked this training or skill. This appears to be a gap that impacts physiotherapists' abilities to enact non-stigmatizing care, as well as a finding with broader implications for quality of care.

In addition to the challenges physiotherapists identified, our project highlights one more: as predicted, learning to disrupt weight stigma is not just cognitive work, but emotional and embodied as well. Physiotherapists were actively grappling with the implications of the workshop, facing the realization that they had, or possibly had, stigmatised former patients. Boler and Zembylas (2003) predict this emotional work in social justice education, which "recognizes and problematizes the deeply embedded emotional dimensions that frame and shape daily habits, routines, and unconscious complicity with hegemony" (Boler & Zembylas, 2003) p. 117). The workshop was successful in navigating the emotional aspects of learning for most participants, allowing for personal acknowledgement of emotions as part of the process.

The workshop also brought up the issue of power differentials. Link and Phelan (2001) argue "the role of power in stigma is frequently overlooked because in many instances power differences are so taken for granted as to seem unproblematic" (p. 375). We understood that unsettling anti-fatness means also disrupting pro-thinness (Nixon, 2019). Power can reflect professional status, but also be expressed through embodied forms, including thinness. By inviting physiotherapists to reflect on these issues and drawing attention to how bodies of physiotherapists and patients can shape interactions, we found this design helped unsettle professional views about what constitutes "good care." For example, participants questioned following guidelines that encourage recommending weight loss as an intervention for different conditions, given the potential for stigmatizing patients (among other problems).

Our study was limited by using a single workshop for participants. While we maximised the data we could create with this design, we anticipate future studies using a longitudinal design and more participatory interventions (e.g. Setchell et al, 2017) will yield additional insights about what, in particular, makes disrupting the anti-fatness and pro-thinness of Western cultures difficult in physiotherapy as well as other professions. Like all qualitative studies, the transferability of our findings is limited to where such cultural influences are similar (Tracy, 2010). Due to our sample being predominantly women, we were unable to consider gender-based variations among participants. And while people seeking physiotherapy services may not share the same Western cultural pro-thinness/anti-fatness references to body size and composition, we limited attention to intercultural differences in beliefs to that of the fat acceptance movement/culture, which is only one of many potentially different possibilities in beliefs about bodies. Strengths of our study include our analytic consideration of variation within the data, which allows us to draw out more of a range of possible responses, and the theoretical and pedagogical orientations of this study. The use of critical reflection via making the familiar strange and dialogical elements allowed physiotherapists to begin to metabolise what this topic means in their professional and personal lives, and the additional theoretical concepts supported a nuanced analysis.

Critical reflection and the creation of emancipatory knowledge

Critical reflection was the tool we used to help physiotherapists to churn the flow of the "river" of status quo, to disrupt the way weight stigmatization manifests in physiotherapy care. Change is the goal of critical reflection – and not just any change: "Critical reflection can . . . produce emancipatory knowledge, as it aims to transform rather than perpetuate perspective and power relations" (Ng et al., 2019, p. 1123). To achieve the vision of person-centered and community-centered care that addresses the human dimensions of illness and injury, the physiotherapy profession needs to disrupt different stigmas that manifest in practice. Our study highlights the value of social theories and critical pedagogies to facilitate critical reflection; by the end of the workshop, the participants were able to identify some gaps in their knowledge and skills, commonly held beliefs in physiotherapy that exacerbate weight stigma, and many possible actions. Our critical reflection-oriented workshop fostered humility in most, while keeping participants focused on the question of how best to provide care.

Future research could explore other critical pedagogical strategies, as well as longitudinal educational or knowledge exchange designs, to deepen our understanding of how to disrupt anti-fatness and pro-thinness in physiotherapy and other clinical practice. In particular, future work can build on other existing critical pedagogies, particularly through engaging in growing field of fat pedagogies (Cameron & Russell, 2016; Cameron & Watkins, 2018).

Notes

1 A quote from fiction written by David Foster Wallace, highlighted by fiction writer Zadie Smith as an aspiration for her writing; see https://millionsmillions.tumblr.com/post/32337897514/litbeat-zadie-smiths-sentences

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