Weight Bias and Weight Inclusivity in Eating Disorder Care

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Off-label indications will not be discussed.
Objectives

At the conclusion of this activity, participants should be able to successfully:

1. Define weight inclusivity and weight bias related terms
2. Describe the impact of weight bias, highlighting specific impact in a healthcare setting
3. Recommend weight inclusive strategies and approaches to integrate into patient interactions
Note on Language:
This presentation uses terms such as “fat”, “obesity”, and “overweight” to demonstrate examples and align with current medical terminology. However, these terms do not reflect preferred weight inclusive language of groups or individuals.
The research and cultural movement discussed in these slides will focus on those living in larger bodies.
BACKGROUND
Definitions

• Stigma:
  -social sign that is carried by a person who is a victim of prejudice and weight bias
  -social rejection and devaluation that accrues to those who do not comply with prevailing social norms of adequate body weight and shape

• Discrimination:
  -unequal treatment of people because of their membership in a particular group

• Bias:
  -prejudice in favor of or against one thing, person or group compared with another, usually in a way considered to be unfair.
  -reflects attitude while discrimination depicts behavior
Implicit vs. Explicit Biases

• Implicit
  - automatic and often occur outside of awareness and in contrast to explicitly held beliefs³
  - automatically activated by situational cues (e.g., the presence of an overweight person) and commonly operate outside of conscious awareness or control¹⁸

• Explicit
  - conscious and reflect a person’s opinions or beliefs about a group³
Weight Bias

The negative attitudes and beliefs towards and about others because of their weight or body size.

Weight bias can lead to weight stigma which refers to discriminatory acts and a negative social sign or label associated with individuals in larger bodies. These can lead to actions that can cause exclusion, marginalization, and ultimately, result in inequality.\textsuperscript{8-9}
Obesity Prevalence

- Utah: 29.2 have a BMI of 30 or higher, over 60% categorized as overweight or obese
- 40% of individuals w/ BMI >35 perceived weight discrimination\(^{15}\)
- Evidence that weight bias has increased by 66% past decade\(^{2}\)
Weight Bias in the Workplace

- “Fat” women rated more negatively than “non-fat” women for job candidate desirability\(^\text{10}\)

- Lower earnings for “fat” women when compared to non-overweight counterparts\(^\text{10}\)

- 10% of CEOs are obese, compared with 61% males\(^\text{10}\)

- Michigan is the only state that prohibits employment discrimination on the basis of weight\(^2\)
Weight Bias in Media

• One of the most popular forums on Reddit, a social networking site, is devoted to mocking and shaming fat people.¹⁸
  • >150,000 subscribers
  • In July of 2015, CEO of Reddit tried to shut down the site subscribers revolted
  • Precipitated her resignation.
• 2008: Mississippi State House Bill proposed to prohibit restaurants from serving food to any person who is obese²
• 2010: British Public Health Minister urged health-care providers in Britain to tell obese patients that they are ‘fat’ rather than ‘obese’ to help motivate them to become healthier and take responsibility for their lifestyles.
  • stated the importance of obese individuals taking personal responsibility for their lifestyles, and called on the National Health Service to ban terms such as ‘obese’ because it would not have the necessary emotional impact for patients²⁶
• District of Columbia, San Francisco, and Santa Cruz are only areas to include body size in human rights ordinances²
Weight Bias in Healthcare

- Reported in physicians, nurses, RDs, physiotherapists, psychologists, nutritionists, exercise professionals, and general population

- 69% of women with BMIs >25 report bias from health providers

- CHANGES study (n=4732 medical students)
  - 75% exhibited implicit bias
  - 67% exhibited explicit bias
  - 16% agreed with the statement I don’t like fat people very much
  - “greater waste of time”

- A survey of >620 PCPs
  - one-third viewed obese patients as weak-willed, sloppy, and lazy
  - more than half viewed them as awkward, unattractive, and noncompliant
Weight Normative Approach

• Healthcare and health improvement practices that prioritize weight as a main determinant of health

• Focus on personal responsibility for “healthy” lifestyle choices and maintaining “healthy” weights

• Emphasis on weight and weight loss when defining health and well-being

• Reliance on weight loss to prevent and treat myriad of health concerns
Impact of Weight Bias on Provider and Equitable Care

- Less patient-centered care\(^3,8\)
- Less respect, less communication and information giving\(^3,8\)
- Spend less time with patients\(^3,8\)
  - spent 28% less time with patients with BMI >30 compared to BMI <30\(^{11}\)
- Over attributes symptoms to problem of obesity\(^3\)

- A study of medical students providing care virtually to patients with SOB\(^{12}\):
  - Patients with BMIs >30 more likely to receive lifestyle change recommendations (54% vs 13%)
  - Patients with BMIs <30 more likely to receive medication to manage symptoms if (23% vs 5%)
Impact of Weight Bias on Patients

- Avoidance of clinical care\(^2,3\)
  - 55% report delaying or canceling an appointment if they anticipated needing to be weighed during the consultation\(^5\)
  - 68% reported they delayed seeking health care because of their weight\(^2\)
  - 83% reported that their weight was a barrier to getting appropriate care\(^2\)
- Increased food consumption\(^6\)
- Decreased physical activity\(^2,6\)
- Increased risk of binge eating\(^13\)
- Increased food consumption\(^2,13\)
- Increased risk for weight gain\(^13\)
- Increased risk for obesity\(^13\)
Impact of Weight Bias on Patients, Continued

- Increased depression, anxiety, stress, low self-esteem, body dissatisfaction, substance abuse and suicidality\(^7,2\)
- Increased physiological stress response\(^{13}\)
  - fosters social isolation
  - compromises quality of health care
  - decreases socioeconomic status
  - increases stress and negative emotions
  - increases physiological reactivity (elevated cortisol, cardiac reactivity)
  - impaired self-regulation and increased comfort eating to relieve stress
  - increased engagement in stigma
Discussion:

• How has internalized weight stigma impacted your patients and the care you provide them?
• Irrespective of baseline BMI, adults who experienced weight discrimination have a 60% increased risk of death.\textsuperscript{22}

• n=6,157 participants who experienced weight discrimination were 2.5 times more likely to become obese by follow up. Participants who were obese were 3 x more likely to remain obese at follow up.
**Obesity Costs**

**HEALTH**
- Medical spending (e.g., specialised equipment).
- Diseases/complications (e.g., diabetes, heart disease).
- Increased life and medical insurance.
- Premature mortality/reduced quality of life.

**WORKPLACE**
- Private monetary losses due to reduced output, job performance, and labour income/profit.
- Absenteeism including paid sick leaves.
- Public monetary costs via tax losses.

**SOCIETAL**
- Increased economic burden/reduced tax income.
- Increased tax revenue used for healthcare.
- Higher treatment, physician, and equipment costs.
- Longer wait times in primary care and hospitals.

**Weight Bias Costs**

**HEALTH**
- Delayed screenings/check-ups.
- Exacerbating/developing medical conditions.
- Costlier eventual treatment.
- Doctors' denial of treatment (until weight lost).
- Mental health compromises (stress, anxiety, depression, eating disorders).

**WORKPLACE**
- Increased absences.
- Heightened likelihood of termination.
- Reduced likelihood of promotion.
- Lower wages.
- Increased discrimination in professional (i.e., 'white collar') jobs.

**SOCIETAL**
- Lower educational attainment.
- Reduced likelihood of attending college/university.
- Lower university/college admission rates.
- Poorer academic performance.
- Fewer interpersonal relationships.
- Dissatisfaction in interpersonal relationships.
- Reduced emotional support.

**PHYSICAL HEALTH**
- (e.g., discrimination leading to delayed check-ups increasing the likelihood of disease/complications).

**MENTAL HEALTH**
- (e.g., stress, anxiety, depression related to discrimination, leading to reduced quality of life).

**EMPLOYMENT**
- (e.g., workplace discrimination leading to reduced job performance/output).
Despite high prevalence of disordered eating behaviors (DEBs), overweight or obese young adults were less likely to receive a clinical diagnosis.¹

High rate of DEBs were reported among those with overweight or obesity compared with under or normal weight.

Compared with young adults of normal weight those with obesity had:

- 2.45 times greater odds of engaging in DEBs such as unhealthy weight control practices and binge eating
- had the highest rate of DEBs among all weight categories (25.3%)
Weight Normative Approach Increases ED Risk

- Rigidity needed to retain a weight suppressed state can cause individuals to develop DEBs

- Very rigid dieting tends to be disrupted by episodes of binge eating
  - Can then lead to episodes of purging

- 81% of 10-year-olds admit to dieting, binge eating, or a fear of getting fat.

- Eating disorders are now diagnosed in children as young as 5
Common Misconceptions

• Everyone who has an eating disorder is “thin”.

• Binge Eating Disorder (BED) is 3x more prevalent than Bulimia Nervosa (BN) and Anorexia Nervosa (AN) combined.
  • 3.2% of individuals who endorsed BED criteria on a survey have been diagnosed by professional.
  • Only 28.4% of individuals with active BED are receiving treatment.
    • Only 43.6% will receive treatment at any point

• 30% of individuals in a weight loss program have BED
• 87% of people with BED are categorized as obese
• Atypical anorexia is typically missed all together due to “healthy” BMI
Discussion:

• How does weight bias create barriers to providing care to patients with eating disorders?
Weight Inclusivity
Weight-Inclusive Approach

• Emphasis on viewing health and well-being as multifaceted while directing efforts toward improving health access and reducing weight stigma\textsuperscript{31}.
  * Patients feel more comfortable to discuss their health concerns.

• Rests on the assumption that everybody is capable of achieving health and well-being independent of weight, given access to non-stigmatizing health care.

• Weight is not viewed as a behavior
  * eating nutritious food when hungry, ceasing to eat when full, and engaging in pleasurable exercise are self-care behaviors that can be made more accessible for people.
The Health at Every Size® (HAES®) Approach

Health Enhancement

Weight Inclusivity

Respectful Care

Eating for Well-Being

Life-Enhancing Movement

Courtesy of the Association of Size Diversity and Health (ASDAH):https://asdah.org/health-at-every-size-haes-approach/
Consider Biases of Well-Intentioned Approaches

• The first HAES book was written by Dr. Lindo Bacon
  • “As proud as I am of the book, I’m also aware of some of its shortcomings, including some of the ways in which it transmits my unexamined privilege and does damage.”

If you write this book, regardless of updating it to a modern perspective, you will be perpetuating harm by centering the experience and perspective of a relatively affluent, thin/straight-sized, white person. Sharing this singular perspective of HAES at this moment in history will drown out the voices of those with lived experiences of being fat, Black, Indigenous, Latinx, disabled, etc. Their voices are the divergent viewpoints the world needs to hear. Additionally, if you write this book, it may bring attention to ASDAH, but I doubt it will expand the reach to the communities and people who we want at the center of our work. ASDAH and the larger Health at Every Size movement, historically has been and currently is overwhelmingly white, thin, affluent, and otherwise privileged. If ASDAH is to survive and thrive, to be a leader in this social justice movement, we cannot have more of the same.

Courtesy of the Association of Size Diversity and Health (ASDAH): https://asdah.org/lindo-accountability/
Discussion:

• How do explore your patients’ individual experiences and perspective in order to provide more equitable care?

• How do you examine and address the power dynamic that exists between you and your patients?
Weight Inclusivity Do’s and Don’ts

Do:
• Encourage self-care practices and internal body focus
• Encourage positive view of the body
• Help patients appreciate their bodies
• Help patients to stop shaming themselves
• Encourage personal advocacy for weight inclusive approaches

Don’t:
• Praise weight loss
• Respond to weight gain by going straight to weight loss recommendations
• If mentioning physical appearance try:
  • “Your hair looks nice today”
  • “Your eyes are so bright today”
• Exhibit frustration based on weight changes
Conflicting Views

- Weight and body size are viewed and utilized differently by different groups.
- Some advocate for obesity to be considered disease, others do not want it pathologized.
- Opposing views can make it feel difficult to be an ally or advocate.

**Healthcare**
- Weight is the equation.

**Advocacy Groups**
- Weight is part of the equation.

**Activists**
- Weight should never be considered in equation.
Where Can We Agree?

- **Ask permission to discuss weight**: If the answer is no, respect patient wishes.
- **Ask about labeling preferences**: No group is a monolith, each person should be treated as an individual.
- **Advocate for appropriate tools and equipment**.
- **Listen to concerns, provide full assessment**: Provide interventions and support beyond weight loss and lifestyle recommendations.
Prevention and Intervention

- Acknowledge our biases
  - Personal assessment and reflection
    - [https://implicit.harvard.edu/implicit/selectatest.html](https://implicit.harvard.edu/implicit/selectatest.html)
- Reduce focus on body weight and size
- Patient-centered communication strategies and policies
- Weight Inclusivity Training
  - Create awareness
  - Advocacy
  - Education on all determinants of obesity
  - Education on implicit bias

**Guiding Principle:**
Provide an inclusive approach to empower patients in achieving health and well-being independent of weight with access to non-stigmatizing, weight-inclusive healthcare.
Discussion:

• How have you taken your personal biases into account?

• How do your biases impact your interactions with patients?
**Bibliography/References**


1. Describe weight bias and weight inclusivity.

2. How does weight bias impact patients with disordered eating and eating disorders?

3. What is one weight inclusive approach you will begin using in your practice?