Weight Bias in Eating Disorder Professionals

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Do you carry weight bias? Many assume that, as eating disorder professionals, we have fewer weight biases. But is this really the case? A recent study "Weight Bias among Professionals Treating Eating Disorders: Attitudes about Treatment and Perceived Patient Outcomes" by Puhl, Latner, King, and Luedicke (2013) investigates whether we are prone to stigmatizing attitudes about obesity.

Previous research has documented the prevalence of weight bias among health providers. Too often, health care providers (including physicians, nurses, medical students, dieticians, psychologists, and fitness professionals) view obese patients as lazy, lacking in self-control, undisciplined, noncompliant with treatment-- and that these traits are the causes of obesity. There is an inverse relationship between body mass index (BMI) and providers' respect for a patient; this means that the more a patient weights, the less respect their doctor has for them. These biases affect the care that patients receive creating a barrier to health care utilization for obese people. Despite the previous research regarding weight bias in healthcare providers, few studies have examined weight biases specifically in professionals who treat eating disorders.

The authors of this study conducted an on-line survey of 369 eating disorder professionals. The anonymous questionnaires assessed opinions about obese people and treating obese patients including fat phobia, perceived causes of obesity, attitudes about treating obese patients, perceptions of treatment compliance and success, perceptions of weight bias, personal history of disordered eating/dieting/fear of fat, and personal history of weight victimization. Participants were predominately female (95%), Caucasian, had an average age of 45 years old, and a mean BMI of 24.

Results indicated that ED professionals hold negative stereotypes towards obese people, although at a slightly lower level compared to other health professionals. These negative stereotypes including characterizing obese people as having poor self-control, no willpower, self-indulgent, unattractive, inactive, insecure, and overeating. A low percentage of ED professionals expressed negative attitudes about treating obese people; however, most did report observations that their colleagues held negative attitudes. Overall, participants reported a high level of pessimism regarding treatment outcomes for obese patients.

Participants who reported higher levels of weight bias were more likely to believe that obesity was caused by behavioral factors, express negative attitudes and frustrations about treating obese patients, and perceive poorer treatment outcomes. ED professionals who themselves were trying to lose weight had higher levels of weight bias and fear of fat. They were more likely to endorse belief in behavioral causes of obesity, hold more negative attitudes towards treatment, and express

greater frustrations about treating obese patients. In contrast, participants with higher BMIs tended to have lower levels of weight bias and were less likely to endorse belief in behavioral causes of obesity. In addition, more experienced therapists tended to have lower weight bias scores.

The authors conclude that ED professionals hold weight biases similar to other healthcare professionals. They suggest that interventions aimed at reducing weight bias among ED professionals are warranted. Many of our patients have been the target of weight-based stigmatization, bullying, or discrimination. Without examination of our own weight biases, we may inadvertently communicate these biases to our patients, resulting in interference with treatment progress and potentially damaging results.