Graduate Student Journal of Psychology
Fall 2025 - Vol. 25

A Conceptual Model for Addressing Weight Stigma and Health: Guiding Practitioner Conversations for Weight Health

Colter K. Clayton, MA
Department of Psychology, University of Mississippi, USA

Practitioners working in a variety of healthcare settings increasingly face a dilemma when speaking with patients about weight health. On one hand, prescriptive weight-related health advice can exacerbate stigma, while on the other, ignoring insufficient health behavior engagement limits health and increases the risk of other adverse weight-related health conditions. Research has demonstrated that higher-than-optimal body weight is a correlate of morbidity and mortality, but has also demonstrated that weight stigma is pervasive, negatively impacting health, health behavior, and well-being. This article introduces a novel conceptual model to help practitioners initiate conversations about weight health by striving to support health behavior change in a way that deactivates and disempowers weight stigma. By advancing the acceptance principle from motivational interviewing and adapting its scope, the model focuses on destigmatizing attitudes and assumptions related to weight health to prevent or reduce generalized and internalized weight stigma. The model also focuses on limiting interpersonal stigma and its disruptive role in practitioner-patient communication by supporting personal autonomy for a lifestyle of health behavior. This article reports results from a rapid review and calls for research efforts to examine the potential causal role of active acceptance for reducing weight stigma. Overall, the conceptual model simultaneously promotes health behavior and reduces weight stigma for weight health.

Keywords: weight stigma, weight health, health behavior, motivational interviewing, healthcare practitioner

> People don't care how much you know until they know how much you care.
>
> — Attributed to Theodore Roosevelt

People need support. Every person faces adversity, and health is a universal concern – whether young or old, rich or poor, all contend with morbidity and mortality. Compassionate individuals are empowered by a deep desire to promote the well-being of others. Whether they work in medicine, health psychology, or public health, their passion for care sparks career interests and fuels professional diligence. However, how can healthcare practitioners (some researchers prefer *practitioner to provider*; Scarff, 2021) from distinct training backgrounds and professional roles navigate the complexities of weight-related health and weight stigma? This paper reconciles promoting health behavior and reducing stigma for weight health by proposing a novel conceptual model for practitioners. The model resolves a dilemma faced by many practitioners: saying too much (e.g., prescriptive weight-related health advice exacerbating stigma) versus too little (e.g., ignoring insufficient health behavior engagement). To fully articulate the model, it is first necessary to review the evidence demonstrating the importance of weight-related health and discuss weight stigma as a barrier to health.

Weight Health

Weight-related health is a principal public health concern globally (Okunogbe et al., 2022; Safaei et al., 2021). Being of higher body weight due to an excess of adiposity large enough to cause reduced health or longevity – at least probabilistically over time – is linked to morbidity and mortality, is largely considered a complex lifestyle concern, and its consequences are associated with increased risk for a myriad of cardiometabolic diseases (Allison et al., 2008; Fruh, 2017; Safaei et al., 2021). Indeed, higher-than-optimal body weight has been linked to increased risk, or at least concomitant to, "... nearly every chronic condition, from diabetes, to dyslipidemia, to poor mental health. Its impacts on risk of stroke and cardiovascular disease, certain cancers, and osteoarthritis are significant" (Hruby & Hu, 2015, p. 10). Whether certain ranges of body weight (e.g., body mass index > 30; Allison et al., 2008; Katz, 2014) are to be medically considered a disease is irrelevant to the development of the model. The strength of evidence demonstrates that it is beyond a reasonable doubt that being of higher body weight due to excessive accumulation of adipose tissue is related to poorer cardiometabolic health and well-being (Hruby & Hu, 2015; Pi-Sunyer, 2009; Robinson et al., 2020; Visscher & Seidell, 2001). Although weight-related health and associated conditions are complex in their etiology and maintenance, consequences related to morbidity and mortality are considered largely preventable or reducible (Fruh, 2017; Hruby & Hu, 2015). Prominent health organizations educate practitioners and patients about the negative impacts of higher-than-optimal body weight. The World Health Organization, Centers for Disease Control and Prevention, and the

National Institutes of Health use websites[1]* to publicly disseminate the latest research on risk factors and best-practice health strategies to educate practitioners and patients.

Healthcare practitioners know that weight loss (when needed) has a large impact on improving health through lowering risk for disease (e.g., type 2 diabetes, hypertension, dyslipidemia; Haase et al., 2021) and is linked to improvement in current health conditions (Pojednic et al., 2022). Even modest amounts of weight loss (e.g., >5% of body weight) are associated with clinically significant improvements in cardiometabolic health and emotional well-being (Fruh, 2017), and weight loss at higher levels can lead to further improvements (Ryan & Yockey, 2017). More engagement in health behaviors is needed; physical activity, eating a healthy diet, and obtaining quality sleep are vital for health. For example, in the United States, only about 1 in 4 adults meets physical activity guidelines, and engagement is even lower among those with lower incomes (Elgaddal et al., 2020).

Practitioners also know that physical activity has health benefits independent of body weight. For example, among people with higher body weight, physical activity has demonstrated positive changes at the cellular level (e.g., improved enzyme function), along with improved metabolic function (e.g., increased insulin sensitivity), and better cardiovascular outcomes (e.g., decreased arterial stiffness; Pojednic et al., 2022). Thus, physiologic improvements observed with increased physical activity are observed despite starting weight and irrespective of whether weight loss occurs, and cardiorespiratory fitness is an indicator of metabolic health (Ortega et al., 2013). Given that health behaviors such as physical activity contribute to health, increased adherence and implementation are needed.

Weight Stigma

Practitioners are increasingly becoming aware of how health stigma and discrimination limit social acceptance and opportunity, and how they exacerbate inequality, which are well-documented barriers to engagement in healthcare and health behaviors (Hatzenbuehler et al., 2013; Stangl et al., 2019). Weight stigma is a form of health stigma. It refers to reduced social status due to excess body weight, and weight-related negative attitudes are linked to discriminatory actions such as unfair treatment in healthcare (Rubino et al., 2020). A landmark study at the turn of the century by pioneering weight stigma researchers introduced its negative impact on employment, education, and healthcare (Puhl & Brownell, 2001). Subsequent research has solidified weight stigma as a major health issue: at least 1 in 2 adults experience stigma related to their weight, which is associated with less regular medical checkups, healthcare avoidance, and worse healthcare quality experiences (Puhl et al., 2021). Recent international research initiatives to address weight stigma have called for more actions from the medical community to promote the education and training of healthcare professionals to practice without participation in or perpetuation of weight stigma (Puhl et al., 2021; Puhl, 2023; Rubino et al., 2020).

Healthcare practitioners are increasingly recognizing that weight stigma is not helpful or healthy. A major concern of weight stigma is its negative effect on health behaviors: decreased physical activity, decreased healthcare engagement, and paradoxically, even weight gain (Tomiyama, 2014). Weight stigma has negative impacts in laboratory and real-life contexts (Major et al., 2014; Panza et al., 2023; Puhl & Suh, 2015; Rubino et al., 2020). For example, brief exposure to reading or watching weight stigma can elicit cardiovascular reactivity and increase overeating behavior (Major et al., 2014; Panza et al., 2023). The everyday consequences of weight stigma include maladaptive eating behaviors (e.g., binge eating), lower engagement in physical activity, and unhealthy weight gain (Puhl & Suh, 2015).

Dilemmas of Weight Health and Stigma

Saying too much can exacerbate stigma. For example, some researchers have called for increased social pressures (e.g., societal shame) to help individuals become more aware of their weight and associated stigmatization (Callahan, 2013), but subsequent stigma research did not support social pressure as a viable method to improve weight health (Puhl et al., 2021). Conversely, saying too little may condone poor health behaviors. The Health at Every Size (HAES) approach is a product of both academic research and social movements that challenge weight stigma, deprioritize weight and weight-related biomarkers of health, and

1 *https://www.who.int/health-topics/obesity#tab=tab_1; https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight; https://www.cdc.gov/family-healthy-weight/php/recognized-programs/index.html; https://www.cdc.gov/obesity/php/about/obesity-strategies-what-can-be-done.html; https://www.niddk.nih.gov/health-information/weight-management/adult-overweight-obesity/health-risks

promote bodily acceptance to improve health and well-being (Bombak, 2014; Penney & Kirk, 2015). Facilitating access to healthcare that is free of shame is a prominent virtue of this framework. However, while intending to reduce stigma, dismissing (whether deliberately or inadvertently) physical health recommendations may occur.

People with higher weight report negative psychological reactions to receiving weight-related advice from healthcare practitioners (Standen et al., 2024), which may explain why some groups reject and even criticize weight health recommendations as unethical (e.g., HAES). Self-affirmation theory describes how people maintain integrity to themselves (Steele, 1988). In weight stigma research, this theory may explain why people may be motivated to maintain a positive self-view regarding their weight when perceiving weight stigma. For example, a healthcare professional recommending weight loss may evoke a patient's efforts to maintain self-integrity, where healthcare recommendations related to body weight are perceived as attacks on personal identity; this may be a reason that recommendations can fail to produce motivation for change. Thus, practitioners must simultaneously preserve patients' self-integrity and recommend health behavior change.

Given the interacting complexities of weight-related health and stigma, practitioners face a daunting responsibility to care for patients. The dilemma practitioners face is two competing risks: over-alerting patients can be counterproductive, eliciting societal or personal shame and exacerbating the distress of stigma; conversely, under-alerting patients to weight-related health risks fails to promote positive health behavior change. A paradigm grounded in theory and evidence is needed to guide practitioners as they navigate the complexities of weight-related health.

Developing the WHISTLE Model

Research on the biopsychosocial factors of weight-related health and healthcare has led to theoretical and conceptual models that are comprehensive and often complex (Marks, 2015; McCabe et al., 2023; Michie et al., 2014; Plotnikoff et al., 2007). However, such models are not specific to stigma, though one model of weight stigma has emphasized a vicious feedback loop of stigma and weight gain (Tomiyama, 2014). Thus, existing models fall short of offering a simple and practical framework to begin helpful discussions about weight health and stigma. The novel Weight Health through Integrated Stigma-Reduction and Lifestyle Engagement (WHISTLE) model serves as a guide for practitioners. In contrast to the traditional "sick" role of passive prescriptions, contemporary healthcare increasingly prioritizes enhancing patient agency to boost health outcomes through more effective health behavior (Armstrong, 2014). However, healthcare practitioners may feel uncomfortable or incompetent in discussing weight with patients (Pont et al., 2017). The WHISTLE model aids practitioners as they practice attitudes of acceptance to reduce weight stigma when opening a conversation about weight-related health that facilitates the encouragement of health behavior change by using a patient-centered approach.

Health behavior change is facilitated through the atheoretical principles of motivational interviewing. At its core, motivational interviewing is an empirically supported, patient-centered approach to talking with people in a way that strengthens their own motivation and commitment for behavioral change (Miller & Rollnick, 2023). Reflections and questions by practitioners help patients work through the natural ambivalence they experience when facing decisions about behavioral change. The proposed mechanism that has received the most empirical support is practitioners' use of selectively reinforcing patients' own motivational statements for behavior change (Bischof et al., 2021). Research on motivational interviewing as a favorable intervention for positive health behavior (e.g., physical activity) and weight-related health outcomes is mixed (Amiri et al., 2022; Frost et al., 2018; Lundahl et al., 2013; Makin et al., 2021; Michalopoulou et al., 2022). However, motivational interviewing as an empirically supported way of effectively being in a helping relationship (e.g., practitioner engagement) and facilitating behavior change has received substantial empirical support across healthcare settings (Bischof et al., 2021; Lundahl et al., 2013; Luty & Iwanowicz, 2018; Magill et al., 2018; Miller & Rollnick, 2023; Rubak et al., 2005).

While motivational interviewing principles broadly support behavioral change, they do not address the issue of stigma – particularly weight-related stigma – in weight-related health outcomes. The novel WHISTLE model is a person-centered framework that tar-

gets weight health conversations and was derived from a component known as acceptance. The WHISTLE model's guiding principle of acceptance was based on a previous edition of the motivational interviewing approach created by Miller & Rollnick (2013) with four 'A's: absolute worth, accurate empathy, affirmation, and autonomy support. In the WHISTLE model, the four 'A's function as fundamental assumptions, attitudes, and actions for practitioners working with patients and weight health concerns. Thus, the WHISTILE model provides a foundation to simultaneously reduce stigma and encourage health behavior change.

In the WHISTLE model, practitioners assume and adopt an attitude that each patient has inherent worth irrespective of weight, health, or behavior, and that each person is innately capable of behavioral change. Actions of practitioner acceptance include expressing accurate empathy and communicating a genuine interest in understanding the patient's experiences and situation (Schumacher & Madson, 2014). Practitioners also provide affirmations and statements to help patients see their own strengths and resources and champion patients' autonomy as they choose whether and how to make behavioral change. Since patients with a history of weight stigma report being less heard and respected by their healthcare practitioner (Puhl et al., 2021), the WHISTLE model's assumptions, attitudes, and actions function to reduce self-stigma, stigma in the practitioner-patient relationship, and prevent or reduce generalized weight stigma from interfering with healthcare discussions about weight health (see Figure 1).

Weight stigma interferes with practitioner-patient communication through shameful language and impaired emotional engagement, which are associated with healthcare disengagement and avoidance (Puhl, 2023). Practitioners with higher weight stigmatizing attitudes report feeling less confident in offering weight health recommendations and less likely to use a person-centered approach when speaking with patients (Bennett & Puhl, 2024). On the other hand, within a motivational interviewing approach, patients who talk about plans for behavior change show better body weight outcomes over time (Copeland et al., 2017). Patients can feel simultaneously motivated to lose weight and feel bad (e.g., guilty) regarding their weight-related health (Standen et al., 2024), highlighting the need for concurrent stigma reduction and health behavior encouragement. Practitioners may be better equipped to work with weight health to deactivate stigma with acceptance-promoting statements.

The WHISTLE model helps practitioners to channel an atmosphere of acceptance to 1) prevent generalized social stigma and their own potentially stigmatizing attitude from entering the relationship, and 2) reduce self-stigmatizing beliefs among patients (though the patient acts as the mediator of this relationship; see Figure 1). Within this atmosphere, practicing acceptance moves generalized practitioner stigma and self-stigma further away from the patient to allow for increased patient self-efficacy, weight-related health information discussions, and encouragement of healthy lifestyle behavior. The figurative cloud represents the subjective, relational aspect in which practitioner-patient communication occurs. Statements of accurate empathy increase connection and empower patients' autonomy for making behavioral health changes (see Table 1). Supporting autonomy is intended to have the dual effect of further reducing stigma while promoting behavior change. Practitioners risk eliciting ambivalent or negative psychological reactions as they offer weight-related advice, but a two-way discussion is a characteristic of patients feeling motivated to begin healthy behavior change (Standen et al., 2024). Practitioners using the WHISTLE model who create an atmosphere for health behavior change, champion patient autonomy, and affirm the value and ability of healthy lifestyle behavior will likely negate the adverse impacts of stigma on health and well-being.

The WHISTLE model extends behavioral change frameworks. For example, motivational interviewing and self-determination theory (i.e., an empirical framework for enhancing behavior change) are conceptually related and aid practitioners in helping patients internalize their own motivation and ultimately foster volitional health behavior change (Abildsnes et al., 2021). Although these informed the development of the WHISTLE model, this model uniquely highlights the necessity of averting weight stigma's disrupting role in hampering practitioner-patient communication and provides a feasible template for accomplishing this task. It is also important to recognize that increasing sensitivity to perceived harm, such as weight stigma, may engender a sense of diminished perceived control among patients, which is a factor that has long been recognized as a facilitator of health behavior change

(Schwarzer & Fuchs, 1996; Strecher et al., 1986). Conversely, while self-affirmation can be a barrier, it is also a catalyst for behavior change (Cohen & Sherman, 2014). Indeed, research has demonstrated the value of affirmation interventions, which are associated with better health, including increased health behavior and even lowering body weight toward healthier ranges (Epton et al., 2015; Ferrer & Cohen, 2019; Logel & Cohen, 2012). For example, self-affirmation is associated with greater acceptance of health information and stronger motivation for health behavior change when receiving health risk information (Epton et al., 2015).

Discussion

The WHISTLE model is not a full-scale intervention but rather emphasizes an attitude of acceptance in which practitioners harmoniously attend to disarming stigma and facilitating health behavior for weight-related health. Other researchers have developed a high-quality guide to foster practitioner-patient communication within a motivational interviewing approach to reduce stigma in weight health (see Scherr et al., 2023, for a review). The WHISTLE model adds to this research by focusing on attitudes and actions of acceptance, and its primary purpose is to initiate conversations about weight health and behavioral change within an attitude of acceptance to prevent and reduce stigma. Beyond initial engagement and discussion about weight health using the WHISTLE model, practitioners use methods and treatments congruent with their expertise, responsibility, and setting. More simply, a broad scope guideline to continue conversations is outlined within a Brief Action Plan (BAP), which is a person-centered approach to facilitate health behavioral change and has supporting evidence across many healthcare settings (Jadotte et al., 2023). The WHISTLE model's biopsychosocial lens allows for a compassionate and health-focused approach to reduce stigma and empower patients to participate in healthy lifestyle behaviors. Consistent with motivational interviewing principles, the WHISTLE model does not imply endorsement of unhealthy behaviors but rather acts as a relational process in which an attitude of acceptance deactivates stigma while still facilitating health behavior change. As practitioners within the WHISTLE model focus on empirically supported health behaviors in an atmosphere of acceptance that affirms one's inherent value, defuses stigma, and supports autonomy for health behavior change, weight-related health is likely to improve.

A Call to Healthcare Practitioners

Psychological theories on behavior change are advancing the landscape of healthcare quality (Hilton, 2023). Healthcare practitioners across training backgrounds and treatment settings have a duty to promote weight health and well-being. Mental health clinicians are even emerging as important, supplementary practitioners to weight-related health concerns (Dandgey & Patten, 2023; Murray et al., 2021). Given the rising adverse health consequences of higher body weight, inaction will have negative global impacts on health, well-being, and economic resources (Okunogbe et al., 2022). Although calls for systemic-based changes are increasing (and likely required) to effectuate lasting weight-related health improvements from a public health perspective (Okunogbe et al., 2022; Puhl & Suh, 2015), practitioners maintain the responsibility to promote health behavior change.

Health psychology research has recognized weight-related health as a persistent public health concern despite decades of targeted resources and research (Brownell, 2010). Health psychologists have a duty to bilaterally support patients based on the advancing empirical literature across health sciences. Just as weight stigma research is progressing, the data establishing the health benefits of healthy lifestyle behavior and the risks for morbidity and mortality related to higher body weight are also advancing. Health psychologists are well-positioned to handle potentially conflicting goals related to stigma, behavior, and weight health. However, to maintain this position, health psychologists and related professionals must maintain fidelity to evidence demonstrating the negative impacts of higher body weight and strive to mitigate risks through facilitating health behavior. For example, contrary to HAES, health psychologists cannot maintain weight-related neutrality when presented with opportunities to promote weight-related health. Health behavior and weight-related health dialogue need not be removed nor disparaged to reduce weight-related stigma. Promoting empirically supported health behaviors (e.g., physical activity) for weight-related health is vital for patients and a duty of practitioners.

Future Research Directions

The WHISTLE model has implications for at least three directions for research. First, there has been

promising research on self-affirmation as a weight-related health treatment (Logel & Cohen, 2012). More research should test whether self-affirmation interventions are effective for protecting patient self-identity in the context of receiving healthcare recommendations, reducing weight stigma, and facilitating health behavior changes congruent with weight health recommendations. Relatedly, compounding stigmas represent a greater health concern (Stangl et al., 2019), but research has only recently begun to investigate weight stigma and diversity, such as the intersectionality of weight stigma, race, and gender. Experienced weight stigma is similar across racial and gender groups but internalized less among Black and Hispanic individuals relative to White individuals, and less among men relative to women (Himmelstein et al., 2017; Reece, 2019; Wetzel & Himmelstein, 2024). Notably, lower self-compassion is associated with greater weight stigma across racial and socioeconomic backgrounds, which represents a potential target for reducing internalized weight stigma (Puhl et al., 2020).

Second, the impact of technical aspects of the WHISTLE model (i.e., acceptance statements and questions) should be empirically investigated to test the hypothesized effect of simultaneously reducing weight stigma and facilitating healthy lifestyle behavioral change (Moizé et al., 2025). To operationalize the processes of the WHISTLE model, researchers could determine whether a practitioner's statement (or question) for initiating conversations about weight health is congruent with the four 'A's of acceptance. For example, 1 = congruent, 0 = partially congruent, and -1 = not congruent, with higher total scores reflecting higher adherence to the WHISTLE model. Table 1 provides appropriate statements, each of which is congruent with assumptions, attitudes, and actions of acceptance in the WHISTLE model. A randomized controlled trial could be conducted to compare the weight stigma and behavioral outcomes of practitioners who use the WHISTLE model to initiate conversations with patients compared to an active control, such as practitioners' treatment as usual, which often involves blunt recommendations to reduce body weight that exacerbate stigma (Standen et al., 2024). Behavioral outcomes may be measured by any relevant health behavior metric (e.g., change in total minutes per week spent participating in physical activity). Weight stigma outcomes may be assessed using existing validated weight stigma measures such as the Perceived Weight Stigma Scale (PWSS; Schafer & Ferraro, 2011).

Third, researchers from disparate training backgrounds (e.g., medicine, public health, psychology, sociology) may consider joint initiatives to synthesize data across biopsychosocial health science domains to elucidate weight health and stigma interactions. Results of such research would inform interventions to simultaneously reduce stigma and promote weight health and well-being.

A major limitation is that extant literature on motivational interviewing has not examined its potential effectiveness (i.e., its potential causal role) for reducing weight stigma, as evidenced by a systematic rapid review (see Appendix) using Approach 3 by Tricco et al. (2016). However, there are theoretical reasons that suggest that acceptance would be potentially effective for reducing stigma given that motivational interviewing is efficacious for behavioral change among people with substance use issues, who experience substance use stigma (El Hayek et al., 2024; Kulesza et al., 2013; Magnan et al., 2024; Miller & Rollnick, 2023; Yang et al., 2018). The only study to quantitatively correlate motivational interviewing and weight stigma showed that physician experience with motivational interviewing was associated with more use of person-first language and positive perceptions of patient adherence to treatment recommendations (Bennett & Puhl, 2024). Although the WHISTLE model's foundation on patient acceptance and engagement lends itself well to reducing weight stigma in healthcare contexts (Moizé et al., 2025), the empirical research previously outlined is a necessary next step to evaluate the potential efficacy of the WHISTLE model.

Conclusion

The WHISTLE model is utilitarian, emphasizing action where health behavior promotion and an attitude of acceptance to reduce stigma occur concurrently. At its basic level, the WHISTLE model is a unifying agent for practitioners and patients working together to improve weight-related health. Practitioners must engage in accepting and collaborative conversations to increase health behavior, whether preventive or reactive, focusing on person-centered care to foster weight health. Attitudes and actions demonstrated in an atmosphere of acceptance are likely to lead to reduced stigma and enhanced practitioner-patient

communication. Healthcare and mental health practitioners who encourage health behavior and discuss weight health may face criticism from colleagues or patients who favor reducing stigma over promoting weight-related health as campaigns against weight stigma become increasingly heard and promoted (e.g., HAES). However, there is no need to campaign for avoiding conversations about health behavior and denigrate health science research for the destigmatization of weight. Indeed, discussing the importance of fundamental health behavior (e.g., physical activity) may appear less popular, but it is more vital than ever. Overall, the WHISTLE model functions to increase patient-centered care by empowering practitioners to face the challenge of initiating weight-related health and health behavior change discussions in a way that deactivates the barriers of stigma.

Acknowledgements

I sincerely thank Dr. Andrew H. Hales for his professorship and writing mentorship.

References

Abildsnes, E., Elin Andresen, N., Storbaekken, S., Beate Samdal, G., Mildestvedt, T., & Meland, E. (2021). How is motivational interviewing (un) related to self-determination theory: An empirical study from different healthcare settings. *Scandinavian Journal of Psychology, 62*(5), 709–716. https://doi.org /10.1111/sjop.12757

Allison, D. B., Downey, M., Atkinson, R. L., Billington, C. J., Bray, G. A., Eckel, R. H., Finkelstein, E. A., Jensen, M. D., & Tremblay, A. (2008). Obesity as a disease: A white paper on evidence and arguments commissioned by the Council of the Obesity Society. *Obesity, 16*(6), 1161–1177. https://doi.org/10.1038/oby.2008.231

Amiri, P., Mansouri-Tehrani, M. M., Khalili-Chelik, A., Karimi, M., Jalali-Farahani, S., Amouzegar, A., & Kazemian, E. (2022). Does motivational interviewing improve the weight management process in adolescents? A systematic review and meta-analysis. *International Journal of Behavioral Medicine, 29*(1), 78–103. https://doi.org/10.1007/s12529-021-09994-w

Armstrong, D. (2014). Actors, patients and agency: A recent history. *Sociology of Health & Illness, 36*(2), 163–174. https://doi.org/10.1111/1467-9566.12100

Bennett, B. L., & Puhl, R. M. (2024). Physicians' stigmatizing attitudes about individuals with type 2 diabetes: Associations with communication practices and perceived barriers to care. *Primary Care Diabetes, 18*(5), 518–524. https://doi.org/10.1016/j.pcd.2024.07.001

Bischof, G., Bischof, A., & Rumpf, H. J. (2021). Motivational Interviewing: An evidence-based approach for use in medical practice. *Deutsches Arzteblatt International, 118*(7), 109–115. https://doi.org/10.3238/arztebl.m2021.0014

Bombak, A. (2014). Obesity, health at every size, and public health policy. *American Journal of Public Health, 104*(2), e60–e67. https://doi.org/10.2105/AJPH.2013.301486

Brownell, K. D. (2010). The humbling experience of treating obesity: Should we persist or desist?. *Behaviour Research and Therapy, 48*(8), 717–719. https://doi.org/10.1016/j.brat.2010.05.018

Callahan, D. (2013). Obesity: Chasing an elusive epidemic. *The Hastings Center Report, 43*(1), 34–40. https://doi.org/10.1002/hast.114

Cohen, G. L., & Sherman, D. K. (2014). The psychology of change: Self-affirmation and social psychological intervention. *Annual Review of Psychology, 65*, 333–371. https://doi.org/10.1146/annurev-psych-010213-115137

Copeland, L., McNamara, R., Kelson, M., & Simpson, S. (2017). The development of a coding system to code planning talk within motivational interviewing. *Patient Education and Counseling, 100*(2), 313–319. https://doi.org/10.1016/j.pec.2016.09.003

Dandgey, S., & Patten, E. (2023). Psychological considerations for the holistic management of obesity. *Clinical Medicine, 23*(4), 318–322. https://doi.org/10.7861/clinmed.2023-0146

Elgaddal, N., Kramarow, E. A., & Reuben, C. (2022). Physical activity among adults aged 18 and over: United States, 2020. *National Center for Health Statistics*. NCHS Data Brief, no 443. https://dx.doi.org/10.15620/cdc:120213

El Hayek, S., Foad, W., de Filippis, R., Ghosh, A., Koukach, N., Mahgoub Mohammed Khier, A., Pant, S. B., Padilla, V., Ramalho, R., Tolba, H., & Shalbafan, M. (2024). Stigma toward substance use disorders: A multinational perspective

and call for action. *Frontiers in Psychiatry, 15*, Article 1295818. https://doi.org/10.3389/fpsyt.2024.1295818

Epton, T., Harris, P. R., Kane, R., van Koningsbruggen, G. M., & Sheeran, P. (2015). The impact of self-affirmation on health-behavior change: A meta-analysis. *Health Psychology, 34*(3), 187–196. https://doi.org/10.1037/hea0000116

Ferrer, R. A., & Cohen, G. L. (2019). Reconceptualizing self-affirmation with the trigger and channel framework: Lessons from the health domain. *Personality and Social Psychology Review, 23*(3), 285-304. https://doi.org/10.1177/1088868318797036

Frost, H., Campbell, P., Maxwell, M., O'Carroll, R. E., Dombrowski, S. U., Williams, B., Cheyne, H., Coles, E., & Pollock, A. (2018). Effectiveness of motivational interviewing on adult behaviour change in health and social care settings: A systematic review of reviews. *PloS One, 13*(10), Article e0204890. https://doi.org/10.1371/journal.pone.0204890

Fruh, S. M. (2017). Obesity: Risk factors, complications, and strategies for sustainable long-term weight management. *Journal of the American Association of Nurse Practitioners, 29*(S1), S3–S14. https://doi.org/10.1002/2327-6924.12510

Haase, C. L., Lopes, S., Olsen, A. H., Satylganova, A., Schnecke, V., & McEwan, P. (2021). Weight loss and risk reduction of obesity-related outcomes in 0.5 million people: Evidence from a UK primary care database. *International Journal of Obesity, 45*(6), 1249–1258. https://doi.org/10.1038/s41366-021-00788-4

Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health, 103*(5), 813–821. https://doi.org/10.2105/AJPH.2012.301069

Himmelstein, M. S., Puhl, R. M., & Quinn, D. M. (2017). Intersectionality: An Understudied Framework for Addressing Weight Stigma. *American Journal of Preventive Medicine, 53*(4), 421–431. https://doi.org/10.1016/j.amepre.2017.04.003

Hruby, A., & Hu, F. B. (2015). The epidemiology of obesity: A big picture. *PharmacoEconomics, 33*(7), 673–689. https://doi.org/10.1007/s40273-014-0243-x

Jadotte, Y., Buchholz, B., Carroll, W., Frum-Vassallo, D., MacPherson, J., & Cole, S. (2023). Brief action planning in health and health care: A scoping review. *The Medical Clinics of North America, 107*(6), 1047–1096. https://doi.org/10.1016/j.mcna.2023.06.018

Katz, D. L. (2014). Perspective: Obesity is not a disease. *Nature, 508*(7496), S57. https://doi.org/10.1038/508S57a

Kulesza, M., Larimer, M. E., & Rao, D. (2013). Substance use related stigma: What we know and the way forward. *Journal of Addictive Behaviors, Therapy & Rehabilitation, 2*(2), 782. https://doi.org/10.4172/2324-9005.1000106

Logel, C., & Cohen, G. L. (2012). The role of the self in physical health: Testing the effect of a values-affirmation intervention on weight loss. *Psychological Science, 23*(1), 53–55. https://doi.org/10.1177/0956797611421936

Lundahl, B., Moleni, T., Burke, B. L., Butters, R., Tollefson, D., Butler, C., & Rollnick, S. (2013). Motivational interviewing in medical care settings: A systematic review and meta-analysis of randomized controlled trials. *Patient Education and Counseling, 93*(2), 157–168. https://doi.org/10.1016/j.pec.2013.07.012

Luty, J., & Iwanowicz, M. (2018). Motivational interviewing: Living up to its promise? *BJPsych Advances, 24*(1), 46–53. https://doi.org/10.1192/bja.2017.7

Magill, M., Apodaca, T. R., Borsari, B., Gaume, J., Hoadley, A., Gordon, R. E. F., Tonigan, J. S., & Moyers, T. (2018). A meta-analysis of motivational interviewing process: Technical, relational, and conditional process models of change. *Journal of Consulting and Clinical Psychology, 86*(2), 140–157. https://doi.org/10.1037/ccp0000250

Magnan, E., Weyrich, M., Miller, M., Melnikow, J., Moulin, A., Servis, M., Chadha, P., Spivack, S., & Henry, S. G. (2024). Stigma against patients with substance use disorders among health care professionals and trainees and stigma-reducing interventions: A systematic review. *Academic Medicine, 99*(2), 221–231. https://doi.org/10.1097/ACM.0000000000005467

Major, B., Hunger, J. M., Bunyan, D. P., & Miller, C. T. (2014). The ironic effects of weight stigma.

Journal of Experimental Social Psychology, 51, 74–80. https://doi.org/10.1016/j.jesp.2013.11.009

Makin, H., Chisholm, A., Fallon, V., & Goodwin, L. (2021). Use of motivational interviewing in behavioural interventions among adults with obesity: A systematic review and meta-analysis. *Clinical Obesity, 11*(4), Article e12457. https://doi.org/10.1111/cob.12457

Marks, D. F. (2015). Homeostatic theory of obesity. *Health Psychology Open, 2*(1). https://doi.org/10.1177/2055102915590692

McCabe, M., Alcaraz-Ibanez, M., Markey, C., Sicilia, A., Rodgers, R. F., Aimé, A., ... Fuller-Tyszkiewicz, M. (2023). A longitudinal evaluation of a biopsychosocial model predicting BMI and disordered eating among young adults. *Australian Psychologist, 58*(2), 57–79. https://doi.org/10.1080/00050067.2023.2181686

Michalopoulou, M., Ferrey, A. E., Harmer, G., Goddard, L., Kebbe, M., Theodoulou, A., Jebb, S. A., & Aveyard, P. (2022). Effectiveness of motivational interviewing in managing overweight and obesity: A systematic review and meta-analysis. *Annals of Internal Medicine, 175*(6), 838–850. https://doi.org/10.7326/M21-3128

Michie, S., Atkins, L. & West, R. (2014). *The Behaviour Change Wheel: A guide to designing interventions*. Silverback Publishing.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). Guilford Press.

Miller, W. R., & Rollnick, S. (2023). *Motivational interviewing: Helping people change and grow* (4th ed.). Guilford Press.

Murray, K., Brichacek, E., & Rieger, E. (2021). Intentions to see a psychologist for weight management: A cross-sectional study investigating beliefs about psychologists, psychological services and obesity. *Journal of Clinical Psychology, 77*(10), 2288–2305. https://doi.org/10.1002/jclp.23163

Moizé, V., Graham, Y., Ramos Salas, X., & Balcells, M. (2025). Motivational interviewing (MI) in obesity care: Cultivating person-centered and supportive clinical conversations to reduce stigma: A narrative review. *Obesity Science & Practice, 11*(1). https://doi.org/10.1002/osp4.678

Okunogbe, A., Nugent, R., Spencer, G., Powis, J., Ralston, J., & Wilding, J. (2022). Economic impacts of overweight and obesity: Current and future estimates for 161 countries. *BMJ Global Health, 7*(9), Article e009773. https://doi.org/10.1136/bmjgh-2022-009773

Ortega, F. B., Lee, D. C., Katzmarzyk, P. T., Ruiz, J. R., Sui, X., Church, T. S., & Blair, S. N. (2013). The intriguing metabolically healthy but obese phenotype: Cardiovascular prognosis and role of fitness. *European Heart Journal, 34*(5), 389–397. https://doi.org/10.1093/eurheartj/ehs174

Panza, G. A., Puhl, R. M., Taylor, B. A., Cilhoroz, B., Himmelstein, M. S., Fernandez, A. B., & Pescatello, L. S. (2023). The effects of an acute weight stigma exposure on cardiovascular reactivity among women with obesity and hypertension: A randomized trial. *Journal of Psychosomatic Research, 165*, Article 111124. https://doi.org/10.1016/j.jpsychores.2022.111124

Penney, T. L., & Kirk, S. F. (2015). The Health at Every Size paradigm and obesity: Missing empirical evidence may help push the reframing obesity debate forward. *American Journal of Public Health, 105*(5), e38–e42. https://doi.org/10.2105/AJPH.2015.302552

Pi-Sunyer, X. (2009). The medical risks of obesity. *Postgraduate Medicine, 121*(6), 21–33. https://doi.org/10.3810/pgm.2009.11.2074

Plotnikoff, R. C., Bercovitz, K., Rhodes, R. E., Loucaides, C. A., & Karunamuni, N. (2007). Testing a conceptual model related to weight perceptions, physical activity and smoking in adolescents. *Health Education Research, 22*(2), 192–202. https://doi.org/10.1093/her/cyl065

Pojednic, R., D'Arpino, E., Halliday, I., & Bantham, A. (2022). The benefits of physical activity for people with obesity, independent of weight loss: A systematic review. *International Journal of Environmental Research and Public Health, 19*(9), Article 4981. https://doi.org/10.3390/ijerph19094981

Pont, S. J., Puhl, R., Cook, S. R., Slusser, W., Section on Obesity, & Obesity Society (2017). Stigma experienced by children and adolescents with obesity. *Pediatrics, 140*(6), Article e20173034. https://doi.org /10.1542/peds.2017-3034

Puhl R. M. (2023). Weight stigma and barriers

to effective obesity care. *Gastroenterology clinics of North America, 52*(2), 417–428. https://doi.org/10.1016/j.gtc.2023.02.002

Puhl, R., & Brownell, K. D. (2001). Bias, discrimination, and obesity. *Obesity Research, 9*(12), 788–805. https://doi.org/10.1038/oby.2001.108

Puhl, R. M., Lessard, L. M., Himmelstein, M. S., & Foster, G. D. (2021). The roles of experienced and internalized weight stigma in healthcare experiences: Perspectives of adults engaged in weight management across six countries. *PloS One, 16*(6), Article e0251566. https://doi.org/10.1371/journal.pone.0251566

Puhl, R., & Suh, Y. (2015). Health consequences of weight stigma: Implications for obesity prevention and treatment. *Current Obesity Reports, 4*(2), 182–190. https://doi.org/10.1007/s13679-015-0153-z

Puhl, R. M., Telke, S., Larson, N., Eisenberg, M. E., & Neumark-Stzainer, D. (2020). Experiences of weight stigma and links with self-compassion among a population-based sample of young adults from diverse ethnic/racial and socio-economic backgrounds. *Journal of Psychosomatic Research, 134*, Article 110134. https://doi.org/10.1016/j.jpsychores.2020.110134

Reece, R. L. (2019). Coloring weight stigma: On race, colorism, weight stigma, and the failure of additive intersectionality. *Sociology of Race and Ethnicity, 5*(3), 388-400. https://doi.org/10.1177/2332649218795185

Robinson, E., Roberts, C., Vainik, U., & Jones, A. (2020). The psychology of obesity: An umbrella review and evidence-based map of the psychological correlates of heavier body weight. *Neuroscience and Biobehavioral Reviews, 119*, 468–480. https://doi.org/10.1016/j.neubiorev.2020.10.009

Rubak, S., Sandbaek, A., Lauritzen, T., & Christensen, B. (2005). Motivational interviewing: A systematic review and meta-analysis. *The British Journal of General Practice, 55*(513), 305–312. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1463134/

Rubino, F., Puhl, R. M., Cummings, D. E., Eckel, R. H., Ryan, D. H., Mechanick, J. I., Nadglowski, J., Ramos Salas, X., Schauer, P. R., Twenefour, D., Apovian, C. M., Aronne, L. J., Batterham, R. L., Berthoud, H. R., Boza, C., Busetto, L., Dicker, D., De Groot, M., Eisenberg, D., Flint, S. W., ... Dixon, J. B. (2020). Joint international consensus statement for ending stigma of obesity. *Nature Medicine, 26*(4), 485–497. https://doi.org/10.1038/s41591-020-0803-x

Ryan, D. H., & Yockey, S. R. (2017). Weight loss and improvement in comorbidity: Differences at 5%, 10%, 15%, and over. *Current Obesity Reports, 6*(2), 187–194. https://doi.org/10.1007/s13679-017-0262-y

Safaei, M., Sundararajan, E. A., Driss, M., Boulila, W., & Shapi'i, A. (2021). A systematic literature review on obesity: Understanding the causes & consequences of obesity and reviewing various machine learning approaches used to predict obesity. *Computers in Biology and Medicine, 136*, Article 104754. https://doi.org/10.1016/j.compbiomed.2021.104754

Scarff, J. R. (2021). What's in a name? The problematic term "Provider". *Federal Practitioner, 38*(10), 446–448. https://doi.org/10.12788/fp.0188

Schafer, M. H., & Ferraro, K. F. (2011). The stigma of obesity: Does perceived weight discrimination affect identity and physical health? *Social Psychology Quarterly, 74*(1), 76-97. https://doi.org/10.1177/0190272511398197

Scherr, K. A., Honeycutt, L. K., Page, S., & Armstrong, S. C. (2023). Communication, bias, and stigma. In C. K. Fox (Ed.), *Managing pediatric obesity using advanced therapies: Practical guide for pediatric health care providers* (pp. 27–51). Springer International Publishing.

Schumacher, J. A., & Madson A. B. (2014). *Fundamentals of motivational interviewing: Tips and strategies for addressing common clinical challenges*. Oxford University Press.

Schwarzer, R., & Fuchs, R. (1996). Self-efficacy and health behaviours. In M. Conner & P. Norman (Eds.), *Predicting health behaviour: Research and practice with social cognition models* (pp. 163–196). Open University Press.

Standen, E. C., Rothman, A. J., & Mann, T. (2024). Consequences of receiving weight-related advice from a healthcare provider: Understanding the varied experiences of people with higher weight. *Social Science & Medicine, 347*, Article 116784. https://doi.org/10.1016/j.socscimed.2024.116784

Strecher, V. J., DeVellis, B. M., Becker, M. H., & Rosenstock, I. M. (1986). The role of self-effica-

cy in achieving health behavior change. *Health Education Quarterly, 13*(1), 73–92. https://doi.org/10.1177/109019818601300108

Tomiyama, A. J. (2014). Weight stigma is stressful. A review of evidence for the Cyclic Obesity/Weight-Based Stigma model. *Appetite, 82*, 8–15. https://doi.org/10.1016/j.appet.2014.06.108

Tricco, A. C., Zarin, W., Antony, J., Hutton, B., Moher, D., Sherifali, D., & Straus, S. E. (2016). An international survey and modified Delphi approach revealed numerous rapid review methods. *Journal of Clinical Epidemiology, 70*, 61–67. https://doi.org/10.1016/j.jclinepi.2015.08.012

Visscher, T. L., & Seidell, J. C. (2001). The public health impact of obesity. *Annual Review of Public Health, 22*, 355–375. https://doi.org/10.1146/annurev.publhealth.22.1.355

Wetzel, K. E., & Himmelstein, M. S. (2024). Weight stigma is uniquely tied to maladaptive eating across different racial, ethnic, and gender groups. *Appetite, 201*, Article 107604. https://doi.org/10.1016/j.appet.2024.107604

Yang, L. H., Wong, L. Y., Grivel, M. M., & Hasin, D. S. (2017). Stigma and substance use disorders: An international phenomenon. *Current Opinion in Psychiatry, 30*(5), 378–388. https://doi.org/10.1097/YCO.0000000000000351

Figure 1.

The Weight Health through Integrated Stigma-Reduction and Lifestyle Engagement (WHISTLE) Model

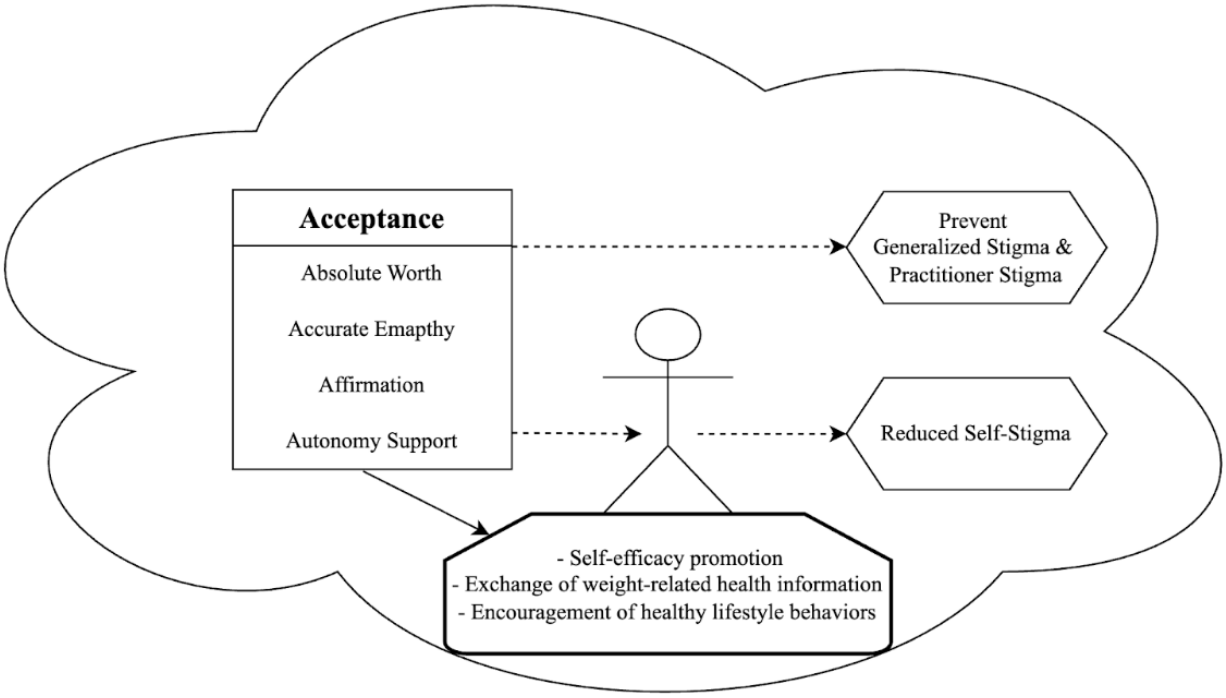

Table 1.

Sample Statements to Initiate Weight Health Conversations Congruent with Acceptance

Absolute Worth
- I care about you and your health regardless of your current body weight or what your physical activity and dietary habits look like right now. If you'd be willing, could we talk about some things that research suggests might support weight health in ways that are meaningful to you? - Your importance as a person does not depend on how much you weigh, how often you go for a walk, or what you eat. Your health, however, can be linked to what you do. If you're up to it, I'd like to hear your thoughts on how you feel about your weight, health, and lifestyle health behaviors right now.
Accurate Empathy
- I can see how it would be frustrating for you to be productive at work when you're feeling judged for your body size and what you eat. And if it would be of interest to you, could we talk together about research on weight and health to see what may be helpful and relevant for you? - It sounds hard to feel excluded from activities like softball that you used to enjoy with friends. I'd like to hear more about that, and if you'd be open to it, we could also explore other activities you might find enjoyable, and that could support your weight health.
Affirmation
- You've been working hard to manage your health condition, and that's really impressive! If it would be okay with you, we could talk about how body weight and physical activity can further support the progress you're making. - Coming in today (e.g., insert any healthcare-related appointment) shows how much you care about your health. Would it be okay if we talked about where weight health fits into what's most important to you?
Autonomy Support
- Over 99% of your life is spent outside this clinic (e.g., insert setting), and I imagine you have some great ideas about what might work best for your health. What are your thoughts on how your health goals, including weight, fit into the bigger picture for you? - I realize that it can be hard to talk about weight health. I want you to know that I'm here to support you as you consider making lifestyle changes that *you* think would be helpful. - You clearly put effort into taking care of your health, which is great. If it sounds okay to you, we could explore how your weight may play a role in what's going on with your health right now and what steps *you* might consider for your health.

Note. Attuned readers may notice the conceptual overlap of the *acceptance* statements and even their near interchangeability. After each of these statements, an additional acknowledgement of patient autonomy may fit as well. For example, "And, of course, any changes (e.g., related to health, physical activity, eating) you choose to make would be completely up to you."

Appendix

Supporting Table 1. *Search strategy for PubMed*

Block 1: *Motivational interviewing*

Search name	Search query	Type of search
1	("motivational interviewing"[MeSH Terms] OR "motivation* interview*"[Title/Abstract] OR "mi style"[Title/Abstract] OR "motivation* intervention*"[Title/Abstract] OR "motivational counseling"[Title/Abstract] OR "motivational counselling"[Title/Abstract])	MeSH terms and Title/Abstract

Block 2: *Stigma*

Search name	Search query	Type of search
2	("social stigma"[MeSH Terms] OR "weight prejudice"[MeSH Terms] OR "social discrimination"[MeSH Terms] OR "perceived discrimination"[MeSH Terms] OR "fat sham*"[Title/Abstract] OR "fat sham*"[Title/Abstract] OR "weight stigma*"[Title/Abstract] OR "weight stigma*"[Title/Abstract] OR "fat stigma*"[Title/Abstract] OR "fat stigma*"[Title/Abstract])	MeSH terms and Title/Abstract

Block 3: *Weight*

Search name	Search query	Type of search
3	("obesity"[MeSH Terms] OR "overweight"[MeSH Terms] OR "body weight"[MeSH Terms] OR "weight loss"[MeSH Terms] OR "ideal body weight"[MeSH Terms] OR "weight health"[Title/Abstract])	MeSH terms and Title/Abstract

Note. Database was accessed 4/2/2025. No filters or date ranges were applied. The three blocks were connected with the Boolean operator 'AND'. The search yielded five results. Screening determined that no study examined the potential relationship between motivational interviewing and weight stigma.

Appendix

Supporting Table 2. *Search strategy for Scopus*

Block 1: *Motivational interviewing*

Search name	Search query	Type of search
1	("motivational interviewing" OR "motivation* interview*" OR "mi style" OR "motivation* intervention*" OR "motivational counseling" OR "motivational counselling")	Title, abstract, keyword

Block 2: *Stigma*

Search name	Search query	Type of search
2	("social stigma" OR "weight prejudice" OR "social discrimination" OR "perceived discrimination" OR "fat sham*" OR "fat sham*" OR "weight stigma*" OR "weight stigma*" OR "fat stigma*" OR "fat stigma*")	Title, abstract, keyword

Block 3: *Weight*

Search name	Search query	Type of search
3	("obesity" OR "overweight" OR "body weight" OR "weight loss" OR "ideal body weight" OR "weight health"])	Title, abstract, keyword

Note. Database was accessed 4/2/2025. No filters or date ranges were applied. The three blocks were connected with the Boolean operator 'AND'. The search yielded five results. Screening determined that no study examined the potential relationship between motivational interviewing and weight stigma.