Addressing Weight in Primary Care: Perspectives of African American Young Adults with Serious Mental Illness

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Abstract

Young adults with serious mental illness (SMI) experience disproportionate rates of physical illness. Morbidity and mortality are even worse for young African Americans with SMI, especially those who are overweight. Primary care physicians (PCPs) have an important role in addressing weight management. Current research explored these young patient’s perceptions of weight management and how PCPs can best address their weight concerns. Using community-based participatory research, we interviewed 25 African American aged 18-30 who were overweight and had a SMI. Results revealed 1) patient perceptions around weight and 2) patient preferences. Participants identified both positive and negative aspects of being overweight, with many connecting their weight gain to the initiation of psychiatric medications. They highlighted their preferences for PCP accessibility, individualized treatment planning, supportive communication patterns with PCPs, and interactive ways to engage with PCPs around weight management. This study highlighted the importance of utilizing shared decision making for providing care.

Keywords: Serious mental illness, African American, obesity, weight management, young adults, primary care
Introduction

Individuals with serious mental illness (SMI) are at heightened risk of developing chronic physiological disorders (De Hert et al., 2011) and have a reduced life expectancy of 15-30 years (John et al., 2018). Medical conditions including diabetes, cardiovascular disease, hypertension, stroke, metabolic syndrome and obesity-related cancer are more prevalent among those with SMI (De Hert et al., 2011; John et al., 2018). While there are many causes of these diseases, obesity contributes tremendously to these health conditions (Scott & Happell, 2011). Primary care, as the entryway into the health services, is a critical point for obesity screening and management (Semlitsch et al., 2019). However, high-quality weight-related services require an understanding of service user perspectives, accompanied by interprofessional collaborations to implement these services. In this paper, we focus on a unique group: African American young adults with serious mental illness who have weight concerns. We aim to understand their weight management experiences specifically within the primary care setting.

Background

Obesity rates are higher among those with SMI than in the general population (Afzal et al., 2021; Dickerson et al., 2006; McElroy et al., 2002). Multiple factors contribute to obesity disparities, including reduced levels of physical activity, poor diet and high calorie intake, poverty, and other social determinants of health (Cabassa et al., 2014; Casagrande et al., 2011; Teasdale et al., 2019). In particular, medication-related weight gain resulting in obesity is a major concern among people with SMI (Holt & Peveler, 2009; Mazereel et al., 2020). For example, around half of individuals taking the antipsychotic medication Clozapine gained weight after beginning the medication (Bai et al., 2006). Research also suggests that African Americans with SMI have the highest rates of obesity among persons within the SMI population (Cabassa et al., 2014). Socioeconomic status, discrimination, neighborhood conditions, and reduced access to healthcare all contribute to health disparities between African Americans and other groups (Allen et al., 2014). Furthermore, race-based discrimination in health care settings inhibits the quality of services and may delay care-seeking (Chesler & Barabino, 2023; Lee et al., 2009).

In particular, young adults with SMI are at risk of significant weight gain that increases the risk factors for disease throughout their lives (Naslund et al., 2017), suggesting that African American young adults with SMI are an important target group for weight management interventions. One common pathway to weight management services is through primary care providers (PCPs; Anderson et al., 2022). The United States Preventive Services Task Force recommends that PCPs screen all adults for obesity, and that providers refer patients with a Body Mass Index (BMI) of 30 or higher to weight loss interventions that include a lower calorie diet, increased physical activity, and behavioral interventions (Moyer, 2012). Similarly, the Affordable Care Act increased access to care for low-income individuals and young adults (Wong et al., 2015) with the potential to make health care providers an affordable point of contact for more young adults with SMI to address health risks such as obesity. Despite this, research shows that screening, intervention and referral are suboptimal (Anis et al., 2004; Welch et al., 2015). Providers report that limited time, lack of training, and beliefs that intervening will be fruitless, contribute to poor adherence to guidelines (Alexander et al., 2012; Foster et al., 2003).

Patients have reported concerns about weight management services they receive in primary care settings (Norman et al., 2023). Among the general population, some patients prefer that health care providers not address weight issues in primary care and report that talking to a
provider about weight is not helpful (Wadden et al., 2000). Instead, some believe that visiting a specialist would more effectively address their weight-related needs (Norman et al., 2023). Other patients feel that health providers blame them for their weight problems and that health appointments do not include time to talk about weight (Ruelaz et al., 2007; Wadden et al., 2000). In a qualitative study with African American patients, participants disliked the provider use of the word “obese,” emphasized the importance of genuine respect and a caring attitude from providers, and underscored the need for individualized weight management methods (Ward et al., 2009).

Although obesity rates have increased globally and associated health issues have become more pronounced, there is a dearth of research examining how African American young adults with SMI and obesity perceive weight-related screening and intervention in primary care. An exhaustive review in APA PsychInfo and MEDLINE reveals a significant gap in literature for African American young adults with SMI. Exploring service experiences for this specific group will reveal opportunities for more effective interventions. Particularly, a comprehensive understanding of their specific challenges and perceptions enables primary care providers to form and implement actionable strategies. This study seeks to bridge this gap, offering specific insights to enhance weight management approaches in primary care tailored to unique needs of this population. Given the exploratory nature of the research, a qualitative interview approach was chosen. Focus groups were identified as the best method for gathering information on shared experiences and allowing participants to validate each other’s perspectives (Rodriguez et al., 2011). This choice is especially pertinent given the multi-marginalized identities of the participants, who frequently expressed mistrust in healthcare (Ho et al., 2022; Kennedy et al., 2007).

Methods

The study was inspired by a grant-funded community-based participatory research (CBPR) initiative. Under this initiative, African Americans with SMI were invited to attend a community research training and join a CBPR team to address a specific physical health disparity that they perceived as a priority for their own community. CBPR is a collaborative approach between community stakeholders and academic researchers (Minkler & Wallerstein, 2011). In particular, CBPR emphasizes equal participation of all partners throughout the entire research process, from generating research questions, to shaping study design, to collecting data, analyzing and interpreting results, and disseminating findings. The current CBPR study began with assembling a team of five African Americans with lived experience of mental illness, a healthcare provider (a nurse practitioner), and two academic researchers. Team members were recruited from local mental health agencies, specifically targeting individuals who are active and influential within their community. To be eligible to join, individuals either needed to self-identify as belonging to the African American community affected by mental illness and experiencing physical health disparities or be providers who worked closely with them. In the current project, academic researchers and service providers were encouraged to collaborate, broadening their areas of expertise in ways that mutually benefited and advanced the study (Willison & Palos, 2010).

Following a curriculum, Inspiring Change, the whole team was trained on the concept of CBPR and learned basic principles for conducting research. Academic researchers introduced literature concerning physical disparities experienced by African Americans with SMI. Then, the team formed research goals consistent with both the research literature and their own lived
experiences to develop an interview guide. In this context, weight concerns emerged as a pressing issue needing attention. Young adults, who are at a critical age for learning and adopting a healthy lifestyle and beginning to navigate the health services system independently, were identified as being at heightened risk for this disparity. In addition, members shared consistent negative interactions with PCPs around their weight management. Thus, the team decided to explore the perceptions and experiences of young African Americans within PCPs on this matter in greater depth.

Guided by the study goal, the CBPR team proposed the following research questions: (a) how do young, overweight, African Americans with SMI perceive their weight?; (b) what are their perceptions and experiences of having weight issues addressed through primary care?; (c) what provider actions or communications have facilitated or hindered weight management and healthy lifestyle?; and (d) what are potential solutions to improve weight management in primary care? Based on these research questions, the CBPR team collaboratively developed an interview guide. A semi-structured interview framework was used to allow follow-ups in clarifying answers and exploring questions in-depth.

The research protocol was approved by the Institutional Review Board at a midwestern university. The CBPR team defined the target populations and determined recruitment strategies. Individuals were eligible to participate in the study if they were ages 18-30, African American, reported a SMI, and had weight concerns related to being overweight or obese. SMI was defined by experiencing a current mental illness that places major limitations in at least one of the following areas: school, employment, and independent living. Recruitment flyers were distributed at three local community mental health agencies.

Sixty-four interested people were screened for study inclusion by phone. A total of 25 individuals were eligible and ultimately attended one of the group interviews. Participants filled out a brief demographic questionnaire prior to the group interview. The duration of the group ranged from 1.5 to 2 hours. Participants were compensated $30 for their time and $10 for travel.

Five group interviews were jointly led by a researcher and a person with lived experience from the CBPR team. Research staff provided trainings on interview facilitation for persons with lived experience. The opening statement that introduced the study purpose, definitions, and group process was scripted, which ensured the standardization of the research and comprehension of participants. All interviews were audio recorded and transcribed verbatim.

Out of 25 participants, 13 (52%) identified as female, 8 (32%) reported as male, and 4 (16%) identified as transgender. Based on their self-reported weight and height, 20 participants (83.3%) had BMI 30 or above, while the remainder had BMI of 25-29. Twenty-one participants (85%) had received primary care services within a year of the study; 20 (80%) received at least one service within the past six months and 16 (65%) had seen a doctor within the past three months.

Data Analysis

Thematic analysis was used to analyze the data (Braun & Clarke, 2006) in MAXQDA. The two academic researchers on the CBPR team reviewed transcripts and developed preliminary codes. Each researcher individually coded the first transcript, then discussed and resolved discrepancies in coding. Additional codes were added to account for responses that did not fit into existing codes. This process was employed for coding two more transcripts. A senior researcher then reviewed the initial coding process and reorganized the coding structure into themes and subthemes. Following the reorganization, the initial two researchers continued with
coding the two remaining transcripts individually, then discussed and resolved discrepancies after each one. After this process, the researcher and research assistant reviewed the coding structure one last time and collapsed some categories with similar content (e.g., perceptions of weight management and perceptions of primary care), and also collapsed codes that were infrequently used into broader categories with a good conceptual fit.

Trustworthiness

The CBPR team took steps to ensure credibility, transferability, confirmability, and dependability during the research process. The interview questions were developed and piloted by the CBPR team. Those members, who possessed a wealth of lived experience regarding their health conditions and deep community expertise, were interviewed while assuming the roles of participants. This approach was taken to ensure all questions were well-structured and resonated effectively from the participants’ perspectives. Interview guides were refined, incorporating pre-designed follow-up prompts to minimize the introduction of biases during the focus groups. Open-ended questions were used to avoid leading participants in any specific direction. During the study, interviews were conducted jointly by the academic researcher and individuals with lived experience. Both interviewers were consistently reminded to maintain objectivity and refrain from imposing their own reflections and experiences. Verbatim transcripts and use of an iterative, systematic process with multiple coders enhanced the confirmability and dependability of data. Feedback sessions were held between the lead academic researcher and a senior researcher, who was independent of the research project, to reinforce a neutral stance in analyzing and interpreting the results.

Results

Results were grouped into two areas: patient perceptions about weight and patient preference for primary care treatment of weight concerns. Key themes for perceptions about weight were: (a) weight gain and medications; (b) positive aspects of extra weight; (c) negative aspects of extra weight. Themes for patient preferences for primary care treatment of weight concerns were: (a) accessibility; (b) provision of education and resources; (c) individualized treatment; (d) supportive communications. These themes are discussed below.

Patient Perceptions about Weight

Participant perceptions around weight were categorized into concerns about the impact of psychiatric medications on weight, positive perceptions of being overweight, and negative perceptions of being overweight.

Weight gain and medications \((n = 10)\). Many participants described dramatic weight gains (30 pounds or more) after starting on psychiatric medications. Some described an increase in appetite, while one said the medication made them stop being active because they felt like a “zombie.” A few participants said their doctor did not discuss the potential for weight gain when the prescription was initiated. Others said that they were informed about the possibility but reacted with frustration that they had to work so much harder than others to maintain current weight or lose weight. One commented, “You want to stay the weight that you are. But you’re taking this medicine that is making you gain weight.” When the person approached their primary care doctor for an alternative medicine, the response they received was, “Is it worth it?” Participants described a difficult trade-off between psychiatric stability and weight gain, along with pressure from doctors to accept the weight gain as necessary to improve mental health.
Positive aspects of extra weight ($n = 4$). A few participants were not concerned about weight, accepted their bodies, or viewed extra weight as attractive. One said, “I’m still pretty big, but I like that,” while another said, “I’ve always wanted to gain extra weight.” A third person discussed how the extra weight did not bother them, saying, “I’m comfortable in my skin.” While a few described more conscious efforts to be comfortable with themselves and their bodies, one described weight as making them more appealing to others and one said that weight made them more intimidating so that others would not approach them.

Negative aspects of extra weight ($n = 8$). In terms of negative consequences of weight, participants expressed concerns about premature death and weight-related illnesses, including hypertension, high cholesterol, asthma, and diabetes. Other negative aspects were centered on physical appearance, perceived attractiveness, and perceptions of others: “…I didn’t want my legs out in the summertime just to be seen, they [stretch marks] looked like someone had beaten me. That’s how I felt.” Participants also spoke about how extra weight limited their functioning and participation in life activities: “If I lose this weight and start eating healthy before I become 35, I could do one of the jobs I wanted to do-- either go into the military or law enforcement.”

Patient Preferences for Primary Care Treatment of Weight Concerns

Participants described their preferences about how they would like their weight concerns to be addressed in primary care. Themes are divided into (a) accessibility; (b) provision of education and resources; (c) individualized treatment; (d) supportive communications.

Accessibility. Participants recounted difficulty around obtaining care, emphasizing their needs and preferences for easier enrollment, availability, and time devoted towards appointments.

Finding and selecting a PCP ($n = 3$). Participants expressed difficulty and uncertainty about how to get connected with and choose a PCP through their insurance. One participant said: When you sign up for primary care over the phone, you know, benefits that [the state] is supposed to give us, they had this picture of who they is, they just had a name and they say ‘If you don’t pick a name, you can’t get the services, so you need to pick a name right now.’ So the very beginning is f’ed up, it’s really messed up, how are you going to expect me to pick somebody right away?

Participants went on to highlight the difficulty of determining whether a provider will be sensitive and culturally competent in terms of serving African Americans, individuals with mental health challenges, weight concerns, history of trauma, or LGTBQ status.

Availability ($n = 5$). Participants stressed that being able to get a timely appointment with a PCP as an extremely important issue: “I feel great about my primary care provider because they’re available--they exist and they’re available.” While some participants saw a psychiatrist, others received mental health care directly through their PCP, and valued a provider that was available, would fill prescriptions quickly, and was located nearby.

Time Constraints ($n = 4$). Participants felt rushed during PCP appointments and did not believe there was enough time to address all concerns related to weight. One participant said, “…I find with primary care providers--and I’m sure a lot of other people will agree--they’ll only be in the room for 5 minutes. They never take time for you. I just feel like they’re taking my money…” Another person said that there were often multiple health issues to address, but there was only time to focus on one or two issues during the visit. Another person recounted a positive experience in which their PCP spent 30 minutes and had a “normal conversation” with them, making them feel much more positive about the health recommendations discussed.
Education, resources & referrals. Participants discussed their experiences and preferences for education, resources, and referrals to other supportive services around weight management, which were categorized into three subthemes: (a) educational strategies; (b) resources; (3) referrals.

Educational strategies ($n = 7$). Participants discussed some informational and educational strategies used by their PCP, which mostly included messages about increasing activity levels and restricting food intake. Messages about food restriction often centered around portion control or limits on specific foods (e.g., fried foods, fast food). Some participants said they would have wanted more education about diet and exercise, or referral to more intensive services. Some participants expressed that their PCP was not knowledgeable or prepared to address weight concerns. One said, “But when it comes to overweight, he [PCP] really doesn’t take the time to do his research. And a lot of primary care providers, they don’t really do a lot of research either. They just give you information and…that’s it.”

Resources ($n = 4$). Participants suggested various resources that PCPs could offer to help with weight management, including exercise programs, nutritionists, cookbooks, videos, pictures, personal training, and gym memberships. One said, “That [classes] would be helpful for certain people that don’t want to do it by themselves. It could be a program, like a swimming program, a basketball program, a treadmill program, all that, even a yoga program.”

Referrals ($n = 5$). While some participants appreciated referrals to specialists or other programs, some participants got the impression that PCPs either did not want to, or did not have the capacity to, provide weight-related services, so they merely made patients aware of the problem and referred them elsewhere. This made at least one participant feel that their PCP did not genuinely care enough to address the issue saying, “They just refer me to services…they don’t want to be bothered.” Another said, “I wish my primary care physician could guide me along the way. When you ask for help, he just pushes you away. He says, ‘Services here, here, here’ but they don’t take the time to talk.”

Individualized treatment. Participants expressed the desire for individualized treatment from PCPs, which included recognizing the social determinants of health and personally getting to know each patient.

Recognize social determinants of health ($n = 3$). Participants felt PCPs did not adjust services to account for poverty, institutional living situations (e.g., nursing home), transportation barriers or other life challenges. One said, “They [doctors] don’t have any alternatives for poor people.” Another said that PCPs lacked knowledge of the neighborhood, “They’re [doctors] taught at a college that makes millions of dollars a year, but yet you’re working in a poverty neighborhood. If you’re going to choose to work in our neighborhood, get to know us! If you don’t want to get to know our neighborhood, why are you in this neighborhood?”

Get to know each patient ($n = 8$). Participants preferred that the PCP get to know them as individuals, see their unique situation and help find the best solutions for them as individuals. This lack of individualized attention was often linked to time constraints and lack of attention to individual differences. As one person expressed, “They don’t give you a chance to get to know you, to put it in one sentence. Every patient is different, every patient doesn’t live with their mom!” Another person emphasized the necessity for PCPs to build rapport and provide individualized services, saying, “The only way to get somebody to do the things that you want them to do is to know about them.” Participants said that getting to know each patient also includes developing services around their readiness to lose weight and their preferences for weight loss strategies.
Supportive communications. Supportive communications emerged as a major theme within the group interviews. Participants gave numerous examples of positive and negative interactions with PCPs, suggesting ways in which they would want PCPs to communicate with them.

Focus on positive actions rather than risks ($n = 5$). Participants wanted PCPs to frame weight concerns more positively and suggest solutions, rather than focusing immediately on weight-related health risks, family history, or need for diagnostic tests. One participant said, “That’s the first thing they [doctors] say, ‘I think you need to get checked for diabetes.’” Another participant responded:

Now, for me, it’s a really strong subject because like [another participant] said, you could just walk into the office and they’ll automatically judge you. You could just walk in and they’ll say, ‘You need to lose weight honey.’ And I didn’t come for that. I came because I have a headache or because I have a cold.

Another participant spoke about the futility of PCPs telling patients about the risk without offering additional support or action, i.e., more of a focus on actions or solutions. When his doctor outlined the health-related risks, according to the participant he said, “So I just look at them like they’re crazy and I tell them if they want me to lose weight, then they should give me solutions to do that. Because you can’t just tell somebody that they need to lose weight and expect them to just drop some pounds for you.”

Initiate conversations ($n = 4$). Participants wanted PCPs to be more comfortable talking about weight concerns and to initiate conversations. One said, “My primary care doctor wouldn’t tell me anything. He would put me on the scale, but he wouldn’t give me any information.” Several participants said that their doctor had never addressed weight with them but would welcome it if it were done in a sensitive way.

Use shared decision-making ($n = 10$). Participants wanted to have bidirectional discussions with doctors around the costs and benefits of medications, diagnostic tests, procedures, or diet and exercise programs. Some participants did not feel heard or respected when they tried to express preferences, with some feeling like medications were forced upon them and others that medications were withheld. For example, one noted, “I just need a pill to help me with this and they don’t give it to me, because they think I’m going to abuse it like street drugs. That’s what I was told.” Participants wanted to have PCPs listen to their perspectives and incorporate their preferences into the care plan. One explained the frustration:

And I come [to the doctor] with a list of meds… and they [the PCP] say, ‘Oh, this will make you gain weight, that won’t work, that won’t work.’ And there’s nothing I can do. So basically, when I do come prepared, they just knock it down as if they don’t care. Basically, they don’t listen to the patient’s opinion- they feel like they’re God.”

Another participant added:

Seriously, if you have depression, they’ll automatically treat you as if, like you’re dumb basically…they’ll say, ‘Oh we are putting you on this medication.’ ‘Why? Why am I on a new med?’ They’ll just be like ‘Just take it.’ They don’t explain what it does, it’s so frustrating. And the thing is, this is not one doctor, this is all the doctors that I’ve interacted with.

Respectful language and tone ($n = 5$). Participants were sensitive to language and tone from their PCPs. Several disliked the word obese and recounted times that they had felt disrespected by language. One participant said, “Yeah he could have just told me, ‘You’re a little
bit overweight.’ That’s what they are supposed to say, they aren’t supposed to say obese.”

Another participant said that her concerns had been discounted:

I [am] actually to the point where I don’t trust doctors, I don’t, it’s really sad to say…. when I talk to them about anything else, especially my knee pain because I have knee issues, but then they don’t believe me. They’re saying like ‘you’re young, you’re perfect, you should have no issues with anything.’

One participant felt that they were disrespected because of their mental illness: “Dealing with people with mental issues, they [doctors] don’t know how to talk to us. They’re scared of us like we are spiders. We are people too, we like to talk, we can have a conversation.”

Another participant described their PCP in a positive light: “My doctor is more soft-spoken, he’s professional… so my doctor is more so about the tone. He looks at my health…and he more goes in depth instead of just telling me to lose weight.”

Engaging (n = 5). Participants described the ideal PCP as being a patient person, a good listener, and one who could actively engage with them around weight loss. A few participants suggested using video, pictures, or graphics rather than giving “a boring speech.” One participant suggested, “Don’t tell the person to tie their shoe, just show them three pictures of people who didn’t tie their shoes and how they fell off a cliff.” Another person shared a positive experience with engagement, “Because once I got me a new doctor, he lets me go work out with him. I go to the gym with him once in a while.” Another described their PCP’s attentiveness, “He sits, but he’s not typing, he pays attention. He won’t be on the computer typing while he’s talking like most doctors do.”

Non-judgmental (n = 5). Participants wanted a PCP who was non-judgmental in the way they expressed genuine caring, empathy, and provided encouragement and reassurance. One said, “What I’ve noticed dealing with doctors, and dealing with my insurance company and overall dealing with the health care network is that they really try to make you feel bad because of your weight.” Another participant told that about having a new PCP who was also overweight: “The first doctor I had, I felt criticized, but then I got me a new one and this one did not criticize me. He actually cared because he was in the same predicament.” Another participant said she felt good when her PCP expressed concern about her health conditions and asked her how she felt about her weight, rather than making judgements or assumptions about her.

Manageable goals (n = 4). Finally, participants wanted a PCP to help them break down information or activities into smaller steps to make it more manageable for them to understand or execute. One participant who was satisfied with her PCP recounted a conversation: “My primary care doctor was saying, ‘You can lose the weight. You just got to take one step at a time, cut back, and don’t put too much pressure on yourself.’” Another participant said, “I believe something my mother told me…you got to lose inches before you can lose pounds. And a lot of the health care providers really, especially when you’re dealing with doctors or the whole health care field, they want you to lose pounds and they don’t go with you step-by-step.”

Discussion

This paper presents the perspectives of young, overweight African Americans with SMI and their preferences for PCPs in addressing weight-related concerns. While some participants identified positive aspects of being overweight (e.g., exhibiting body positiveness), they were acutely aware of negative consequences of excess weight. Consistent with past research (Bai et al., 2006; Holt & Peveler, 2009; Mazereel et al., 2020), participants in this study connected
weight gain to their initiation of psychiatric medications, and highlighted the need for PCPs to acknowledge the difficulties of managing weight while on psychiatric medications.

Results of this study also highlighted the need for PCPs to prioritize the patient-provider relationship and provide personalized, culturally competent care when addressing weight. Participants in this study were sensitive to language (e.g., obese), tone, and weight-based judgments from PCPs. Effective communications in care is not only about what information is being communicated but how it is being communicated (Honavar, 2018). Presenting messages in a way that resonates with patients can enhance both their service experience (Yağar, 2021) and treatment outcomes (Jahan & Siddiqui, 2019). Given the disenfranchisement of this population (due to age, disability, minoritized status, etc.), additional time spent with patients to understand their cultural context and life experiences, and to develop an individualized treatment plan that addresses their specific needs at the outset of the relationship, may result in enhanced rapport and engagement in weight management activities over the longer term. This perspective is supported by an earlier study that examined the factors contributing to quality relationships between low-income individuals with SMI and their providers (Ware et al., 2004). Their study highlighted how individuals in treatment often seek “extra things,” such as activities and conversations that transcended their diagnosis, allowing them to feel understood as a whole person.

Additionally, the emphasis on individualized services herein suggested the need for recovery-oriented providers who support and empower a diverse range of treatment participation and outcomes, tailored to each patient’s desires (Borg & Kristiansen, 2004). Such an approach grants patients the agency to collaborate with their PCPs, laying a foundation for truly personalized care. Weight management, being an ongoing commitment, is intertwined with individuals’ lifestyles and daily activities; hence, a one-size-fits-all approach is not suitable. In congruence with our findings, another study recommended personalizing weight management by listening to the internal narratives of the patients. These narratives were then reconstructed to create care plans that resonate with the person’s values and goals (Luig et al., 2018). Overall, findings from our current study align with themes from other qualitative research, such as the importance of relationships (Denhov & Topor, 2012), including trust (Galon & Graor, 2012), empathy, care, and understanding (Andreasson & Skärsäter, 2012), along with the value placed on partnership in treatment decisions having recurrently been stressed by persons with SMI in the literature.

Use of various mediums and engagement around weight was another preference of participants in this study. Contrary to the common belief among providers that comprehensive engagement is time-consuming (Ekdahl et al., 2012), our findings suggest otherwise. Rather than an extended lecture, participants preferred PCPs who would provide videos, visual representations, or in one case, the offer to exercise together with the PCP. Participants did not want to be repeatedly told about risks, but rather offered with practical solutions that are broken down into measurable goals. While referrals to services were welcomed in many cases, referrals could give the impression of “passing off” the patient to other providers or give the impression that the PCP does not care (Mehrotra et al., 2011). A lack of community resources and supports (e.g., affordable exercise coaches) may make recommendations or referrals futile. Meeting the needs of these patients may require PCPs to collaborate closely with other human service providers who can deliver more intensive services in alignment with PCP recommendations (Eliot et al., 2021).

Interestingly, participants in this study did not overtly mention racism as a barrier to weight-related treatments. However, several participants did highlight their provider’s lack of
understanding of social determinants of health, neighborhood contexts, and failure to respect individuals with SMI. In fact, some of our study participants spoke about changing PCPs several times before finding a doctor who they were satisfied with. In response to these concerns, health providers could design weight management programming that addresses structural barriers (e.g., transportation to safe exercise spaces; Anand et al., 2023). Weight management advice often puts the onus on the person to take actions to restrict food intake or increase exercise, placing blame on the patient and underemphasizing social determinants of health, such as poverty and the impact of psychiatric medications, which are largely outside of the patient’s control. When PCPs and allied human service professionals can reorient their perspectives and services to recognize impacts of the societal factors, patient’s may experience less shame and be more comfortable engaging around weight issues (Greener et al., 2010).

Implications

The communication approaches suggested by our findings align with the principles of shared decision-making. This refers to an interactive communication process between providers and patients while making health decisions, may be a useful strategy for enhancing discussions around weight in this population. Shared decision-making involves three components: 1) providers inform patients on the target health condition as well as the benefits and risks of related intervention options; 2) patients discussed their self-defined health goals and personal preferences and values for weighing the pros and cons of each intervention; and 3) providers facilitate patients to review all available information to decide on intervention, and set up subsequent plans to assist patients in following through their decisions (Agency for Healthcare Research and Quality, n.d.). An expert panel, consisting of PCPs and obesity specialists, recently developed a guide for addressing obesity in primary care, a key component of which was shared decision-making (Gallagher et al., 2021). The other components included asking the person for permission to discuss weight, addressing weight-based biases/discrimination, and discussing the diagnosis (Gallagher et al., 2021). Shared decision-making can also be applied to the referral process led by PCPs, whereby patients are informed about available weight management programs and specialists (e.g., dietitians, nutritionists, social workers, nurses, counselors, community health workers). Familiarity with these various resources and opportunity for interprofessional care enables individuals to exert more agency in their weight management and determine the best course of action for their health.

Motivational interviewing (MI) is another tool that PCPs and allied health professionals might use to facilitate discussions around weight and build rapport. For instance, two key ingredients of this approach, active listening and empowering communication, can help providers become more engaging and supportive in delivering care. Growing research has explored the possibility of implementing MI in primary care settings (e.g., Berkel et al., 2021). A two-year randomized controlled trial found that PCPs and registered dietitians who used MI could better assist their patients with weight management than the control group (Resnicow et al., 2015). Another advantage of using MI is fostering behavioral changes in patients, which can complement PCPs’ behavioral counseling to weight management recommended by the U.S. Preventive Services Task Force (Moyer, 2012).

The current study also demonstrated the advantages of implementing a CBPR design and promoting interprofessional collaboration in research. The unique CBPR design enabled the study to be responsive to the community’s concerns, while also effectively relaying information back to the community. Individuals with lived experience have significantly supported our
interpretation and delivery of results, offering valuable insights to those who may be navigating similar situations. Providers within the CBPR team have played a crucial role in identifying potential, viable solutions (e.g., shared decision making, motivational interviewing). Translating the results into an actionable strategic plan, with the aim to bring feasible and tangible changes to the community, was a primary goal for this CBPR team. Therefore, we advocate for future research endeavors to increasingly incorporate this design approach.

**Limitations and Future Research**

A strength of this study was the CBPR approach, in which people with lived experience of the health condition and other stakeholders were active in the design and execution of the research study, including development of research questions, data collection, and interpretations. This allowed us to align the project with community needs, strengthen the project through team knowledge, and empower and build the skills of team members. However, this study includes a small sample from an urban area, so caution should be exercised when generalizing these findings. Health care experiences are heavily contextualized. For instance, receiving weight management services in rural areas may differ significantly from experiences in urban cities. Future research could examine if similar results hold constant across varying local cultures and geographic variations. Limited resources and referral choices in a community may add additional barriers for PCPs and allied professionals to address patients’ weight concerns. Even more so, the shortage of PCPs in rural areas may amplify the accessibility issues. Finally, this study did not include the perspectives of health care providers or other stakeholders who could offer their own important insights about weight management in primary care. While the present narratives reflect the experiences of service recipients, understanding why services were not rendered as requested could be better addressed by incorporating providers’ perspectives. Future research could seek further input from the providers as well as validate some of the current findings using quantitative methods, or directly observe interactions between patients and PCPs to gain further insight into communication patterns.

**References**


Semlitsch, T., Stigler, F. L., Jeitler, K., Horvath, K., & Siebenhofer, A. (2019). Management of overweight and obesity in primary care—A systematic overview of international evidence-


