Understanding the influence of obesity bias in the development and management of obesity.

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Objectives

1. Give an overview of the current prevalence of weight bias in clinical and public settings.
2. Describe the influence of weight bias on weight-related behaviors.
3. Describe the influence of weight bias on access to obesity care.
4. Describe the influence of weight bias on public health policy.

Weight Bias is Pervasive

- General population:
  - Implicit and explicit anti-fat bias is highly prevalent.
  - Weight bias decreases as body mass index (BMI) increases.

"Fat people lazier" % Who Agreed:

Underweight	Normal Weight	Overweight	Obese	Extremely Obese
42.7%	35.3%	29.8%	26.5%	22.6%

Schwartz et al. 2006

Weight Bias is Pervasive

- In many forms of media, negative stereotypes are used (Ata et al 2010).
- Weight bias is prevalent in higher education admissions (Burmeister et al. 2013).
- Weight bias is involved when making hiring decisions (Pingitore et al. 1994).

Weight Bias is Pervasive

- In the Healthcare Sector:
  - Medical Doctors: Strong implicit and explicit bias (Sabin et al. 2012, Foster et al. 2003).
  - Dietetics students: Moderate fat phobia (Puhl et al. 2009).
  - Obesity researchers and clinicians: strong implicit and explicit bias (Schwartz et al. 2003).

Weight Bias is Pervasive

- From the Patient's perspective (Puhl et al. 2006)

Table 2. Mean scores of stigmatizing situations and the percentage of respondents experiencing each situation across both samples*

	Sample 1		Sample 2			
			Women		Men	
Stigmatizing situation (subscale)	Mean (SD)	%	Mean (SD)	%	Mean (SD)	%
Others making negative assumptions	1.58 (1.11)	68	1.67 (1.00)	74	1.59 (1.07)	70
Nasty comments from children	1.38 (1.00)	63	1.55 (0.98)	69	1.47 (0.98)	66
Physical barriers and obstacles	1.16 (0.91)	50	1.18 (0.91)	52	1.16 (0.87)	53
Inappropriate comments from doctors	1.12 (0.92)	53	1.21 (0.90)	62	1.11 (0.90)	54
Nasty comments from family	1.05 (0.74)	51	1.08 (0.69)	53	1.21 (0.72)	62
Nasty comments from others	1.04 (0.71)	48	1.12 (0.66)	49	1.07 (0.72)	49
Loved ones embarrassed by your size	0.98 (0.87)	50	0.99 (0.85)	50	1.01 (0.91)	52
Being avoided, excluded, ignored	0.87 (0.95)	48	0.83 (0.87)	50	0.96 (0.90)	54
Being stared at	0.81 (0.76)	37	0.88 (0.78)	46	0.81 (0.60)	40
Job discrimination	0.54 (0.79)	25	0.55 (0.74)	28	0.49 (0.73)	23
Being attacked	0.17 (0.62)	9	0.21 (0.68)	10	0.20 (0.64)	11

% refers to percentage of respondents who experienced the stigmatizing situation. SD, standard deviation.

* Scores for items in each subscale range from 0 (never) to 3 (multiple times).

Weight Bias Experiences and Weight-Related Behaviors in Patients

- Comments about weight may be well intended, but can have unintended consequences. (Puhl et al. 2006)

  Coping strategies to stigmatizing situations :

  - 75% report refusing to diet
  - 73% report negative self talk
  - 79% report eating
  - 74% report crying, isolating self

Weight Bias Experiences and Weight-Related Behaviors in Patients

- Weight stigmatizing experiences associated with:
  - Depression, low body image
  - Increased binge eating episodes
  - Exercise avoidance

- Particularly apparent for individuals who internalize weight bias, or believe it to be true.

(Puhl et al. 2007; Puhl et al. 2006; Carels et al. 2010; Vartanian et al. 2008)

Weight Bias Experiences and Weight-Related Behaviors in Patients

Greater weight bias is associated with less weight loss in a weight loss program. (Carels et al. 2009)

Influence of Weight Bias on Access to Obesity Care

What does weight bias translate to?

Overweight/obese individual = lazy, overeats, unhealthful diet, lacks willpower

Translation: People have overweight/obesity because they eat too much, and move too little

Influence of Weight Bias on Access to Obesity Care

- Weight Bias is reflected in access to obesity care (Brownell et al. 2010):
  - Because of underlying biases, obesity has historically been an issue of personal responsibility.
  - "Personal responsibility" used by society and the government to not address the issue.
  - As a result, limited infrastructure and health practitioner training currently exists to treat it.

Influence of Weight Bias on Access to Obesity Care

Training of physicians in obesity care is limited:

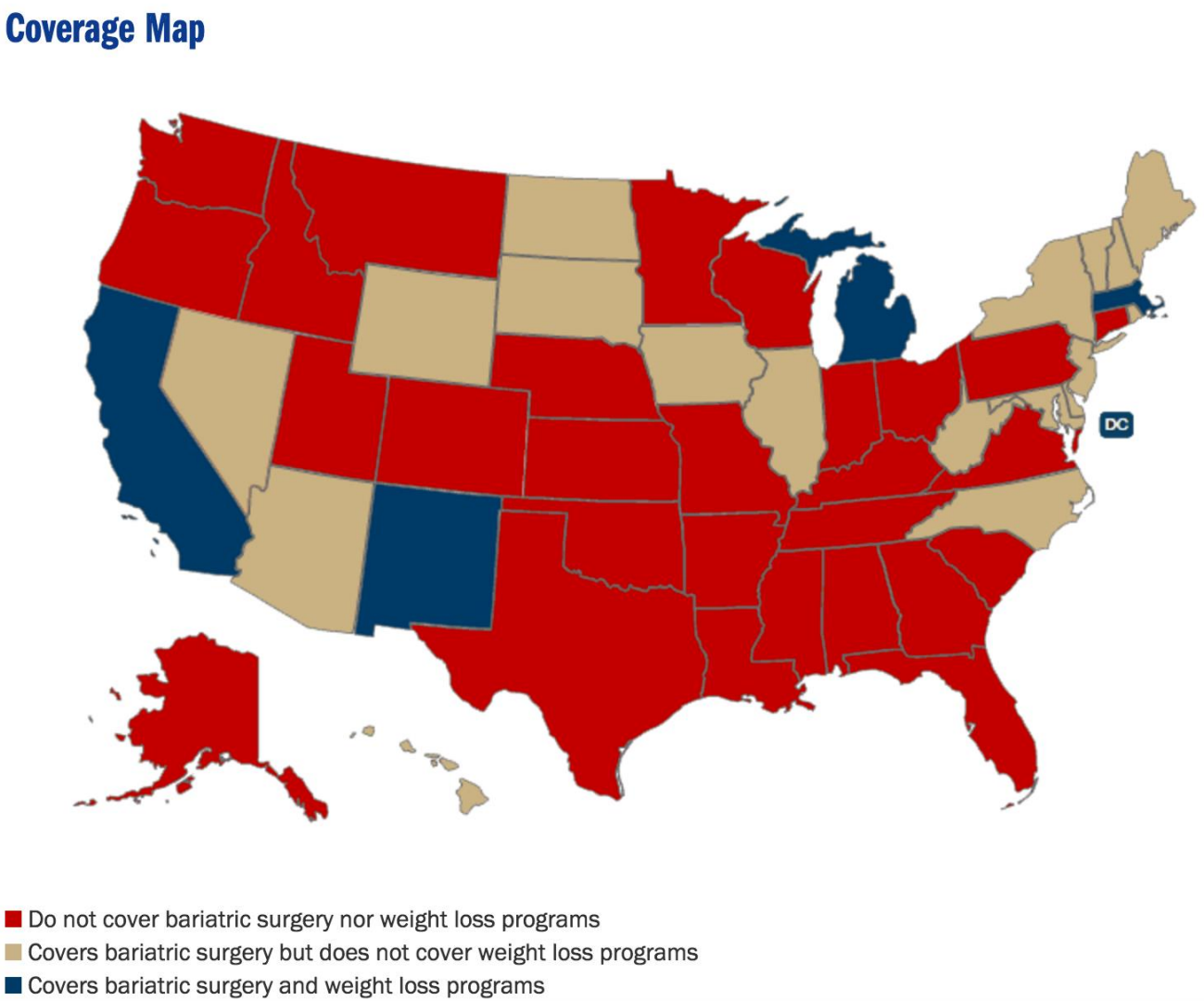
- Only 56% of physicians feel they are competent in treating obesity (Jay et al. 2009).
- 72% of Family Physicians believe they have limited effectiveness in obesity treatment; 60% feel they do not have adequate nutrition training (Fogelman et al. 2002).
- Treatment of obesity was rated as significantly less effective ($p < 0.001$) than therapies for 9 of 10 chronic conditions (Foster et al. 2003).

Influence of Weight Bias on Access to Obesity Care

- There is a paucity of questions about causes and treatment on the US Medical Licensing Exam (Kushner et al, unpublished data).
- 71% of U.S. medical schools do not provide the recommended 25 hours of nutrition education.
- Only seven of 133 medical schools in the U.S. provide integrated nutrition course and clinical practice sessions. (Adams et al. 2015).

Influence of Weight Bias on Access to Obesity Care

Evidence-based treatments are largely not covered under the ACA



Influence of Weight Bias on Access to Obesity Care

- Intensive Behavioral Therapy for weight loss is covered under Medicare, however:
  - The intensity is less than the evidence-based treatment.
  - It is only reimbursable for primary care physicians, rather than the required team of healthcare practitioners.
  - Several tools, such as weight loss drugs, are not covered at all.
  - Weight loss maintenance phase beyond 1 year is not covered.
  - Many providers and patients are not aware that it is covered.

Influence of Weight Bias on Obesity Policy

- Policies arising from obesity being an issue of "personal responsibility" sometimes take a shaming approach.
  - Children's Healthcare of Atlanta childhood obesity campaign in 2012:
    - "It's hard to be a little girl if you're not."
    - "Being fat takes the fun out of being a kid."
  - NYC Department of Health add campaign

Influence of Weight Bias on Obesity Policy

- Stigmatizing, shaming messages are:
  - Rated negatively compared to messages about general healthful behaviors
  - Rated as least likely to be complied with
- Most effective messages have no mention of weight or obesity at all.

Puhl et al. *International Journal of Obesity* (2013) **37,** 774–782.

Potential Outcomes of Reduced Weight Bias?

1. Improved access to care:
   - Better physician training.
   - Improved infrastructure for treatment.
   - Improved reimbursement for treatment.

2. Policies that focus on healthful behaviors, rather than body weight or fat.

1. Less internalization of negative stereotypes, and improved treatment success.

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