Effects of Obesity Bias and Stigma on Health

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Disclosures

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Overview

- Nature/extent of weight stigma and discrimination
- Health consequences of obesity stigma
- Implications for reducing bias in patient care
Weight Stigma

• Negative attitudes toward individuals because of their excess body weight

• Stereotypes that persons with obesity are at fault for their weight, lazy, sloppy, lacking will-power & discipline, gluttonous

• Rarely challenged, socially acceptable – leads to bullying, prejudice, and discrimination
Weight Stigma Affects Diverse Groups

*Gender:* women and men

*Age:* children, adolescents, adults

*SES:* low income/education, high income/education

*Body weight:* healthy weight, overweight, obese

*Race/Ethnicity:* Caucasian, African American, Hispanic/Latino, Asian, Indian

*Nationality:* U.S., Canada, Britain, France, Germany, Australia, China, Iceland

Obesity is stigmatizing throughout the lifespan

**Age 3-5**
- Negative weight stereotypes begin in preschool
- Parental and media weight biases are present

**Youth**
- Stereotypes worsen; leads to weight-based teasing, bullying victimization by
  - Peers
  - Parents
  - Teachers
  - Media

**Adolescence**
- Continued bias/bullying from multiple sources
- Negative impact on psychological, social, academic, physical wellbeing
- Inequities in education begin

**Adulthood**
- Bias becomes institutionalized as discrimination:
  - Employment
  - Healthcare
  - Education
- Continued health consequences

**Mid/Late Adulthood**
- Weight stigma and discrimination remain present, especially for women.
- Some evidence that stigma may decrease in older age, and is lower than bias toward younger individuals
Rates of Reported Discrimination Among Adults Ages 25-74 (N = 2290)

Error bars indicate 95% confidence intervals

Trends in rates of reported discrimination among adults ages 25-74 (N = 2962)

Error bars indicate 95% confidence intervals

Fat is the new ugly on the playground

By Katia Hetter, Special to CNN
updated 12:25 PM EDT, Fri March 16, 2012
Weight-based Bullying in Adolescence

Adolescent reports of why peers are teased/bullied, and observed frequency (N = 1555)

<table>
<thead>
<tr>
<th>Reason for teasing</th>
<th>Primary reason students are teased</th>
<th>Observed sometimes, often, very often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Being overweight</td>
<td>40.8</td>
<td>78.5</td>
</tr>
<tr>
<td>Gay/lesbian</td>
<td>37.8</td>
<td>78.5</td>
</tr>
<tr>
<td>Ability at school</td>
<td>9.6</td>
<td>61.2</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td>6.5</td>
<td>45.8</td>
</tr>
<tr>
<td>Physical disability</td>
<td>3.3</td>
<td>35.8</td>
</tr>
<tr>
<td>Religion</td>
<td>1.2</td>
<td>20.8</td>
</tr>
<tr>
<td>Low income/status</td>
<td>0.8</td>
<td>24.9</td>
</tr>
</tbody>
</table>

- 95% observed WBV toward peers with overweight/obesity
- 75% observed WBV at least “sometimes” or “often”

Parental Perceptions of Why Youth are Bullied

N = 918; National sample of parents (Survey Sampling International)

Figure 5. Percentage of Staff Who Reported that Bullying Behaviors Were a Moderate/Major Problem

National Education Association, 2011
Sources of weight-based victimization

- 361 adolescents in weight-loss camps (40% female)
- 71% Caucasian, 18% African American, 6% Hispanic

Perpetrators: *Who has teased or bullied you because of your weight in the last year?*

- Peers – 90%
- Friends – 70%
- Parents – 37%
- PE teachers/coaches – 42%
- Classroom teachers – 27%

# Sources of perceived weight stigma among women

Puhl & Brownell, *Obesity* 2006

- **N = 2,449**
- **Mean BMI = 37.6**
- **Mean Age = 49.9**

<table>
<thead>
<tr>
<th>Perpetrator of Weight Bias</th>
<th>Ever (%)</th>
<th>Multiple Times (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family members</td>
<td>72</td>
<td>62</td>
</tr>
<tr>
<td>Doctors</td>
<td>69</td>
<td>52</td>
</tr>
<tr>
<td>Classmates</td>
<td>64</td>
<td>56</td>
</tr>
<tr>
<td>Sales clerks</td>
<td>60</td>
<td>47</td>
</tr>
<tr>
<td>Friends</td>
<td>60</td>
<td>42</td>
</tr>
<tr>
<td>Co-workers</td>
<td>54</td>
<td>38</td>
</tr>
<tr>
<td>Mother</td>
<td>53</td>
<td>44</td>
</tr>
<tr>
<td>Spouse</td>
<td>47</td>
<td>32</td>
</tr>
<tr>
<td>Servers at restaurants</td>
<td>47</td>
<td>35</td>
</tr>
<tr>
<td>Nurses</td>
<td>46</td>
<td>34</td>
</tr>
<tr>
<td>Members of the community</td>
<td>46</td>
<td>35</td>
</tr>
<tr>
<td>Father</td>
<td>44</td>
<td>34</td>
</tr>
<tr>
<td>Employer/supervisor</td>
<td>43</td>
<td>26</td>
</tr>
<tr>
<td>Sister</td>
<td>37</td>
<td>28</td>
</tr>
<tr>
<td>Dietitian/nutritionist</td>
<td>37</td>
<td>26</td>
</tr>
<tr>
<td>Brother</td>
<td>36</td>
<td>28</td>
</tr>
<tr>
<td>Teacher/professor</td>
<td>32</td>
<td>21</td>
</tr>
<tr>
<td>Authority figure (e.g., Police)</td>
<td>23</td>
<td>15</td>
</tr>
<tr>
<td>Mental Health Professionals</td>
<td>21</td>
<td>13</td>
</tr>
<tr>
<td>Son</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>Daughter</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>13</td>
</tr>
</tbody>
</table>
Health care providers hold stereotypes that patients with obesity are:

Non compliant
Lazy
Lacking in self-control
Awkward
Weak-willed
Sloppy
Unsuccessful
Unintelligent
Dishonest

Physicians
Physician Assistants
Nurses
Dietitians
Psychologists
Fitness Professionals
Students in medicine, nursing, occupational therapy, psychology

Berryman et al., 2006; Brown, 2006; Creel & Tillman, 2011; Ferrante et al., 2009; Gujral et al, 2011; Hebl & Xu, 2001; Huizinga et al., 2009, 2010; Miller et al., 2013; Pantenburg et al., 2012; Pascal & Kurpius, 2012; Phelan et al., 2014; Puhl et al., 2013, 2014; Vroman & Cote, 2011; Waller et al., 2012; Wolf, 2012.
Physicians

View patients with obesity as...

- less self-disciplined
- less compliant
- more annoying

As patient BMI increases, physicians report:

- having less patience
- less desire to help the patient
- seeing these patients is a waste of their time
- having less respect for patients

Strong implicit bias and explicit bias:

- as prevalent as weight bias in the general public

(N = 2,284 MDs from a general population sample of 359,261)

Ferrante et al., 2009; Hebl & Xu, 2001; Huizinga et al., 2009; Sabin et al, 2012
Medical Students

5823 first-year medical students from 49 medical schools

Majority of students express explicit and implicit weight bias

*Stronger weight bias among students who were male, white or Hispanic, and with lower BMI

Phelan, Dovidio, Puhl, Burgess, et al., Obesity, 2014
Weight Bias Among Dietitians and Dietetic Students

Weight bias expressed as:

- Blaming patients for excess weight
- Anger and frustration with patients
- Assuming patients lack commitment, motivation, and compliance with health behavior changes

- 76% of registered dietitians expressed moderate/high implicit weight bias

Levels of implicit weight bias among dietitians are higher than the general population (52%)

Reactions of Patients

• Report negative judgment by providers because of weight
• Upset by comments about their weight from doctors
• Perceive lack of empathy from providers
• Perceive that they will not be taken seriously
• Report that their weight is blamed for all problems
• Reluctant to discuss weight concerns
• Patients who feel judged about weight have lower trust in their primary care provider

Anderson & Wadden, 2004; Bertakis & Azari, 2005; Brown et al., 2006; Edmunds, 2005; Gudzune et al., 2013; 2014; Mulherin et al., 2013; Turner et al., 2012
Is Care Affected?

Provider interactions with patients (obesity versus lower weight):

- Less time spent in appointments
- Less discussion with patients
- More assignment of negative symptoms
- Less intervention
- Build less emotional rapport

Bacquier et al., 2005; Bertakis & Azari, 2005; Campbell et al., 2000; Galuska et al., 1999; Hebl & Xu, 2001; Kristeller & Hoerr, 1997; Price et al., 1987; Gudzune et al., 2013; Merrill & Grassley, 2008
Avoidance of Health Care

Amy et al., *Int J Obesity* 2006

Women with obesity (N = 498) delayed preventive services, despite high access to care

Women attributed their decisions to:

- Disrespect from providers
- Embarrassment of being weighed
- Negative provider attitudes
- Medical equipment too small

Barriers increased with BMI

Gudzune et al., *Obesity* 2014

A subset of patients with obesity report switching doctors due to perceived differential treatment due to their weight
Avoidance of Health Care

Language that doctors use about body weight...

LONDON | Thu Jul 29, 2010

(Reuters) - British Public Health Minister has urged doctors to call overweight patients 'fat' rather than ‘obese.’

“Doctors and health workers are too worried about using the term ‘fat’” said the health minister, “but doing so will motivate people to take personal responsibility for their lifestyles.”

“Calling them ‘obese’ does not provide sufficient motivation. Just call them fat: Plain-speaking doctors will jolt people into losing weight.”
How would Americans react?
Adults (N = 1064) and Parents (N = 445)

Perceptions of language used by doctors

**Least Stigmatizing/Blaming**
- weight
- unhealthy weight
- high BMI

**Most Stigmatizing/Blaming**
- fat
- morbidly obese

**Most Motivating**
- unhealthy weight
- overweight

**Least Motivating**
- fat
- morbidly obese
- chubby

If your doctor described your weight in a way that makes you feel stigmatized, how would you react?

<table>
<thead>
<tr>
<th>Reactions</th>
<th>Adults (n = 1064)</th>
<th>Parents (n = 445)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would be upset/embarrassed</td>
<td>41%</td>
<td>37%</td>
</tr>
<tr>
<td>I would seek a new doctor</td>
<td>21%</td>
<td>35%</td>
</tr>
<tr>
<td>I would avoid future doctor appointments</td>
<td>19%</td>
<td>24%</td>
</tr>
</tbody>
</table>

*Findings were consistent across sample characteristics

*The language we use about weight is important

Cycle of Stigma and Obesity

- Increased Medical Visits
- Health Consequences
- Stigma in Health Care
- Negative Feelings
- Avoidance of Health Care
- Obesity

Unhealthy Behaviors, Poor Self Care

★
Weight Bias

Increased Risk

Depression  Anxiety  Low Self-Esteem  Poor Body Image  Suicidality

Stigma and Obesity

Weight stigma associated with increases in the likelihood of becoming and remaining obese.

Regardless of age, baseline BMI, race/ethnicity, and socioeconomic factors

Sutin & Terracciano (2013); Sutin et al. (2014); Quick et al. (2013); Schafer & Ferraro (2011); Hunger & Tomiyama (2014)
Perceived weight discrimination predicts weight gain

Nationally representative study that followed 6,157 adults from 2006 to 2010:

** Regardless of age, sex, ethnicity, education, and controlling for baseline BMI

Sutin & Terracciano (2013)
English Longitudinal Study of Aging

- Experiences of weight stigma reported in 2010-11

- Weight & waist circumference measured in 2008/09 and again in 2012/13

- Perceived weight discrimination significantly associated with increases in weight (+1.66kg) and waist circumference (+1.12cm), and odds of becoming obese during follow-up period

2944 adults (>50 years)

*Adjusted for baseline BMI, age, sex, SES

Jackson, Beeken, Wardle, *Obesity*, 2014
Why? What are possible mechanisms?

- Maladaptive and disordered eating behaviors
- Avoidance of physical activity
- Psychological distress
- Turning to food as temporary coping mechanism
- Physiological stress responses

Evidence ➔ All of the above

Weight bias contributes to obesity-promoting behaviors and responses
Experiences of weight stigma increase:

- Frequency of binge eating episodes
- Risk for developing binge eating disorder
  - *Independent effect* above other risks such as sex, BMI, race/ethnicity, body dissatisfaction, depression, and social isolation

Adults with obesity reporting weight stigmatization were *three times* more likely to have a binge eating diagnosis compared to those without experiences of weight stigma.

Almeida et al. (2011); Ashmore et al. (2008); Aubie & Jarry (2009); Friedman et al. (2008); Durso et al. (2012)
Weight Stigma and Binge Eating: Youth

• Adolescents who experience weight-based victimization have an **80% greater likelihood** of severe binge eating

• Among girls with earlier experiences of weight teasing, significantly more (18% vs. 11%) become regular binge eaters as adults compared to those with no teasing history

• Binge eating becomes **more likely** with:
  Multiple types of weight teasing
  Frequency of weight teasing
  Feeling upset/bothered by weight teasing

Eisenberg et al. (2003); Haines et al. (2006); Libbey et al. (2008); Neumark-Sztainer et al. (2007); Puhl & Luedicke (2012); Quick et al. (2013)
Coping with weight stigma…

Study: Survey of 2449 women

*How do they cope with stigma experiences?*

79% reported eating; turning to food as coping mechanism

* Stigma is a stressor *

• Both acute and chronic form of stress
• Eating is common coping strategy in response to stress

Puhl & Brownell, *Obesity*, 2006
Both boys and girls who reported emotional distress in response to weight bullying were more likely to cope by:

1) avoidance of physical activity
2) increased food consumption
3) binge eating

N = 394 adolescents reporting WBV in the last year

Puhl & Luedicke, J Youth & Adolescence 2012
Self-blame / Internalization of weight bias

Weight Bias Internalization: extent to which an individual believes negative weight stereotypes are applicable to him or her; blames oneself for being stigmatized.

Studies

<table>
<thead>
<tr>
<th>Study Details</th>
<th>Correlates of weight-bias internalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1013 women (overweight/obese)</td>
<td>More frequent binge eating, controlling for self-esteem, depression, stigma</td>
</tr>
<tr>
<td>148 adults (diverse body weights)</td>
<td>Binge-eating, lower self-esteem, higher depression and anxiety</td>
</tr>
<tr>
<td>177 women (overweight/obese)</td>
<td>Lower exercise motivation and less exercise behavior</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study</th>
<th>Weight Bias Internalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>120 treatment-seeking adults obesity(^1)</td>
<td>- predicted both physical and mental with health impairment, controlling for BMI, age, and other physical health indicators</td>
</tr>
<tr>
<td>87 adults with obesity in intervention study(^2)</td>
<td>- predictor of HRQOL</td>
</tr>
<tr>
<td>General population sample of 1158 adults with overweight obesity(^3)</td>
<td>- mediated relationship between BMI and HRQQL</td>
</tr>
<tr>
<td>81 women with obesity(^4)</td>
<td>- predicted low core-self evaluation, &amp; lower global health</td>
</tr>
<tr>
<td></td>
<td>- association between higher BMI and poor HRQOL only among those reporting high internalized bias</td>
</tr>
</tbody>
</table>

\(^1\)Latner et al., *J Eat Disord*, 2013; \(^2\)Lillis, Levin, Hayes, *J Health Psychology*, 2011; \(^3\)Hilbert et al., *Obesity*, 2014; \(^4\)Latner et al., *Eat Beh*, 2014
Exposure to weight stigma increases calorie consumption

N = 73 women

Schvey, Puhl, Brownell. *Obesity*, 2011
Increased calorie consumption

Experimental study: participants exposed to weight-stigmatizing stimuli vs. control (no stigma)

Among those who perceived themselves to be overweight, exposure to weight stigma led to increased caloric intake

Major et al., 2014; Brochu & Dovidio, 2013; Carels et al. 2009; Seacat et al., 2014
Physiological Risk Factors

• Perceived weight discrimination is associated with physiological risk factors independent of BMI
  - C-reactive protein levels
  - Blood pressure
  - Cortisol levels
  - HbA$_{1c}$ levels
  - Oxidative stress

  \[\text{Increased Physiological stress}\]

• Longitudinally, perceived weight discrimination leads to declines in:
  - Functional ability in individuals with obesity
  - Self-rated health, regardless of body weight

Sutin et al. (2014); Schafer & Ferraro (2011); Schvey et al. (2014); Major et al. (2012); Tsenkova et al. (2011); Sutin et al. (2014); Tomiyama et al., 2014
N = 128 women. F(1, 94) = 6.436, $p = .013$, $\eta^2 = .06$

Covariates in the model are evaluated at the following values: Minutes since waking = 384.56, Days since last menstrual cycle = 16.21, Age = 26.63, BMI = 26.47, Stress = 20.05, Depression = 7.12

Experiences of weight bias are associated with:

- More negative feelings towards exercise
- More avoidance of exercise, *regardless of age, body dissatisfaction, or self-esteem*
- Less intention to be physically active
- Less willingness to participate in exercise
Lower Physical Activity: Youth

Experiences of weight-based victimization leads to decreases in:

- Enjoyment for sports
- Motivation for physical activity
- Levels of physical activity
- Self-efficacy for physical activity and physical self-concept

Desmet et al. (2014); Greenleaf et al. (2014); Jensen et al. (2014); Jensen & Steele (2009); Puhl & Luedicke (2012); Faith et al. (2002); Hayden-Wade et al. (2005); Storch et al. (2007); Schwimmer et al. (2003); Bauer et al. (2004); Haines et al. (2006)
Weight-based teasing during physical activity

“I don’t like exercising at school because I’m fat and often get hit by others. When we play dodge ball, I’m often the target that gets hit.”

• Weight teasing during gym class:
  - Avoiding physical activity
  - Skipping gym class

• 85% of adolescents observe peers being teased about weight during gym class and physical activities

Jensen et al. (2014); Puhl & Luedicke (2012); Lee et al. (2009)
Barrier to Weight Loss Treatment Outcomes

Among adults with obesity in weight loss treatment:

- Greater weight bias
- ↑ caloric intake
- ↓ percentage of weight loss
- Inconsistent self-monitoring
- Shorter bouts of physical activity
- ↓ energy expenditure

Carels et al., *Annals of Behavioral Medicine*, 2009
Barrier to Weight Loss Treatment Outcomes

- Adults in WL treatment who report weight stigma
  - Consume *more* calories
  - Expend *less* energy through physical activity
  - Are *less* likely to achieve clinically significant weight loss

  Especially if they have a PCP from whom they perceived being judged about weight

- Compared to institutional stigma, interpersonal experiences are particularly detrimental

Wott & Carels (2011); Sharma et al. (2011); Gudzune et al. (2014)
Bias, Stigma, and Discrimination

- Diminished Income, Education
- Diminished Self-Esteem, Perceived inadequacy
- Compromised Health Care
- Diminished Social Support
- Avoidance of Health Care

- Impaired Ability to lose weight
- Elevated Risk Factors
- Psychological Disorders
- Unhealthy Eating Behaviors
- Less Physical Activity
- Physiological Stress

Morbidity and Mortality
Insight: America's hatred of fat hurts obesity fight

Prejudice is impeding anti-obesity efforts, experts say

Some anti-obesity campaigns may backfire, researchers say

Obesity Campaigns: The Fine Line Between Educating and Shaming
Weight Bias and Discrimination

ABSTRACT

There is substantial evidence of clear and consistent bias, stigmatization, and discrimination against obese children and adults. The Obesity Society (TOS) strongly opposes any form of weight bias or discrimination, and is committed to increasing public awareness about weight bias and its negative consequences.
What Can Health Professionals Do to Reduce Weight Stigma?
Efforts to Address Obesity

*Include weight stigma on the agenda:*

Increase attention to weight stigma and its consequences

Use respectful language with patients, colleagues, students

Avoid approaches that shame and blame

Remove stigma from existing efforts

Support efforts that empower patients, rather than shame or stigmatize
In obesity-related research...

- Consider vulnerability of study participants to weight bias
- Ensure research/study materials are non-stigmatizing
- Train research staff to deliver research protocol with sensitivity and without unintentional stigma
- Consider assessing for history of weight stigmatization
- Use appropriate language / images in scientific communication
Non-stigmatizing Images

A public resource for unbiased portrayals of obese people

- Media
- Research
- Education
- Health care

Yale Rudd Center
Media Gallery
www.yaleruddcenter.org
Increased awareness of personal attitudes

Studies using Implicit Attitude Tests and neural imaging document implicit weight bias in health professionals

Personal biases can unintentionally harm the quality of patient-provider relationships

*Be aware of how implicit biases can affect your:*

- Body language
- Tone of voice
- Facial expression
- Gestures
- Eye contact
- Spatial distance

Azevedo et al. (2014); Schupp & Renner (2011); Phelan et al. (2014); Miller et al. (2013); Sabin et al. (2012); Waller et al. (2012)
Address Causal Beliefs about Obesity

Causal Beliefs about Obesity

- Lack of self-discipline
- Poor eating/activity

Stereotyping & stigma

- Understanding of complex etiology
- Reduced stigma

Biological, genetic, environmental causes

Among patients with obesity:
- Reduces self-blame
- Increases self-efficacy for weight loss

Ebneter et al. (2011); Lippa & Sanderson (2012; 2013); O’Brien et al. (2010); Pearl & Lebowitz (2014); Persky & Eccleston (2011)
Establish an appropriate office environment

Be mindful of needs of patients with obesity, and create an environment promoting mobilization and independence.

- Equipment with proper stability and weight capacity (e.g., beds, wheelchairs, and exam tables)
- Correct size medical instruments and supplies (e.g., blood pressure cuffs, syringe needs, and robes)
- Well-configured doorways, hallways, and restrooms
- Waiting room with variety of sturdy seating
Communication skills training

Increasing calls to add communication skills training in provision of weight management and obesity counseling

Intervention with first year medical students (N = 127):

- Readings on communication and stigma
- Structured encounter with a standardized patient with OB
- Facilitated discussion about empathy and communication skills

Significant improvements in stereotyping, empathy, and counseling confidence from baseline. Improvements remained in empathy and counseling confidence at one year follow-up.

Kushner et al., BMC Medical Education, 2014
Patient Perspectives of Weight Labels

**Study**
- 390 primary care patients with obesity

**MOST Acceptable/desirable terminology**
- “weight”, “BMI”, “excess weight”

**LEAST Acceptable/desirable terminology**
- “fatness”, “large size”
- “obesity”, “heaviness”

**Study**
- National sample of 1064 adults

**MOST Acceptable/desirable terminology**
- “weight”
- “unhealthy weight”

**LEAST Acceptable/desirable terminology**
- “morbidly obese”, “fat”
- “obese”

**Study**
- National sample of 445 parents
- (preference for language about child’s weight)

**MOST Acceptable/desirable terminology**
- “weight”
- “unhealthy weight”

**LEAST Acceptable/desirable terminology**
- “fat”, “obese”
- “extremely obese”

**Results consistent across socio-demographic factors and body weight**

New tool to respond to uncertainty among providers about how to initiate empowering and sensitive conversations about weight with their patients.

www.stopobesityalliance.org

Includes strategies for:

- Building trust and connections
- Beginning the conversation about weight and health
- Assessing patient readiness
- Promoting active listening
- Addressing realistic goals
- Discussing culture, tradition, and social supports
Use People-First Language

Put people first, rather than labeling them by their disease or disability

Established standard for respectfully addressing people with diseases or illness (e.g., mental illness, Autism, diabetes, chronic diseases)

Broadly accepted as important aspect of efforts to reduce disease stigma

New to the obesity field

Instead of “obese”, use “has obesity”, “with obesity”, “affected by obesity”
Educational Video for Providers

Weight Bias in Healthcare
by Yale University

Online CME for Providers

Preventing Weight Bias
Helping Without Harming In Clinical Practice

How to talk about ‘weight’ with your overweight and obese patients

Approaching the topic of body weight with patients is a sensitive issue. It can be challenging for providers to discuss health issues related to excess weight while also remaining sensitive to terminology and language that may offend patients. To help facilitate patient-provider interactions that are both productive and positive experiences, it may be useful to recognize and implement language about weight that patients prefer and feel comfortable with.

A recent study examined terms that obese patients found desirable or undesirable for describing obesity (Wadden & Didie, 2003). Specifically, patients rated the desirability of 11 terms to describe excess weight. Here are the findings:

Desirable terms to refer to body weight: Weight, Excess Weight, BMI

Online Clinician Toolkit

Module 2
Improving Provider-Patient Interactions

www.yaleruddcenter.org
Assess stigma and its impact on patients

1) Identify sources and settings of patients' stigma experiences

- Experiences in public
- Family and friends
- Health care
- Workplace
- Educational settings
- Other

Stigmatizing Situations Inventory (SSI)

Below is a list of situations that people encounter because of their weight. Indicate whether, and how often, each of these situations happens to you. In the spaces below, write the number that best describes how often you encounter each situation. Use the scale below:

0 - Never 1 - Once in your life 2 - More than once in your life 3 - Multiple times

- Experiences in public
- Family and friends
- Health care
- Workplace
- Educational settings
- Other
Assess patient coping strategies

2) Identify patients’ coping responses to deal with stigma

**Adaptive strategies:**
- Social support
- Positive self-talk
- Therapy
- Faith/religion
- Assertiveness

**Maladaptive strategies:**
- Internalization/blame
- Isolation/avoidance
- Negative self-talk
- Eating
- Engaging conflict
Support Broader Initiatives to Address Weight Bias

Advocate for…

• Adequate training on obesity, weight bias, and weight management counseling in medical training/curriculum

• Sensitivity training for medical staff and providers

• Implement respectful language as the required standard

• Support policy efforts to help reduce stigma and prohibit societal weight discrimination
Stigma is a Known Enemy to Health

1) Broad recognition that stigma undermines prevention/treatment

2) Public health policies addressed stigma as a legitimate barrier

1) Funding, research, and programs to reduce stigma

Stigma remains a glaring omission
Rebecca.puhl@yale.edu

Rudd Center for Food Policy & Obesity
www.yaleruddcenter.org
Can patients be biased towards physicians’ weight?

N = 358 adults

Compared to normal weight physicians, participants viewed physicians of overweight or obese status much more negatively:

- Lower trust of heavier physicians
- Lower inclination to follow medical advice
- Greater intention to switch physicians

Effects did not depend on participants’ BMI; but, their level of weight bias matters.

Puhl, Gold, Luedicke, & DePierre (2013)
Impact on Provider’s Weight Management Practices

Compared to providers of normal weight, providers with obesity and overweight experience:

- Lower confidence in exercise & diet counseling
- Lower self-perception as role model
- Greater belief in patients’ distrust of their weight loss advice

- Lower positive expectations for weight loss
- Less likely to discuss weight loss
- Less likely to record obesity diagnosis

Zhu et al. (2011); Stanford et al. (2014); Bleich et al. (2012)
Trainees in Professional Health Disciplines

*Perceived acceptability of weight bias in the medical setting:*

- It is acceptable to make jokes about patients with obesity: 3%
- Witnessed peers making fat jokes/negative comments: 63%
- Witnessed instructors making fat jokes/derogatory comments: 40%
- Witnessed health providers making fat jokes/derogatory comments: 65%

*Attitudes toward patients with obesity:*

- Feel confident to treat obesity: 80%
- Patients with obesity lack motivation to change lifestyle: 33%
- Feel frustrated with patients with obesity: 36%
- Patients with obesity are non-compliant with treatment: 36%

*Students treatment perceptions influenced by their beliefs about the causes of obesity (N = 107)*

Puhl, Grilo, Luedicke, *Obesity* 2013
Video Educational Intervention

- Challenges stereotypes
- Describes consequences of bias
- Summarizes bias-reduction strategies
- Used in sensitivity training in bariatric clinics and centers across the country

Tested with medical trainees:

1) RCT: compared to control group, video exposure improved explicit attitudes and beliefs toward patients with obesity. (Swift et al., Obesity Facts, 2013)

1) Increased beliefs that genetic and environmental factors play an important role in causing obesity, and decreased negative stereotypes toward patients with obesity. (Poustchi et al., Family Medicine, 2013)
In a study of weight-loss treatment-seeking adults with obesity:

Greater weight bias

- ↑ caloric intake
- ↓ percentage of weight loss
- Inconsistent self-monitoring
- Shorter bouts of physical activity
- ↓ energy expenditure

Carels et al., *Annals of Behavioral Medicine*, 2009