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Views of Black women patients with obesity on desired and undesired weight-focused clinical encounters

Carolyn M. Tucker¹ | Julia Roncoroni²  | Kirsten G. Klein¹ | Terry O. Derias¹ |
 Wafaa Ateyah¹ | Jaime Williams³ | Nwakaego A Nmezi⁴ | Nipa R. Shah⁵ |
 Lori A. Bilello⁶ | Stephen Anton⁷

¹Department of Psychology, University of Florida, Gainesville, Florida

²Department of Counseling Psychology, University of Denver, Denver, Colorado

³Jackson Health System, Miami, Florida

⁴Department of Physical Medicine and Rehabilitation, Johns Hopkins University, Baltimore, Maryland

⁵Department of Community Health and Family Medicine, University of Florida Jacksonville, Jacksonville, Florida

⁶Department of Medicine, University of Florida, Jacksonville, Florida

⁷Department of Aging and Geriatric Research, University of Florida, Gainesville, Florida

Correspondence

J. Roncoroni, Department of Counseling Psychology, University of Denver, 1999 E Evans Ave, Denver, CO 80210, USA.
 Email: juliaroncoroni@gmail.com

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Summary

Non-Hispanic Black women have the highest rates of overweight/obesity of any group in the United States. To date, few interventions have worked to reduce overweight/obesity in this population. This study investigated the views of Black women with overweight and obesity treated in a primary care setting regarding desired and undesired verbal and non-verbal behaviours by providers in provider-patient clinical encounters focused on losing weight, maintaining weight loss, and/or obesity. Two focus groups and an individual interview (n = 15) were conducted. Qualitative data analysis yielded five distinct themes, with 11 codes (listed in parenthesis): (a) desired weight-focused discussions (codes: Discussing weight loss with patients and discussing weight-loss maintenance with patients), (b) desired weight-focused support (codes: Supporting patients experiencing weight loss and supporting patients experiencing weight gain), (c) undesired weight-focused discussions (codes: Things to avoid during weight loss discussions and things to avoid during weight gain discussions), (d) desired attitudes and behaviours during weight-focused discussions (codes: Show caring and understanding and encourage behaviour change for weight loss), and (e) building physician-patient rapport (codes: Enable patients to feel respected by doctors, enable patients to feel comfortable with doctors and enable patients to trust their doctors). The qualitative approach employed in this study generates a deep understanding not only of the experiences of Black women patients but also of potential strategies that physicians could employ to succeed in their discussions with patients regarding healthy weight achievement and maintenance.

KEYWORDS

black health, obesity, overweight, patient-centred care, primary care, weight management

Non-Hispanic Black women have the highest rates of overweight, obesity, and severe obesity of any group in the United States.¹⁻³ Nearly 80% of Black women have overweight or obesity,³ and this number is steadily on the rise.¹ Obesity is a risk factor for negative health outcomes such as diabetes, high blood pressure, and hyperlipidaemia—all precursors to heart disease and stroke.^{1,3} Given

that heart disease is a leading cause of death in non-Hispanic Black women,⁴ monitoring and preventing overweight and obesity in non-Hispanic Black communities is imperative for reducing racial/ethnic health disparities.⁴

To date, few interventions to address overweight and obesity in non-Hispanic Black adults have yielded meaningful results.^{5,6}

The persistence of overweight and obesity in Black women suggests that the strategies employed thus far may not be effective. Notably, Black women are underrepresented within the obesity-related literature,⁷ suggesting the need for an increased prevalence of interventions informed by the views of Black community members who are living with overweight or obesity. Obtaining such views from Black community members requires the empowerment of Black community members to be partners in the development of overweight and obesity prevention and intervention programs/approaches.

There is a growing consensus that community-based primary care sites are ideal for obesity prevention and intervention programs/approaches.^{8,9} Thus, patient-centred primary health care to prevent and treat obesity among Black women seems needed to reduce health disparities related to obesity.^{10–12} Culturally sensitive health care involves (a) an awareness of providers' biases (eg, racial and income-related biases) and patients' biases (eg, provider preferences); (b) empowering patients to be respected partners in the clinical encounter; (c) providers and staff engaging in behaviours that enable their patients to feel comfortable, respected, and trusting during these encounters and (d) creating physical and social environments in clinical settings that enable patients to feel a sense of belonging.¹³

Health care provider engagement in patient-centred culturally sensitive health care (PC-CSHC), for example, direct eye contact and supportive facial expressions, is a best-practice approach to reducing health disparities, including overweight- and obesity-related disparities.^{14–16} PC-CSHC promotes patients' trust in their provider, satisfaction with provider's care, perceived interpersonal control, and treatment adherence.¹⁷ Training primary care physicians to discuss weight and obesity with their Black patients with obesity in culturally sensitive ways is fundamental in furthering intervention efforts to prevent and treat obesity in primary care settings.

There is a paucity of research to examine whether health care providers even talk with their patients about their weight and/or obesity. In a published pilot study that was conducted with 25 physician participants (80% White; 12% Asian; 64% female) from among 39 primary care clinics results showed that only 24% of these physicians discussed healthy eating and physical activity with their patients, and 20% of them rarely tracked diet, physical activity, or weight of their patients. In this pilot study, the participating primary care physicians stated that the major barrier to patient-focused weight counselling is their belief that patients were not interested in such counselling by their physicians.¹⁸ In another published study involving 520 culturally diverse patient participants (42.6% of whom were Black, and 66.2% of whom were women) from among the same clinics in the aforementioned study, it was found that almost half (45.8%) of the participating patients reported that their physicians never or rarely talked to them about managing their weight and obesity.¹¹ Additionally, it was found that 56.9% the participating patients were interested in receiving help from their providers in connecting with resources for weight management in their community; African Americans (vs non-Hispanic Whites) were particularly interested in receiving this help.

1 | PURPOSE OF THIS STUDY

The purpose of the present study was to identify the views of Black women primary care patients with overweight or obesity regarding desired and undesired verbal and non-verbal behaviours by providers in provider-patient clinical encounters focused on losing weight, maintaining weight loss, and/or obesity. Special attention was given to provider behaviours that enabled Black women to feel comfortable with, trusting of, and respected by providers in discussion of these patients' weight and/or obesity in clinical encounters with physicians. A focus group approach was used in this qualitative study to generate culture-specific knowledge, that is, less accessible via quantitative research.

2 | METHODOLOGY

The present study was part of a larger comparative effectiveness study designed to compare the efficacy of two physician-implemented weight loss maintenance programs for use by primary care physicians with their African American/Black women patients with obesity—a culturally sensitive weight loss maintenance program and a standard behavioural/motivational interviewing-focused weight loss maintenance program. The results from the present focus group study informed the development of the culturally sensitive, physician-implemented weight loss maintenance program. Approval for the larger study and thus the present study was obtained from the Institutional Review Board of the participating university.

2.1 | Procedure

2.1.1 | Participant recruitment

Focus group participants were recruited via flyers in clinics where the larger study was being conducted and in churches. These flyers provided information on the study and contact information for the research team. Interested individuals were screened for eligibility, and eligible individuals were invited to participate. Two focus groups and an individual interview were conducted.

2.1.2 | Conducting of the focus groups (qualitative data collection)

The focus groups were conducted in accordance with standard focus group procedures.¹⁹ All participants signed an informed consent form agreeing to participate. Participants were then asked to anonymously complete a demographic data and health-related information questionnaire (DDHIQ) and answer the focus group questions.

To protect anonymity, participants used a fictitious name. A trained focus group facilitator and co-facilitator, both of whom were

Black women, facilitated the groups. The focus-group facilitator and co-facilitator utilized a discussion guide to facilitate discussion. In addition to the facilitator and co-facilitator, paired research assistant note-takers took notes during each session. Additionally, the focus groups were audio-recorded. All data obtained from the DDHIQ, audio-recordings, and focus group notes were secured in a locked file cabinet at the participating university. All participants received a healthy boxed lunch and a \$30 gift card.

2.2 | Participants

A total of 15 African American/Black women participated in the focus group study. Participant inclusion criteria were as follows: (a) Self-identifying as African American/Black female, (b) being at least 21 years or older, (c) expressing concern about one's weight on a researcher identified screener, (d) attending at least one health-care visit within the last calendar year, (e) being able to communicate orally and in writing in English, and (f) not participating in the larger comparative effectiveness study by the principal investigator (PI), that is, in progress. Originally, three focus groups were planned; however, only one person showed up for the third focus group. This one participant was individually asked the focus group questions. Thus, only two focus groups were conducted—one consisting of participants between ages 36 and 64 years, and one consisting of participants ages 65 and older. The majority of participants (80%) self-reported an educational level of 2 years of college or less. The majority (66.6%) of participants reported an annual household income of less than \$20 000. Nearly 80% of focus group participants rated their health as “good” or “very good”; and 60% expressed a desire to lose weight. Most participants (93%) perceived their weight status as “overweight” or “obese”. See Table 1 for additional information on participants' demographic and health characteristics.

2.3 | Measures

2.3.1 | Demographic data and health-related information questionnaire

This 20-question survey was developed by the PI of the study to gather participants' age, race/ethnicity, perceived health status and level of comfort discussing weight with their respective primary care physician.

2.3.2 | Focus group discussion guide

The focus group discussion guide (FGDG) included instructions to ensure confidentiality of the study participants (eg, use a fictitious name, not sharing personal information shared in the group), an ice-breaker exercise to facilitate comfort among the group participants, a review of focus group rules (eg, one person talk at a time), and the focus group questions. See Table 2 for a list of the focus group questions asked in this study.

TABLE 1 Demographic and health characteristics of the black women participant sample. (n = 15)

Characteristics	n	%
Age		
36 to 64	6	40.0
65 or older	9	60.0
Education level		
Highschool or GED	3	20.0
Trade/technical School	4	26.7
2-year college	5	33.3
4-year college/university or higher	3	20.0
Income level		
<\$5000	2	13.3
\$5000–\$19 000	8	53.3
\$20 000–\$39 000	1	6.7
\$40 000–\$59 000	2	13.3
\$60 000–\$79 000	1	6.7
>\$80 000	1	6.7
Employment status		
Full-time	3	20.0
Part-time	3	20.0
Unemployed (stay-at-home parent, retired, on disability etc.)	9	59.0
Relationship status		
Single, living without a partner	4	26.7
Single or married, living with a partner	6	40.0
Divorced or separated	4	26.7
Widow/widower	1	6.7
Perceived weight status		
Healthy weight	1	6.7
Overweight	10	66.7
Obese	4	26.7
Perceived health status		
Very good	2	13.3
Good	10	66.7
Fair	3	20.0
Poor	0	—
Very poor	0	—
Desire to lose weight		
Yes	9	60.0
No	6	40.0

2.4 | Qualitative data analysis

Audio recordings from the groups and interview were transcribed using NVivo. Transcriptions were checked for accuracy by trained research assistants and edited to correct any identified errors prior to data analysis. Three pairs of research

TABLE 2 Focus group questions

- (1) What should doctors do or say to bring up the need to lose weight?
- (2) What should doctors do or say to bring up the need to maintain a recent weight loss?
- (3) What can doctors do or say to help empower their Black women patients with obesity lose weight?
- (4) What can doctors do or say to encourage their Black women patients with obesity to make behaviour changes to lose weight?
- (5) What can doctors do or say to help their Black women patients with obesity avoid regaining weight that they have recently lost?
- (6) What should doctors not do or not say when talking with their Black women patients with obesity about the need to lose weight or maintain weight loss?
- (7) What are some behaviours or attitudes of doctors that enable Black women with obesity to feel respected when doctors talk with them about losing weight?
- (8) What are some behaviours or attitudes of doctors that enable Black women with obesity to feel comfortable when doctors talk with them about losing weight?
- (9) What are some behaviours or attitudes of doctors that enable Black women with obesity to feel that they can trust what the doctors tell them about losing weight?

assistants coded the data using the constant comparative method. The research assistants utilized the FGDG as an overall guide when extracting instances (specific behaviours/attitudes) from the transcripts of the participating Black women's responses to questions regarding (a) what they wanted their doctors to do and say (and/or not do and say) when discussing weight, weight loss, and/or weight loss maintenance with Black women patients who have obesity and (b) what behaviours and attitudes they wanted their doctors to display in order to enable Black women patients with obesity to feel comfortable with, respected by and trusting of their doctors.

After these instances were identified, the research assistants completed open coding, which involved having each pair of researchers separately assign themes to the instances. After open coding was complete, each research assistant pair met to review their identified codes and refine any identified discrepancies. Next, the research assistant pairs identified an agreed-upon list of codes to be used for closed coding. During closed coding, each research assistant separately assigned each of the instances to one of the agreed-upon list of codes. Once this was completed, the research assistants completed another review process to determine whether or not they had matching code structures. The number of matched instances was then divided by the total number of instances to calculate the inter-rater reliability for the coding in relation to each theme agreed-upon by the pair of research assistants. These inter-rater reliabilities ranged from 0.75 to 1 with an overall average inter-rater reliability of 0.95.

TABLE 3 Characteristics of Black women participants' interactions with their doctors (n = 15)

Characteristics	n	%
Frequency of doctor visits in past year		
2-5 times	8	53.3
6-10 times	5	33.3
Over 10 times	2	13.3
Engagement in weight-related discussions with doctor in past year		
Yes	12	80.0
No	3	20.0
Gender of doctor most frequently seen		
Male	7	46.7
Female	8	53.3
Race of doctor most frequently seen		
African American/Black American	7	46.7
White/European American	5	33.3
American Indian/Native American	1	6.7
Other	1	6.7
Comfort level with doctor most frequently seen		
Very comfortable	9	60.0
Comfortable	3	20.0
Very uncomfortable	3	20.0
How comfortable did you feel during weight-based discussions with your doctor?		
Very comfortable	6	40.0
Comfortable	4	26.7
Neither comfortable nor uncomfortable	2	13.3
Uncomfortable	0	—
Very uncomfortable	1	6.7
How respected did you feel during weight-based discussions with your doctor?		
Very respected	6	40.0
Respected	5	33.3
Neither respected nor disrespected	2	13.3
Disrespected	0	—
Very disrespected	0	—
How trusting did you feel during weight-based discussions with your doctor?		
Very trusting	7	46.7
Trusting	3	20.0
Neither trusting nor distrusting	2	13.3
Distrusting	0	—
Very distrusting	1	6.7

3 | RESULTS

All participants reported visiting their doctor within the past year (see Table 3). Of the participants, 80% reported engagement in

weight-focused discussions with their providers; 53% reported most frequently seeing a female doctor, and this doctor was most frequently African American/Black American ($n = 7$); and 60% reported feeling “very comfortable” with their doctor, while 20% reported feeling “very uncomfortable”. The majority of participants (73%) reported feeling “respected” or “very respected” and most (67%) reported feeling “trusting” or “very trusting” during these weight-focused discussions.

A qualitative data analysis yielded five distinct themes, which have been broken down into 11 codes (see Table 4). From each code emerged three to five subcodes, which are generally summarized below and inclusive of participants' quotes provided to illustrate reflective comments made during the focus groups.

3.1 | I. Desired weight-focused discussions

Respondents expressed a desire to have their doctors initiate discussions focused on weight. This theme was broken into two codes: *Discussing weight loss with patients* and *discussing weight-loss maintenance with patients*.

3.1.1 | Discussing weight loss with patients

Respondents expressed a desire for their doctors to show genuine concern. Some respondents stated that they felt unimportant when they perceived their appointments as rushed or their doctors as unprepared. This feeling, they discussed, stemmed from the experience of feeling as if their weight loss concerns were being dismissed. One respondent highlighted the importance of their doctor taking their weight loss concerns into consideration among their other health issues:

“They should show more concern. Here's how I feel: I had a five-way bypass two and a half years ago and I had renal and heart medication. I've tried seven or eight pills a day. When I told my specialist that I was gaining 10 pounds a month, it wasn't his concern. I understand that he's a specialist and his concern is my heart, but when you put on 100 pounds in a year, that can affect my heart”.

Respondents also underscored the importance of obtaining patient-centred care. They emphasized having their doctor take the time to make conversation with them about themselves and non-medical concerns. They welcomed interactions where they felt that their needs were central in the conversation:

“I'd like to say get to know me first. Have a conversation. See what's going on with me, because I've learned that a lot of my over-eating was emotional. Emotional eating. And making bad choices. So get to strike up a conversation and get to know me”.

Respondents wanted to have their lifestyle choices and behaviours reviewed with their doctors, so that they could learn more about how their weight impacts their overall health. One respondent stated that “it's critical because it plays such a major part in everything else that's going on in [their] body”.

3.1.2 | Discussing weight loss maintenance with patients

Respondents describe encouragement and support as key. Respondents emphasized the role of support in affirming the progress made towards weight loss goals:

“Well, when I went to the doctor, he was like, 'I'm happy with your weight loss.' And I'm like, 'Well, I didn't lose much weight'. And he was like, 'Well, [you] lost like 15 pounds since the last time [you] came'. It wasn't like he was saying it in a bad way. He was just like, 'I'm happy you lost weight!'”.

Furthermore, respondents reflected on the value of having their doctors acknowledge their weight loss. One respondent stated: “You know it'd be nice for a doctor to say, “Good, you're doing well”. while another stated: “Sometimes just acknowledging and saying 'Oh, I see you've lost some weight'. It does not have to be difficult”. Respondents reflected on their experiences of discussing their concerns with their primary providers, requesting more tests be run and their desire to be referred to specialists, for example, for mental health, nutrition, cardiovascular concerns and gastrointestinal issues.

3.2 | II. Desired weight-focused support

Respondents expressed a desire to have their doctors provide them with weight-focused support. This theme was broken into two codes: *Supporting patients experiencing weight loss* and *supporting patients experiencing weight gain*.

3.2.1 | Supporting patients experiencing weight loss

Respondents expressed a desire for doctors to take the time to understand their cultural backgrounds, as they wanted these backgrounds and personal experiences to be considered doctors recommendations for behavioural change. Respondents discussed the unique experiences that Black women may face:

“I found a lot of black women that are not currently employed or not employed in a field that they enjoy, and they suffer from anxiety and depression. They have a tendency to overeat because this is the way they feed it...because doctors don't want to do suffering unless you diagnosed bipolar or something...they don't want to give you a damn Valium So, you deal-you self-medicate...and the only way you self-medicate is with food. Food is a therapy. Believe me, I know. It's a comfort too”.

Respondents discussed the desire to receive more information and education about accessible weight loss resources. One respondent stated: “Tell us about resources that's available. Yeah, give us some resources. Tell us about weight loss clinics. Tell us about weight loss focused groups”. Other respondents agreed, with many expressing interest in the possibility of attending a weight loss focused support group. One respondent reflected on her current experience of attending this focus group:

TABLE 4 Themes, codes and subcodes from the Black women participants' data

Themes, codes and subcodes	n	N
Theme: Desired weight-focused discussions		
Code: Discussing weight loss with patients		20
Subcode: Show genuine concern	10	
Subcode: Be patient-oriented	5	
Subcode: Educate about potential future health impacts	3	
Subcode: Prepare before appointment	2	
Code: Discussing weight-loss maintenance with patients		14
Subcode: Be encouraging and supportive	8	
Subcode: Acknowledge weight loss so far	5	
Subcode: Connect patient to specialists	1	
Theme: Desired weight-focused support		
Code: Supporting patients experiencing weight loss		31
Subcode: Understand patient's background	13	
Subcode: Educate about weight loss resources	11	
Subcode: Suggests healthy habits	5	
Subcode: Emphasize medications	2	
Code: Supporting patients experiencing weight gain		12
Subcode: Encourage patients to set more goals	4	
Subcode: Take weight loss more seriously	4	
Subcode: Address concerns	4	
Theme: Undesired weight-focused discussions		
Code: Things to avoid during weight loss discussion		16
Subcode: Be offensive	8	
Subcode: Scare patients	3	
Subcode: Lack communication	3	
Subcode: Not using culturally sensitive language	2	
Code: Things to avoid during weight gain discussion		13
Subcode: Offend the patient	5	
Subcode: Fixate on the problem	3	
Subcode: Should not say anything	3	
Subcode: Tell them to stop eating	2	
Theme: Desired attitudes during weight-focused discussion		
Code: Show caring and understanding		14
Subcode: Show genuine support and concern	9	
Subcode: Positive body language	3	
Subcode: Prepare before patient's appointment	2	
		21

TABLE 4 (Continued)

Themes, codes and subcodes	n	N
Code: Encourage behaviour change for weight loss		
Subcode: Be sensitive	5	
Subcode: Learn patient's barriers	4	
Subcode: Be positive	4	
Subcode: Provide resources	4	
Subcode: Have an open and honest dialogue	4	
Theme: Building physician-patient rapport		
Code: Enable patients to feel respected by doctors		12
Subcode: Show genuine concern	4	
Subcode: Create a safe environment	3	
Subcode: Be honest	3	
Subcode: Address patients appropriately	2	
Code: Enable patients to feel comfortable with doctors		13
Subcode: Get to know patient	5	
Subcode: Positive body language	3	
Subcode: Make more time for patients	3	
Subcode: Be patient	2	
Code: Enable patients to trust their doctors		15
Subcode: Be positive	4	
Subcode: Prepare for patient's appointment	4	
Subcode: Connect with patients	3	
Subcode: Be knowledgeable	2	
Subcode: Be reliable	2	

Note: n is an abbreviation for the number of subcodes; N is an abbreviation for the number of codes.

"I'm just so glad I'm in this kind of study because I feel like it's very very important because with the obesity and everything going on, we start picking up weight and start having a lot of health problems. It's just such a blessing to be here because a lot of people cannot afford this information and it's just...it's just such a mess. I'm here to learn because I know this about me".

Respondents discussed the value of having their doctor suggest healthy habits and behaviours, with a specific emphasis on their physical activity, eating and mental health. While some respondents emphasized behavioural change, others discussed the role of medication in their care. Respondents expressed both satisfaction and frustration with their medications. Some respondents perceived their medication as a resource while others perceived it as a burden:

"I look at my medication, I've got a box of pills that I'm tired of taking and I'm like; 'Why do I have to take all this stuff?', and I'm not losing, I'm still gaining. I went from 195 to 300 and from 300 to 249 and from 249 back to 300 again. I'm sick of the rollercoaster- the rollercoaster is aggravating".

Many respondents expressed a desire for their doctors to spend more time providing education on their medications, as well as its potential side effects.

3.2.2 | Supporting patients experiencing weight gain

Respondents highlighted the importance of receiving encouragement when they have experienced weight gain. One respondent expressed a need for receiving positive reinforcement, due to “a tendency to doubt [them]selves”. Respondents expressed a desire to have their doctors keep them motivated. Many discussed the benefit of collaborative goalsetting, personalizing goals and readjusting goals to overcome barriers:

“I like doctors that approach me with information and resources and then ask me, partner with me, by saying; ‘What are your healthier weight goals?’, you know. ‘Would you like to set some?’, you know, ‘We can help you with that’ and then they can steer me in the direction that I need to go”.

Ultimately, respondents reflected on the need for weight loss to be taken more seriously. Respondents discussed the impact of their stressors on their weight and the importance of these socioenvironmental concerns being validated by their doctors:

“You don’t know what that person is going through or why their weight is like it is...like stress. A lot of people gain weight from stress, kids...like you never know...”.

3.3 | III. Undesired weight-focused discussions

Respondents discussed aspects of undesired weight-focused discussions with their doctors. This theme was broken into two codes: *Things to avoid during weight loss discussions* and *things to avoid during weight gain discussions*.

3.3.1 | Things to avoid while discussing weight loss

Respondents stated that one of their primary concerns was that doctors were not offensive. Respondents reflected on experiences where they felt disrespected by their doctors:

“Well, basically previously she stated, you know; ‘You need to lose weight’. It just do not need to be insulting and offensive to the individual. Do not make them feel worse. Basically, find a positive word without insulting them...offending them”.

Additionally, respondents expressed concern with the use of scare tactics for weight loss from practitioners. Respondents gave examples such as “You’re going to have a heart attack” or “You’re going to have a stroke”. They discussed ways around this, such as the doctor’s use of a more thoughtful and sensitive tone. Another major concern from respondents was the perceived lack of communication from doctors.

Many respondents expressed frustration with their medical experiences, while one respondent reflected on feeling ignored and unheard:

“Sometimes they hear what you say but they don’t listen to everything that you say and every Black woman that comes in there is not alike...so you can’t fit them into a cookie cutter and say; ‘OK, this applies to all blacks in suits and women’. No, it does not...no, it does not. When I complained about coughing because I had a cough for 2 years and they would not diagnose it. They gave me all kinds of pills. It was none of that—it was asthma. I went to a specialist, he diagnosed me in 5 minutes”.

3.3.2 | Things to avoid while discussing weight gain

Respondents emphasized the importance of doctors avoiding being offensive. Simply put, respondents stated, “Don’t be negative about it”. Respondents expressed awareness of their lived experience and having an awareness of when something was physically wrong. Doctors should “at least give [them] the dignity” when addressing ways they have struggled to meet weight-related goals. Similarly, doctors were advised to stop fixating on the weight concern. One respondent aptly stated:

“You know when a person’s in the mud. Don’t holler at the mud. Show them how to get out of the mud. Have a way for them to get out. No way of knowing for many of them how to get out of this”.

In a similar vein, respondents discussed the option for doctors to say nothing regarding their weight gain. Respondents explained that, having the results from the scale right in front of them, was acknowledgment enough. Instead, respondents recommended that doctors shift the conversation almost immediately towards strategies for weight loss. Finally, respondents stated that direct demands such as “You need to lose weight” or “You’re eating too much” were unnecessary and often inappropriate.

3.4 | IV. Desired attitudes and behaviours during weight-focused discussions

Respondents discussed desired attitudes and behaviours from practitioners while discussing weight loss and weight gain. This theme was broken into two codes: *Show caring and understanding* and *encourage behaviour change for weight loss*.

3.4.1 | Show caring and understanding

Respondents stated that doctors could show that they care simply by showing genuine concern. One respondent discussed why this was so important:

“Doctors are so important because they are coaches, they are mentors, and they are a lifeline to us improving our health...and they are leaders. So, that doctor can take how that person or individual may be

feeling and see how they see themselves and boost up their motivation and boost up their self-esteem. That will be great. That would be awesome. So, if that doctor or physician can take that moment to highlight just positive things that they see and even something like being consistent coming into the doctor's office. I mean, it may seem like a small thing but even taking that and that can be positive to say, 'Hey you're coming. So that lets me know that you want change'.

Respondents resonated with this experience, highlighting the importance of their doctor's body language while having these conversations. Smiling, consistent eye contact and a welcoming posture were all underscored in the responses.

3.4.2 | Encourage behaviour change for weight loss

Overall, respondents expressed a desire for their doctors to be sensitive towards their current weight and health goals. One respondent shared the age-old adage; "Treat people like you want them to treat you". Another respondent shared an unpleasant and insensitive experience she had with her doctor:

"I had to go to a specialist because I had a hernia. It was causing me pain, so I went to a specialist. And you know, it's like a pulled stomach muscle. OK so I went to a specialist, I wanted to get it fixed. I was tired of the pain and he said... he said to me, what he said to me was nasty and mean. He said, 'there was no need for me to fix it because, at your size, you would just blow a hole in it again'".

Other respondents echoed similar unpleasant experiences. Many discussed ways these interactions could be avoided, simply by understanding the patient's barriers and having an open and honest dialogue. Validation and affirmations seemed key in respondent's statements regarding needing encouragement from their doctors.

3.5 | V. Building physician-patient rapport

Respondents discussed ways to build physician-patient rapport. This theme was broken down into three codes: *Enable patients to feel respected by doctors*, *enable patients to feel comfortable with doctors* and *enable patients to trust their doctors*.

3.5.1 | Enable patients to feel respected by doctors

Respondents stated that they felt respected when their doctor was prepared and engaging, as it "lets [them] know that [they] care too". Respondents expressed a desire for their doctors to have solutions and the necessary tools and resources. One respondent mentioned the importance of "sensitivity training" for doctors that focuses on how to interact respectfully with patients from different backgrounds.

3.5.2 | Enable patients to feel comfortable with doctors

Respondents reflected on their experiences with their practitioners where they felt comfortable:

"My doctor will sit and have a conversation with me. He has said all the right things. He's always listening to my concerns. He asked me about the medication. If I feel like it's doing something to me that I don't like, he'll try to change it up. You know, he consistently tells me that I need to walk, you know, ask me to walk. And what I love about him is that he does reach out to me even when I don't have an appointment".

Respondents talked about experiences where they had a genuine relationship with their doctor. These experiences appeared to centre on the doctor's ability to humanize and truly connect with their patients. Respondents highlighted the importance of the doctors asking patients about their needs, inviting questions from them, and addressing patients' concerns.

3.5.3 | Enable patients to trust their doctors

For many respondents, trust in their doctors was associated with their perceived expertise and skill. One respondent expressed this sentiment:

"I think their words—your words are powerful when you speak truth and you speak with confidence. And we look for leaders to be integrable [sic]—to have integrity. So, I believe that you have given me this and this is going to work. You're not just giving me something that is going to have me to fall down a rope, so I have to trust what you're saying. I trust your information you provided for me".

4 | DISCUSSION

The present study is the first to utilize a qualitative approach to identify and synthesize the views of Black women patients with obesity on their desired and undesired weight-focused discussions with their providers. The qualitative approach employed in this study generates a deep understanding not only of the experiences of Black women patients but also of potential strategies that physicians could employ to succeed in their discussions with patients regarding healthy weight achievement and maintenance.

The majority (60%) of participants in this study reported an interest in losing weight, which is in contrast to the commonly espoused perspective that Black women do not have interest in weight loss and weight loss maintenance.^{20,21} This result, instead, is in line with research showing that Black women are interested in their providers connecting them with weight management resources—support that Black women patients do not always receive.^{11,22} Yet, of the women participating in this study, 20% did not feel trusting or very trusting during weight-based discussions with their doctors. This may indicate that, even when conversations are occurring, they are not occurring in a patient-centred culturally sensitive manner.

Participants in the focus groups expressed interest in physicians taking the time to understand their personal experiences (eg, daily habits), emotions, stressors and cultural background. They also wanted their physicians to offer culturally relevant and accessible resources to them. Yet, 20% of participants said they had not engaged in weight-related discussions with their doctor in the past year. While most interventions to address overweight and obesity in Black women have not demonstrated success,⁶ a personalized approach focusing on individual variability may advance the understanding of some of the major factors contributing to overweight and obesity in Black women and lead to new strategies to improve health care outcomes.²³

Interventions to address overweight and obesity in non-Hispanic Black women must focus on modifiable psychological and knowledge variables that may empower these individuals to engage in weight loss and weight maintenance under whatever conditions that may exist in their lives.²² The themes and codes that emerged from the focus groups support the cultural adaptation of existing weight loss programs and strategies to meet the needs of Black women patients.

4.1 | Limitations of the study

Despite its methodological strengths and important findings, this study has two notable limitations. The first limitation is sample size ($N = 15$). The present study is important because it targets a hard to reach group of Black female patients who have obesity and whose views about how they want their physicians to talk to them about their weight was not known prior to the present study. Notably, even though the sample size in the present study is small, this sample size is consistent with that of most of the few published qualitative health-focused studies that with Black participants²⁴⁻²⁶ and with that of many articles published on patients' views of obesity management and treatment.²⁷⁻³² It is also notable that we used content analyses using the comparative method to analyse the obtained focus group data—a rigorous, highly respected qualitative data analysis method.

An additional limitation, which is common to the focus group approach, is that participants were self-selected. Moreover, all patients lived in Florida at the time of the study and there were no patients between the ages of 21 and 36 represented in the study. All of these may limit generalizability of results, especially in the context of obesity rates rising in young Black females. Therefore, the results of this study may not capture the diversity of views that Black women patients with obesity may have on their desired and undesired weight, weight loss, and weight loss maintenance-focused discussions with their physicians and on provider behaviours and attitudes that promote patients' feelings of comfort, respect and trust in interactions with their doctors. Future research should include the perspective of a larger number and broader range of Black women to increase generalizability.

4.2 | Strengths of the study

Despite the noted limitations, the present study has important strengths. First, the use of a qualitative research approach encouraged the Black women participants to expand on their responses and to open conversations that may not have been initially considered due to limited research involving Black women with obesity and their interactions with physicians who treat obesity. Second, this study was also facilitated by Black women who were very similar to the focus group participants, which appeared to promote open, honest, and substantive responses to each of the presented focus group questions.

5 | CONCLUSION

This study provides support for actively involving Black women with obesity in the development and modification of treatment programs for obesity that exist and are increasing in community-based primary care clinic. Considering that Black women are experts on their own bodies and health, the success of interventions to address overweight and obesity requires that they are heard and that their experiences are validated.

Additionally, the results of this study also suggest that providers who treat Black women with obesity as well as others with obesity should be trained in assessing and addressing the emotional aspects of obesity. Such training involves learning basic counselling skills and behaviours that convey support, encouragement, and listening, all of which are not difficult to learn and can easily be integrated into clinical encounters with patients. This training can and should also be incorporated in the training of medical students.

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CONFLICT OF INTEREST

The authors declare that they no conflict of interest.

AUTHOR CONTRIBUTIONS

Study concept and design (study's principal investigator): Dr Carolyn M. Tucker; Funding acquisition: Dr Carolyn M. Tucker; Writing-original draft preparation and corresponding author: Dr Julia Roncoroni; Data analysis and writing: Kirsten Klein, MA; Writing-review and editing: Terry O Derias, Wafaa Ateyah, Jaime Williams, Nwakaego Nmezi, Nipa Shah, Lori A. Bilello, Stephen Anton.

ORCID

Julia Roncoroni  <https://orcid.org/0000-0003-2931-9202>

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