Addressing Weight Stigma and Bias in Sexual and Reproductive Health Care - May 16, 2023

Transcript

Slide 1

- [Amanda] Hello, everyone. This is Amanda Ryder with the Reproductive Health National Training Center, and I am delighted to welcome you all to today's webinar about addressing weight stigma and bias in sexual and reproductive health care. I have a few announcements before we begin. Everyone on the webinar today is muted given the large number of participants. We do plan to have some time for questions at the end of the webinar. You can ask your questions using the chat at any time throughout the session. A recording of today's webinar, the slide deck and a transcript will be available on rhntc.org within the next few days. Close captioning has been enabled for this webinar. To view, click on the CC icon at the bottom of your screen. Your feedback is extremely important to us and has enabled the RHNTC to make quality improvements in our work based on your comments. Please take a moment to open the evaluation link in the chat and consider completing the evaluation realtime. In order to obtain a certificate of completion for attending this webinar, you must be logged in to rhntc.org when you complete the evaluation. This presentation was supported by the Office of Population Affairs and the Office on Women's Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA or OWH or HHS.

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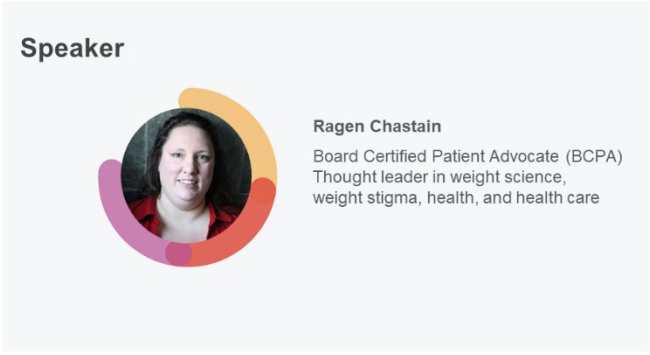

I'm thrilled to kick off today's webinar by introducing our two speakers. First is Ragen Chastain. Ragen is a speaker, writer, researcher, board certified patient advocate, multi certified health and fitness professional and thought leader in weight science, weight stigma, health and health care. Utilizing her background in research methods and statistics, Ragen has brought her signature mix of humor and hard facts to health care, corporate, conference and college audiences from Kaiser Permanente and the Diabetes Education Specialist National Conference to Amazon and Google to Dartmouth and CalTech. Author of the, "Weight and Healthcare" newsletter, co-author of Health At Every Size Health Sheets and editor of the anthology, "The Politics of Size." Ragen is frequently featured as an expert in print, radio, television, and documentary film. In her free time, Ragen is a triathlete and marathoner who holds the Guinness World Record for heaviest woman to complete a marathon. Ragen lives in LA with her fiance, Julian, and their adorable dog.

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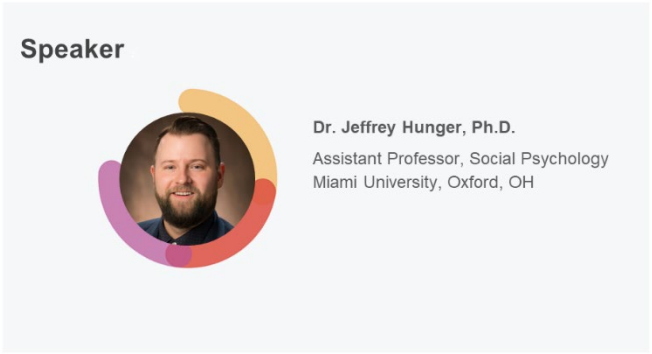

We are also joined today by Dr. Jeffrey Hunger, an assistant professor in the department of Psychology at Miami University. He directs the Hunger Stigma and Health Lab, which conducts research on the mental and physical health consequences of stigma. Much of his work has focused on effects of weight stigma, although his lab has recently initiated work related to disability, sexual identity and social class as well. Jeff's research is supported by funding from the National Institutes of Health as well as the National Science Foundation. Previously he completed his PhD in social psychology from the University of California, Santa Barbara, followed by his postdoctoral training in health psychology at UCLA. When not on campus, Jeff is an avid cyclist, home cook and self-described annoying booty. He currently lives in Cincinnati but prefers to spend his time traveling with his husband, Alex, whenever possible.

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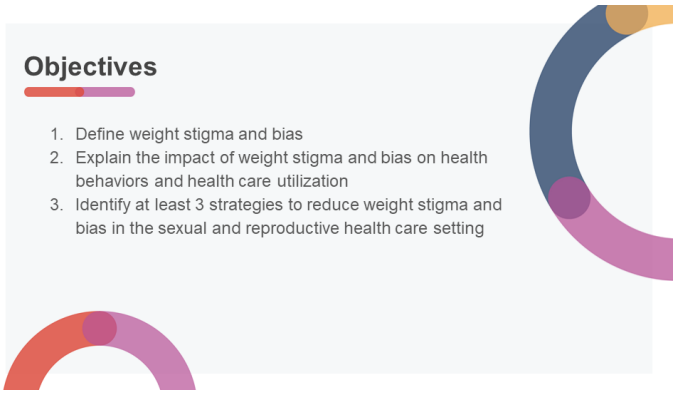

On the slide you see today's session objectives. We'd like to see as a group where we're starting from in terms of how confident we are that we can do what the objectives state. We're going to launch a brief poll where we'll ask you to rate your confidence on a one to five scale where one is not at all confident and five is very confident for each objective. So, how confident are you that you can do the following? Describe weight stigma and bias. Explain the impact of weight stigma and bias on health behaviors and health care utilization. And identify at least three strategies to reduce weight stigma and bias in sexual and reproductive health care settings. Pause for just a moment as the results come in and then we will broadcast your responses. And let's see, we've got a mixed bag in terms of confidence with most folks clustering around that midway point. And then some, about 30% feeling pretty confident. Explaining the impact on health behaviors and health care utilization, similarly, about half are at that midpoint. And identifying strategies, we've got a little bit lower confidence, but still a good number of folks at that midway point. All right. Great, that's really helpful and we'll revisit that later, so thank you for completing that. And with that introduction complete, I am pleased to pass it on to Jeff to kick things off.

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- [Dr. Hunger] Awesome, thank you so much for that introduction, Amanda. And honestly for having me here today to discuss such an important topic. So I'll kick us off with an introduction to weight stigma and weight related bias. This could be, and in my department is its own full class, so consider this a bit of a crash course.

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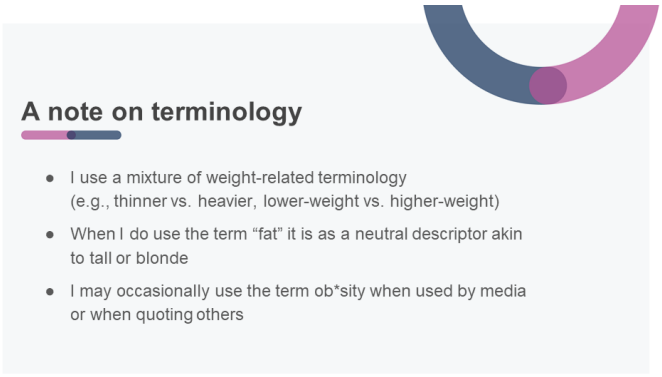

So as a quick note, I use a mixture of weight related terminology and it's typically relative such as thinner versus heavier or lower versus higher-weight. This signals that body weight naturally falls on a distribution with some folks being thinner or heavier than others. Now when I do use the term fat, I do so as a neutral descriptor, similar to tall or blonde. Doing so in part normalizes reclaiming a word that has traditionally been derogatory. If I ever use the term obesity, it will only be when quoting media, US guidelines or other researchers. I generally don't do this, but just wanted folks to be aware.

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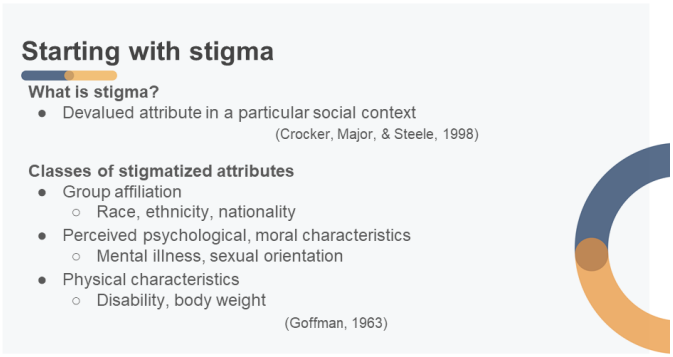

So although we're focusing on weight today, I'd like to begin by thinking about stigma a bit more broadly. So if I were to ask you all to identify groups that are stigmatized in society, what comes to mind? Think about stigmas you've encountered, perhaps stigmas that apply to you or close others and add them to the chat if you feel comfortable doing so. Folks who use drugs, folks with disabilities, race, LGBT. Tons of tons of great things coming into the chat there. That's wonderful. So I think beyond the multitude of things that were offered there, a wide variety of groups may have come to mind, which kind of underscores a really important point. There really is no single feature or even set of defining features that unambiguously signifies that someone is stigmatized. Rather stigmatization occurs when a person possesses some attribute or characteristic that is devalued in a particular social context. What's stigmatized in the US may not be stigmatized in Mexico or Japan, may not have been stigmatized a century ago or may not be in another century. That being said, a few broad classes of potentially stigmatized attributes

are worth noting. So the first are group affiliations that are generally passed on from generation to generation and this includes attributes such as race and ethnicity. The next class are stigmas based on one's perceived psychological, moral or behavioral flaws such as mental illness or sexual orientation. And the last are physical characteristics such as disabilities or higher body weight, which is where where we're going to land when we talk today.

References:

- Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In S. Fiske, D. Gilbert, & G. Lindzey (Eds.), Handbook of social psychology (Vol 2, pp. 504-553). Boston, MA: McGraw Hill
- Goffman, E. (1963). Stigma: Notes on the management of spoiled identity. Prentice-Hall

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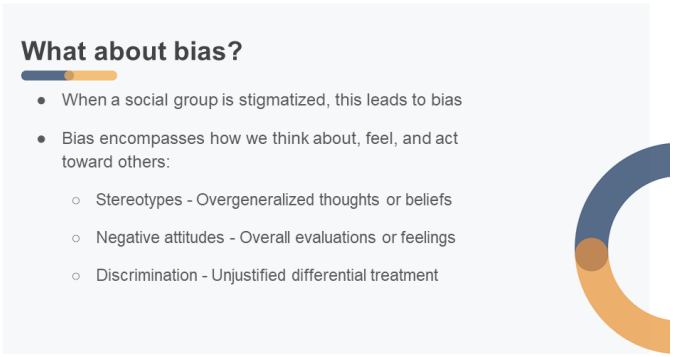

So, what about bias? This may be a term folks are a bit more familiar with, and it's closely connected to stigma. So when groups are stigmatized, this leads to bias against them. Bias is defined as how we think about, how we feel about and ultimately how we act toward and treat certain groups of people. So this includes overgeneralized thoughts or beliefs about a group, what we tend to refer to as stereotypes, it also includes attitudes or our general feelings toward a group. These can be explicit, so attitudes that we can consciously, that we are consciously aware of and can easily report on. But our attitudes can also be implicit, meaning they operate more automatically and outside of our conscious awareness. And finally, bias includes discrimination, which is unjustified and unfair differential treatment of a particular group.

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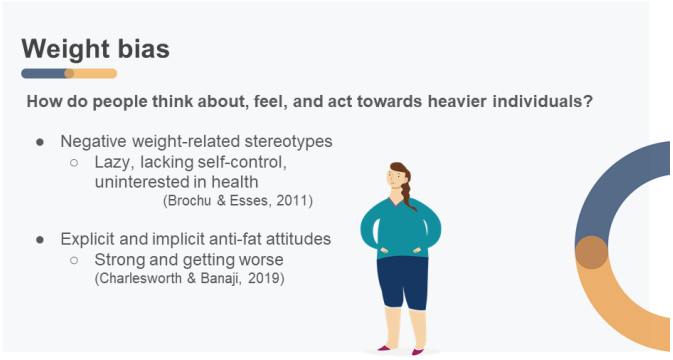

So we can then think about weight related bias as being comprised of those same three components encompassing how people think about, feel and act towards heavier individuals. So in this context there are a host of negative weight related stereotypes, including those related to laziness, lack of self-control, and a general disinterest in health. There are also strong negative weight-related attitudes, both explicit and implicit. And unlike attitudes towards other stigmatized groups such as gay and lesbians, negative attitudes about heavier folks seem to be increasing over time as opposed to decreasing. And these stereotypes and negative attitudes can contribute to weight-based discrimination. We see this at most every stage of the employment cycle from recruitment and hiring to salary promotion and firing decisions. We also see this play out in the educational context. For example, heavier children are graded more harshly by their teachers. Heavier college students are less likely to receive financial support from their family and are less likely to get into graduate school and psychology even with comparable GPA's test scores and letters of recommendation. Weight bias is so powerful, it can even color how guilty a criminal defendant is, with simulated jurors perceiving a higher-weight defendant as more likely to be guilty than the thinner one, even when the description of the crime is identical, and the only thing that differs is their mugshot.

References:

- Brochu, P. M., & Esses, V. M. (2011). What's in a name? Preference for "fat" versus "obese" among the overweight and nonoverweight. Journal of Applied Social Psychology, 41(10), 2469-2488. https://doi.org/10.1111/j.1559-1816.2011.00825
- Charlesworth, T. E. F., & Banaji, M. R. (2019). Patterns of implicit and explicit attitudes towards weight in a national sample. Psychological Science, 30(3), 324-335. https://doi.org/10.1177/0956797618819341

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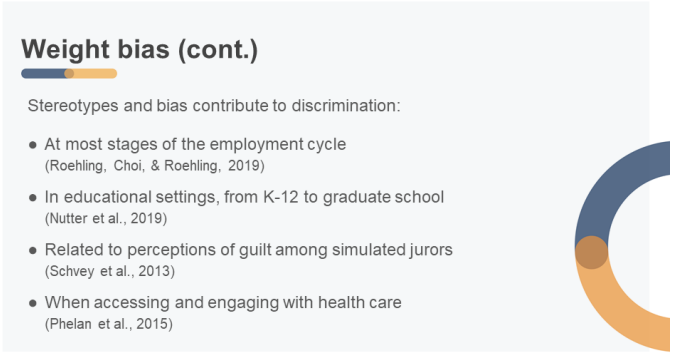

So justice stereotypes and negative attitudes can lead to discrimination in employment, education and law. They can also lead to differential health care for higher-weight patients. For example, providers tend to spend less time with their heavier patients, are less and are also, you know, building less emotional rapport, which over time can sort of harm the strength and effectiveness of that patient-provider relationship or that patient-provider rapport. So obviously weight-based discrimination as you know, consequences of across these very important life domains. Yet this form of discrimination is only currently outlawed in two states and a handful of cities in the United States right now.

References:

- Roehling, M. V., Choi, S., & Roehling, P. V. (2019). Weight discrimination in employment. In T. L. Pittinsky & B. M. Bell (Eds.), The psychology of workplace discrimination (pp. 233-254). https://doi.org/10.1007/978-3-319-65636-4_11
- Nutter, S., Ireland, A., Alberga, A. S., Brun, I., Lefebvre, D., Hayden, K. A., & Russell-Mayhew, S. (2019). Weight bias in educational settings: A systematic review. Current Obesity Reports, 8, 185-200. https://DOI.org/10.1007/s13679-019-00330-8
- Schvey, N. A., Heuer, L., Ready, R. E., Sanchez, D. T., & Bornstein, B. H. (2013). The impact of defendant gender and weight on perceptions of guilt among simulated jurors. Journal of Applied Social Psychology, 43(10), 2059-2068. https://doi.org/10.1111/jasp.12147
- Phelan, S. M., Burgess, D. J., Yeazel, M. W., Hellerstedt, W. L., Griffin, J. M., & van Ryn, M. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. Obesity Reviews, 16(4), 319-326. https://doi.org/10.1111/obr.12266

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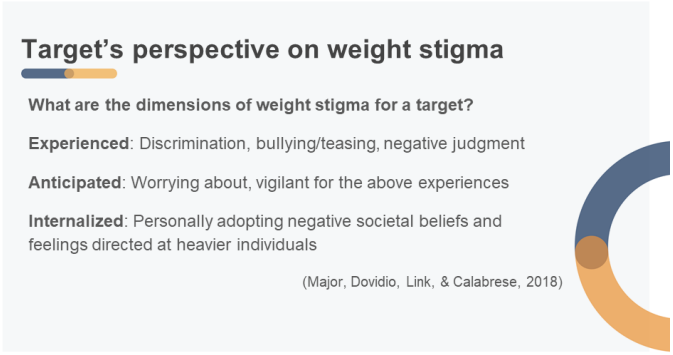

For those past few slides, we've addressed weight-related bias, which again is how folks are thinking about feeling and acting towards heavier individuals. But what about heavier individuals themselves? There can be this tendency to focus on the social actors who harbor bias, which leads us to often lose sight of how this actually impacts folks targeted by it. So from here on out that's where I really want to center us specifically thinking about weight stigma and its impact from the viewpoint of heavier folks. So to me this is comprised of three parts. Weight stigma can be directly experienced such as experiences with discrimination, bullying and teasing or weight-related judgment. Unsurprisingly folks can also come to anticipate weight stigma, you know, where they worry about and are constantly vigilant for those very same experiences. And sadly folks can come to internalize weight stigma or agree with the negative societal beliefs and feelings about heavier folks.

Reference: Major, B., Dovidio, J. F., Link, B. G., & Calabrese, S. K. (2018). Stigma and its implications for health: Introduction and overview. The Oxford handbook of stigma, discrimination, and health, 3-28.

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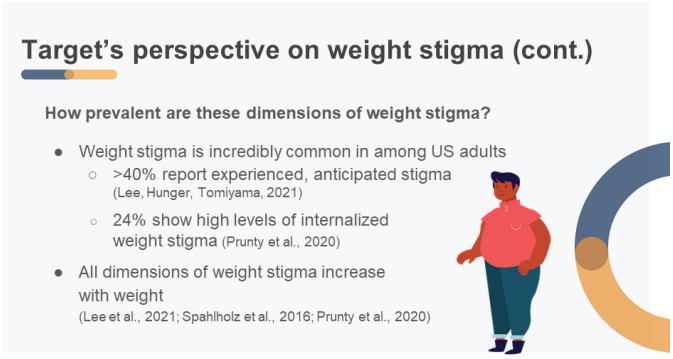

These three dimensions of weight stigma are incredibly prevalent, especially in the US context. In some research from my lab we find that over 40% of US adults report frequently experiencing and anticipating weight-based stigma. Others have shown that nearly a quarter of US adults report very, very high levels of internalized weight stigma. And in general, all three dimensions tend to increase with a person's weight, meaning that the burden of weight stigma is felt most acutely at the higher end of the weight-based distribution.

References:

- >40% report experienced, anticipated stigma (Lee, Hunger, Tomiyama, 2021)
- 24% show high levels of internalized weight stigma (Prunty et al., 2020)
- Weight stigma increases with weight (Spahlholz et al., 2016; Prunty et al., 2020)
- Weight stigma also escalating over time – bring in the statistics from 2005 and 2010 and contrast with Lee et al. (2021) statistics
- Lee, K. M., Hunger, J. M., & Tomiyama, A. J. (2021). Weight stigma and health behaviors: evidence from the Eating in America Study. International Journal of Obesity, 45(7), 1499-1509. https://doi.org/10.1038/s41366-021-00814-5
- Prunty, A., Clark, M. K., Hahn, A., Edmonds, S., & O'Shea, A. (2020). Enacted weight stigma and weight self stigma prevalence among 3821 adults. Obesity Research & Clinical Practice, 14(5), 421-427. https://doi.org/10.1016/j.orcp.2020.09.003
- Spahlholz, J., Baer, N., König, H. H., & Riedel-Heller, S. G. (2016). Obesity and discrimination—a systematic review and meta-analysis of observational studies. Obesity Reviews, 17(1), 43-55. https://doi.org/10.1111/obr.12344

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With that very quick foundation on weight-related stigma and bias in hand, I'd now like to turn to what we know about the impact of weight stigma. Again, focusing on this through the lens of fat folks themselves and focusing specifically on health behaviors.

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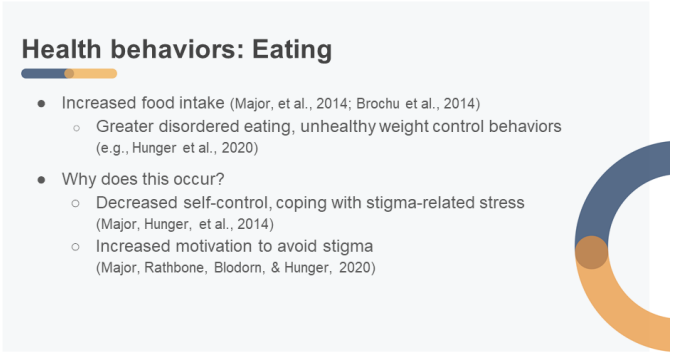

Of course weight stigma also harms mental health is also associated with numerous physiological health outcomes. All those things. However, given the scope of what we're covering today, that won't be sort of in the slides, but I'm more than happy to address that during Q&A. I want to focus more on health behaviors in particular because they are often a vital part of overall health and wellbeing and often figure into health promotion recommendations at multiple levels.

References:

- Decreased self-control, coping with stigma-related stress (Major, Hunger, et al., 2014)
- An increased motivation to avoid stigma (Major, Rathbone, Blodorn, & Hunger, 2020)
- Brochu, P. M., & Dovidio, J. F. (2014). Would you like fries (380 calories) with that? Menu labeling mitigates the impact of weight-based stereotype threat on food choice. Social Psychological and Personality Science, 5(4), 414-421. https://doi.org/10.1177/194855061349994
- Hunger, J. M., Dodd, D. R., & Smith, A. R. (2020). Weight discrimination, anticipated weight stigma, and disordered eating. Eating behaviors, 37, 101383. https://doi.org/10.1016/j.eatbeh.2020.101383
- Major, B., Hunger, J. M., Bunyan, D. P., & Miller, C. T. (2014). The ironic effects of weight stigma. Journal of Experimental Social Psychology, 51, 74-80. https://doi.org/10.1016/j.jesp.2013.11.009
- Major, B., Rathbone, J. A., Blodorn, A., & Hunger, J. M. (2020). The countervailing effects of weight stigma on weight-loss motivation and perceived capacity for weight control. Personality and Social Psychology Bulletin, 46(9), 1331-1343. https://doi.org/10.1177/0146167220903184

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However, weight stigma represents a significant barrier to engaging in numerous health behaviors. The first of which is our eating behavior. And this is an area where my colleague and I have done a decent amount of research. So for example, in one of our lab studies we found that simply being reminded of the prevalence of weight-based discrimination can impact folks' eating behaviors. So participants were brought into the lab where they read and reflected on a news article discussing either weight-based discrimination and employment or discrimination against sort of a non-relevant group, so our control conditions. After reading the article, we had it set up where they had access to snacks in a waiting room as they sat and were ready for the next part of the study. What we found was that individuals who read the weight-based discrimination article ended up consuming a lot more food in that waiting room during that waiting period compared to the participants in our control condition. At the same time we also have a lot of survey-based research showing that weight stigma is associated with greater disordered eating outcomes like binging as well as a greater use of unhealthy weight control behaviors like skipping meals and using diet pills. But why does this occur? So some of our work points to increased eating resulting from a decrease in momentary self-control, but there's also work to suggest that it occurs because folks are simply coping with stigma-related stress and they do so by engaging in comfort eating. This stress may also stimulate sort of a biological drive for high fat high calorie foods and that's something that we are actually currently working on my lab, so one of the stay tuned but I think it's another way in which weight stigma can sort of lead to our altered eating behavior. On the sort of the disordered eating side, we found that weight stigma increases the motivation to avoid being stigmatized. And this seems to be driving greater dietary restriction and engagement in unhealthy weight control behaviors. So put simply, folks are so motivated to no longer be the target of weight stigma that they will enact these incredibly harmful behaviors that they believe will result in significant amounts of weight loss to sort of avoid that. But by altering our eating behaviors in a variety of ways and for a variety of reasons, weight stigma represents a significant barrier to eating in an intuitive manner that is not motivated by external factors or guided by external rules, but instead rooted in our own bodily cues of hunger and satiety. Weight stigma is also associated with poorer outcomes related to physical activity. So for example, greater experiences with weight stigma are associated with the motivation to avoid physical activity, particularly in public spaces or in social settings like the gym. The exercise domain, especially the gym, are a significant source of weight stigma for fat folks. So it's unsurprising that they're going to be motivated to avoid a domain in which these types of negative experiences are likely to occur. Likewise, even subtle cues that heighten the anticipation of weight stigma and reported levels of internalized weight stigma are linked to less

physical activity intentions, a lower motivation to be physically active and just generally feeling less capable of engaging in routine physical activity. And the enjoyment of physical activity can also be harmed by weight stigma, which is a particularly big issue because the lack of enjoyment is a huge barrier to finding sustainable physical activity. There's often an assumption that getting enough physical activity means slogging away on a treadmill or running a marathon, which I know, Ragen, you are the badass in that domain, so this is no slight to you, but what's really most important is finding enjoyable and sustainable movement. Something that weight stigma can just rob from people than it can take from people. And so with its impact on motivation, intentions and enjoyment, it only follows that weight stigma is also associated with less physical activity engagement overall. I will say that this is one area where we could use a little bit of additional research that gives us a little stronger data in kind of an ongoing review of this literature, my team and I have found that a lot of researchers have used less, well, less well-validated measures of physical activity, so this is something that we're actively working on in our lab to fix. We have an ongoing study that's following folks across two weeks using much more objective measures of physical activity to sort of hammer home this relationship between weight stigma and physical activity. But overall I can say pretty confidently that it's clearly a negative relationship. When folks hear the term health behaviors, they probably thought about what I just covered, you know, eating behaviors and physical activity.

References:

- Increased motivation to avoid physical activity (Vartanian & Shaprow, 208; Schvey et al., 2017) – explain that is because exercise domain and environments highly stigmatizing
- Decreased exercise intentions, motivations, and enjoyment (Seacat & Mickelson, 2009; Pearl et al., 2015; Boros et al., 2017) – explain the experimental design of Seacat and Pearl studies. Discuss why harming enjoyment is a barrier to finding sustainable physical activity
- Less physical activity (e.g., Wott & Carels, 2010) à Note that although some studies do see less actual physical activity behavior, we need better data. Bring in how we are currently studying this with more sophisticated activity measurement
- Vartanian, L. R., & Shaprow, J. G. (2008). Effects of weight stigma on exercise motivation and behavior: a preliminary investigation among college-aged females. Journal of health psychology, 13(1), 131-138. https://doi.org/10.1177/1359105307084318
- Schvey, N. A., Sbrocco, T., Bakalar, J. L., Ress, R., Barmine, M., Gorlick, J., ... & Tanofsky-Kraff, M. (2017). The experience of weight stigma among gym members with overweight and obesity. Stigma and Health, 2(4), 292-306. https://doi.org/10.1037/sah0000062
- Seacat, J. D., & Mickelson, K. D. (2009). Stereotype threat and the exercise/dietary health intentions of overweight women. Journal of Health Psychology, 14(4), 556-567. https://doi.org/10.1177/1359105309103575
- Pearl, R. L., Puhl, R. M., & Dovidio, J. F. (2015). Differential effects of weight bias experiences and internalization on exercise among women with overweight and obesity. Journal of health psychology, 20(12), 1626-1632. https://doi.org/10.1177/1359105313520338

- Boros, P., Fontana, F., & Mack, M. (2017). A comparison of physical activity engagement and enjoyment in female college students with and without a history of weight-related teasing. College Student Journal, 51(3), 444-452. https://www.ingentaconnect.com/content/prin/csj/2017/00000051/00000003/art00014
- Wott, C. B., & Carels, R. A. (2010). Overt weight stigma, psychological distress and weight loss treatment outcomes. Journal of health psychology, 15(4), 608-614. https://doi.org/10.1177/1359105309355339

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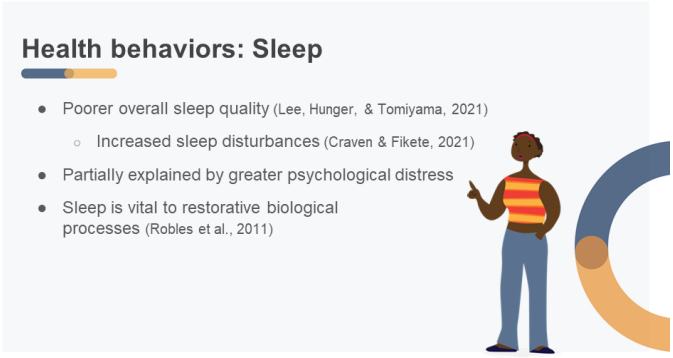

But a hugely important but often overlooked health behavior that is impacted by weight stigma is our sleep. So for example, in a large national survey that we conducted with about 2,000 US adults, greater experiences with weight stigma were associated with poor overall sleep quality. At the same time other researchers have seen that greater internalized weight stigma that you know, again that stigma that's kind of directed at the self can also harm our sleep. So in a study by Craven and Fikete, internalized stigma was led to more sleep disturbances. So these are things like being restless, waking up throughout the night or waking up earlier than planned. And this was partially explained by depression and anxiety symptoms that often accompany internalized weight stigma. It's not all too surprising that psychological distress can profoundly interfere with our ability to get a good night's sleep, especially when that is sort of yoked to something so central to our identity as our weight. But this is important however, because sleep is, if you were, thankfully you are not students in my class or you hear me like rant about this for an entire 15 weeks. But sleep is just so critical because it is vital to restorative biological processes. Our sleep is our time when our body can repair itself sort of from the slings and arrows of the day and ready us for the next one. If this is consistently disrupted, there's inevitably going to be cumulative impact on health. So for example, we know that chronic poor sleep is associated with an elevated risk of cardiovascular disease, poor diabetes-related outcomes and also impacts our other health behaviors like eating, so sleep truly is this really integral component of health that unfortunately is harmed as a result of weight stigma.

References:

- Poorer overall sleep quality (Lee, Hunger, & Tomiyama, 2021) – explain that this is in a large, national sample of US adults
- Greater sleep disturbances (Craven & Fikete, 2021) – explain what is meant by sleep disturbance

- Partially explained by greater psychological distress – that is, more depression and anxiety
- Sleep is vital to restorative biological processes (Robles et al., 2011) – sleep is when our body repairs itself from the day and readies us for the next – if this is disrupted a lot, there will be cumulative health effects
- Lee, K. M., Hunger, J. M., & Tomiyama, A. J. (2021). Weight stigma and health behaviors: evidence from the Eating in America Study. International Journal of Obesity, 45(7), 1499-1509. https://doi.org/10.1038/s41366-021-00814-5
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- Robles, T. F., & Carroll, J. E. (2011). Restorative biological processes and health. Social and Personality Psychology Compass, 5(8), 518-537. https://doi.org/10.1111/j.1751-9004.2011.00368.x

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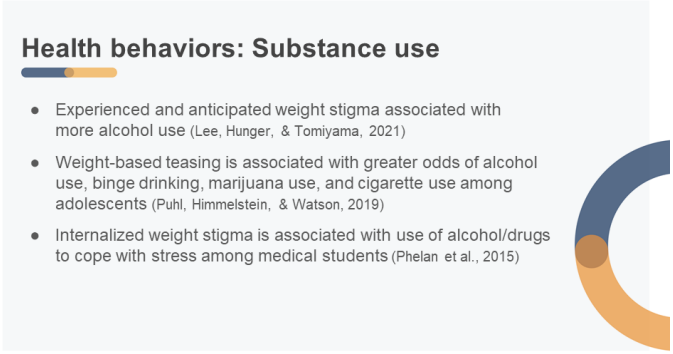

We also see weight stigma contributing to substance use. Once again in our large national sample of US adults, both experienced and anticipated stigma were associated with more alcohol use. They were associated with an overall increased use of alcohol but also with the likelihood of meeting the criteria for heavy drinking that may indicate an alcohol use disorder. So this is consistent with other large scale research which has found that individuals reporting weight-based discrimination are nearly twice as likely to meet the diagnostic criteria for alcohol dependence. Even when controlling for a host of other really important risk factors. Among adolescents, we see that weight-based teasing and bullying is associated with a greater odds of using alcohol, of engaging in binge drinking, of marijuana use and of tobacco smoking. Although, the particular study that I show here on the slide was the a large scale survey of sexual and gender minorities. We see the same relationship between teasing and substance use across adolescent groups. And we also see this relationship unfold longitudinally such that weight-based victimization is associated with greater substance use over time. So it's not just that we're capturing this at a single shot, it's that these experiences are changing the trajectory of folks engaging in substance use over time. And there are also similar evidence for internalized weight sigma from Phelan and colleagues who conducted this, in my opinion, wildly impressive study of medical students. So, they surveyed nearly 5,000 medical students across 49 schools, which that year represented over half of all first year medical students in the country. Like super impressive. So these researchers found that higher levels of internalized

weight stigma were associated with a greater use of alcohol and drugs to cope with stress specifically. And this was particularly pronounced among the higher body weight medical students in the study. Sort of across the ways that we think about operationalizing weight stigma or the different dimensions of it. Each of them are associated with various forms of substance use from alcohol to drugs primarily as a form of coping.

References:

- Experienced and anticipated weight stigma associated with more alcohol use (Lee, Hunger, & Tomiyama, 2021) in national sample
- Weight-based teasing is associated with greater odds of alcohol use, binge drinking, marijuana use, and cigarette use among adolescents (Puhl, Himmelstein, & Watson, 2019) - sexual and gender minority adolescents in particular
- Internalized weight stigma is associated with the use of alcohol/drugs to cope with stress among higher body weight medical students (Phelan et al., 2015) – explain a bit about how this was a national study of nearly 5000 medical students across 49 schools
- Lee, K. M., Hunger, J. M., & Tomiyama, A. J. (2021). Weight stigma and health behaviors: evidence from the Eating in America Study. International Journal of Obesity, 45(7), 1499-1509. https://doi.org/10.1038/s41366-021-00814-5
- Puhl, R. M., Himmelstein, M. S., & Watson, R. J. (2019). Weight-based victimization among sexual and gender minority adolescents: Implications for substance use and mental health. Health psychology, 38(8), 727-737. https://doi.org/10.1037/hea0000758
- Phelan, S. M., Burgess, D. J., Puhl, R., Dyrbye, L. N., Dovidio, J. F., Yeazel, M., ... & van Ryn, M. (2015). The adverse effect of weight stigma on the well-being of medical students with overweight or obesity: Findings from a national survey. Journal of General Internal Medicine, 30, 1251-1258. https://doi.org/10.1007/s11606-015-3266-x

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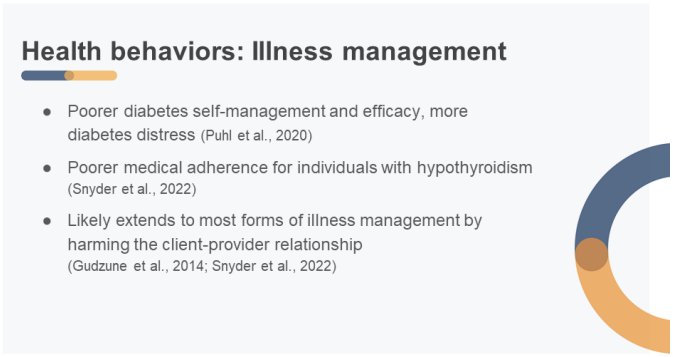

And finally there is emerging evidence that weight stigma can impact chronic illness management. Just like sleep, I think this as a health behavior doesn't often get as much attention. It's not as flashy, it's not as sexy, but it's something that needs to be at the forefront when we think about the suite of health behaviors that we need to be supporting among our patients. We see in this literature that weight stigma is associated with poor diabetes self-management behaviors such as routine blood sugar monitoring, is related to feeling less self-efficacy or less kind of capacity to engage in diabetes management and is associated with more diabetes related distress. So ultimately poor diabetes self-management is going to exacerbate

the health implications of diabetes itself, which can make future attempts at self-management even more challenging setting off sort of this vicious cycle. Weight stigma is also associated with poor medical adherence for individuals contending with hypothyroidism. Here, lack of medical adherence can similarly make future attempts at illness self-management even more challenging as the condition itself becomes more poorly controlled, potentially resulting in the need for more aggressive treatment options moving forward. So to me this is an incredibly important area of research, and one that really needs more systematic attention. It's likely that the impact of weight stigma extends to most forms of illness management in part by increasing distress, undermining health related self-efficacy and harming that patient-provider relationship. If folks are too stressed and don't feel like they have the ability to manage their illness and also don't trust or don't feel empathy from their primary care providers, their health will inevitably suffer as the quality of their illness management deteriorates.

References:

- Weight stigma is associated with Poorer diabetes self-management behaviors, less efficacy for diabetes management, more diabetes distress (Puhl et al., 2020)
- It is also associated with poorer medical adherence for individuals with hypothyroidism (Snyder et al., 2022)
- This is a really important area of research, and one that really needs more attention. I think it’s likely that the impact of weight stigma extends to most forms of illness management by harming the patient-provider relationship (Gudzune et al., 2014; Snyder et al., 2022)
- Puhl, R. M., Himmelstein, M. S., Hateley-Browne, J. L., & Speight, J. (2020). Weight stigma and diabetes stigma in US adults with type 2 diabetes: Associations with diabetes self-care behaviors and perceptions of health care. Diabetes Research and Clinical Practice, 168, 108387. https://doi.org/10.1016/j.diabres.2020.108387
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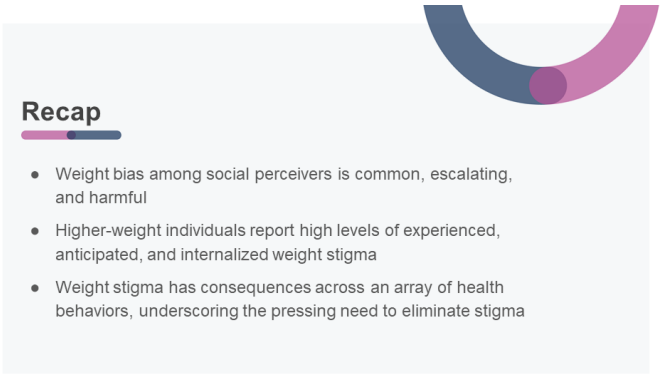

So I know it was a whirlwind covering a bunch of things, but just to quickly recap, you know at the opening, I showed evidence that weight bias among social perceivers is common, is escalating and is harmful leading to discrimination across a variety of life domains from education and employment to health care. And we also know that heavier individuals report high levels of experienced, anticipated and internalized weight stigma, at least in the US context. And importantly, weight stigma has consequences across an array of health behaviors from eating and exercise to chronic illness management, which to me really underscores the dire need to eliminate weight stigma at all levels. Something that Ragen will actually tackle a bit later. And so with that, I'll actually hand it off to you, Ragen.

- [Ragen] Thank you so much, Jeff. And thank you for your work, I reference it all the time. I'm so grateful for what you're doing.

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So moving in, we're going to talk a bit about the impact of weight stigma on health care utilization.

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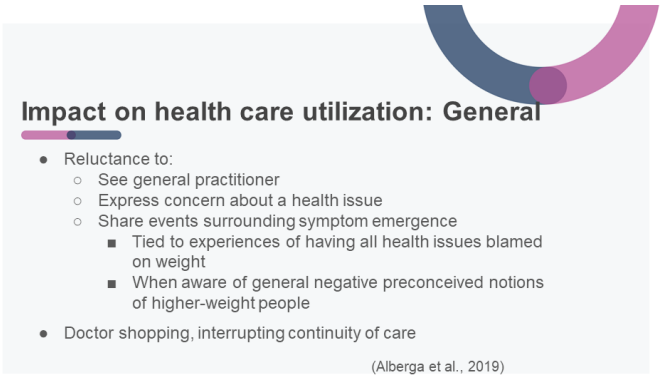

And in a general way what we see is a reluctance and disengagement from care and that includes a reluctance to see a general practitioner or a doctor. It includes a reluctance to express concern about a health issue and it includes a reluctance to share events surrounding symptom emergence. And this can come from internalized weight stigma, right? When people start to believe that their bodies aren't valid and worthy of care than they tend to take less good care of those bodies. But what we find is that often this is blamed on higher-weight people, the idea that they must be ashamed to go to the doctor, they must be ashamed to talk about their symptoms or injuries when what has happened is these reluctances are tied to their experiences of going to the doctor, which you know can include everything from getting time off work and possibly losing money, finding childcare, getting transportation, the ability to make a copay. All of these things that go into going to the doctor only to have all of their health issues blamed on their weight. Or to have their presenting concern ignored by a doctor who wants to focus on their body size and changing their body size. And these reluctances also happen more when those patients are aware of general negative preconceived notions about higher-weight people. And so when we see for example, sharing events surrounding symptom emergence, that can be someone who doesn't want to say that they twisted their ankle running because they've experienced doctors who don't believe that they could participate in running as a higher-weight patient. It can also be a patient who doesn't want to say that the chest pain started after they ate buffalo wings because they're afraid that there'll be stereotyped or shamed for their eating behavior, which can then impact the diagnosis and the understanding of where that chest pain might have come from. And so this can also lead to doctor shopping where patients are looking for a doctor who will provide help for their presenting complaint rather than focusing on their weight. And in reproductive care, that interruption of continuity of care can be a serious issue for pregnant people who are undergoing prenatal care. And so that kind of reluctance is an impact of weight stigma and again, there intended to be a tendency to blame it on higher-weight people rather than on the weight stigma that they experience was important to understand that weight stigma itself is what's driving this reluctance and this disengagement from their care.

Reference: Alberga, A. S., Edache, I. Y., Forhan, M., & Russell-Mayhew, S. (2019). Weight bias and health care utilization: a scoping review. Primary health care research & development, 20, e116. https://doi.org/10.1017/S1463423619000227

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Also, structural weight stigma. So structural weight stigma happens when the things that higher-weight people need are made for thin bodies and to the exclusion of higher-weight bodies. So that can be everything from the chairs in the waiting room, right? Are there armless chairs and love seats that accommodate higher-weight people? It can be the tables and the weight rating of the tables, it can be blood pressure cuffs. And not just having the correctly sized cuff but if you have all of the cuffs accept the thigh cuff for example at a station where you're taking blood pressure, so that when you do have a higher-weight patient, you have to, everybody has to go and look for the thigh cuff which is stigmatizing to the patient who realizes they're not getting the same experience that everyone else does and can make the practitioner more likely to say, well, let's just try a smaller cuff 'cause we don't know where the thigh cuff is and then the patient gets a too high reading. Also a client experiences, right, when a client needs a gown, and gowns for the properly, that are properly sized for the patient don't exist in a health care environment. Specula, when we talk about reproductive health care, I was actually a patient advocate in a situation where a patient went to a gynecological appointment just for a pap smear and was told that they didn't have the proper specula for that patient, but that if she wanted to go and get one on Amazon she could bring it and they could reschedule. And like bring your own speculum, I don't think a gynecological appointment should be kind of a BYOS party, but this is the kind of weight stigma that people experience every day. Just basic things where thin people just expect, yes, there will be a chair I can sit in, a table that is rated for me, a gown that will fit me, the proper blood pressure cuff. higher-weight patients can't expect that to happen. And that again can cause that disengagement from care and that reluctance to get care. And then even when they do overcome those things and go to the doctor, it can cause a disruption to their care or a lower level of care than a thinner patient would receive.

Reference: Lee, J. A., & Pausé, C. J. (2016). Stigma in practice: Barriers to health for fat women. *Frontiers in Psychology*, *7*. https://www.frontiersin.org/articles/10.3389/fpsyg.2016.02063

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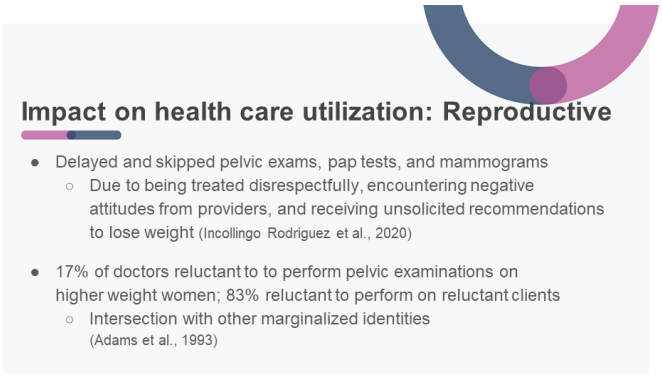

In terms of reproductive care specifically, we know that the experience of weight stigma can cause delayed and skipped pelvic exams and pap tests and mammograms. And again, research finds that that's due to being treated disrespectfully to encountering negative attitudes from providers and to receiving unsolicited recommendations to lose weight. And this is a common experience among higher-weight people where they've gone to get an exam, a pelvic exam, a pap smear, mammogram where they are feeling vulnerable, right? They're literally exposed. And then in those moments, all of a sudden a practitioner starts asking them do they snack a lot or giving them advice about losing weight that they did not ask about and that isn't appropriate to the context. And that again can lead to disengagement. And the disengagement of care in particular for this preventative type care can mean delayed diagnosis. We find in some research about 17% of doctors were reluctant to perform pelvic examinations on higher-weight CIS women. And in this study, as in almost all the studies we're talking about, there is no trans and non-binary representation and underrepresentation of patients of Color in ways that also create additional marginalizations for those folks because they're not even included in the research we're talking about. So 70% of doctors reluctant to perform pelvic exams on higher-weight women, CIS women, 83% were reluctant to perform the exams on reluctant clients and patients. And so what we see is this experience of weight stigma causes higher-weight people to be reluctant, which causes their practitioners to be reluctant, and so it's this layering upon layering of ways that these patients are not getting equal treatment. And this also intersects with other marginalized identities. As Dr. Hunger pointed out, weight stigma is something that can harm people of all sizes, but it does the most harm to those at the highest weights and those with multiple marginalized identities. And so those who are also dealing with racism or ableism or transphobia within the health care experience who are then also fat will experience using Kimberle Crenshaw's concept of intersectionality, they'll be marginalized in those individual identities but then at the intersections of those identities as well.

References:

- Incollingo Rodriguez, A.C., Smieszek, S.M., Nippert, K.E. et al. Pregnant and postpartum women's experiences of weight stigma in healthcare. BMC Pregnancy Childbirth 20, 499 (2020). https://doi.org/10.1186/s12884-020-03202-5
- Adams, C. H., Smith, N. J., Wilbur, D. C., & Grady, K. E. (1993). The relationship of obesity to the frequency of pelvic examinations: do physician and patient attitudes make a difference?. Women & health, 20(2), 45–57. https://doi.org/10.1300/J013v20n02_04

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And in terms of contraception, again, health care disengagement means that higher-weight patients may be less likely to seek out or to be recommended contraception. And also because of weight bias, they may be less likely to want to take contraception that might result in weight gain because that will result in an increase in the bias that they experience. Practitioner bias means that some practitioners may assume that higher-weight people aren't having sex and that's in particular higher-weight adolescents or may be reticent to put higher-weight people on a birth control method that may cause weight gain. And then there's lack of accommodation. We know that emergency contraception in pill form is simply not formulated for higher-weight people. And what's been done about that to this point is simply to put a notice on the box that it doesn't work as well or at all for higher-weight people as opposed to figuring out how to create pill form emergency contraception that does work for higher-weight people. IUDs are an option. Copper IUDs show the same efficacy regardless of weight, but again, much more difficult to get, requires that provider appointment, requires that vulnerability that the patient may be reluctant to participate in. And so all of these things may impact the use of contraception among higher-weight people. All right, so that's what weight stigma does.

Reference: Chang, T., Davis, M. M., Kusunoki, Y., Ela, E. J., Hall, K. S., & Barber, J. S. (2015). Sexual Behavior and Contraceptive Use among 18- to 19-Year-Old Adolescent Women by Weight Status: A Longitudinal Analysis. The Journal of Pediatrics, 167(3), 586–592. https://doi.org/10.1016/j.jpeds.2015.05.038

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Let's take some time and talk about how we can reduce weight stigma and bias.

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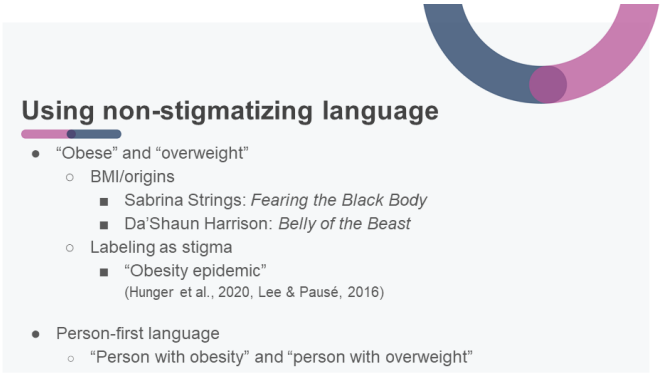

So let's start with language, and I'm going to start with language that is stigmatizing. So obese and overweight are terms that were literally made up to pathologize bodies based on shared size rather than shared symptomology or shared cardiometabolic profile. And so, they come from body mass index. And I want to point out here that the idea of pathologizing higher-weight bodies, the body mass index itself, weight stigma in general, these things are rooted in an inextricable from racism and anti-blackness. And I absolutely urge you to read Sabrina Strings, "Fearing the Black Body," and Da'Shaun Harrison's, "Belly of the Beast," to learn more about how these things are not just rooted in racism and anti-blackness, but how they continue to disproportionately impact these communities today. And so as Dr. Hunger's research points out, labeling itself becomes stigma. So when we say that obesity is a bad thing and then we say you're obese and then we start saying things like there's an obesity epidemic, we're further and further stigmatizing someone's identity, especially we're talking about an identity that is visible, right? People are, this is an identity based on size and on height-weight ratio when we talk about the BMI. So, that can become stigmatizing. And again, overweight is an overtly stigmatizing term. It literally says there's a correct weight and you are not it. Obese comes from a Latin word that means to eat one self fat. So again, more stereotype than science there. And then recently you may have heard this idea of person first language that it's better to say a person with obesity or a person with overweight. And I want you to know, first of all, that is not coming from weight neutral health community and it is not coming from fat activism community, it's being driven by the diet industry. And it's part of an overall goal to have simply existing in a

higher-weight body seen as a chronic lifelong health condition that requires chronic lifelong treatment. And it ends up being more stigmatizing. And I also want to quickly point out that it was co-opted from disability community where it's quite controversial, and so urge you to read authors in that community to understand the nuances there, but sort of without any of those nuances, it was co-opted by the weight loss industry and put upon fat people. And then because of their enmeshment with health care, it's become disseminated throughout health care as a non-stigmatizing option or less stigmatizing option. In fact, it's more stigmatizing because it talks about higher-weight bodies differently than any other bodies, right? There's no call to say the person with thinness, right? The person affected by tallness. And so, it says what you are is so terrible that we have to kind of find a semantic workaround to talk about that. And so, it ends up being more stigmatizing overall.

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So non-stigmatizing language, we can use terms as we have today, higher-weight, larger body, person of size. We're looking for terms that accurately describe these bodies without pathologizing or medicalizing them and that weren't used as like a taunt or an insult in ways that can trigger folks. Fat is the preferred term of many higher-weight people, myself included. It's a reclaiming term kind of a way. We tell our bullies they can't have our lunch money anymore. And again, it doesn't pathologize or medicalize our bodies. And Meadows and Higgs found that in-group identification with a group fat was in fact the major predictor of stigma resistance versus internalization. So seeing yourself as a higher-weight person, as a fat person rather than as a person with fat was actually the major predictor of stigma resistance, which again speaks against the idea of person first language. And fat isn't the right term all the time. There are

people who couldn't be identified as fat who don't align with the term. And of course that's totally valid. The idea here is that if we're using fat, we use it as a neutral or positive descriptor. And that if somebody chooses to use fat for themselves as a neutral or positive descriptor, we don't correct them or tell them that that's the wrong thing to do.

Reference: Meadows, A. Higgs, S. (2022) Challenging oppression: A social identity model of stigma resistance in higher-weight individuals. Body Image, Vol 42, p237-245 https://doi.org/10.1016/j.bodyim.2022.06.004

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In terms of accommodation, looking around your facility to find ways that higher-weight clients are simply not having the same experience as thinner clients. And again, that can be chairs that accommodate, blood pressure cuffs that are easily available, gowns that fit, exam tables, diagnostic equipment, and then see what we can fix. And you may not be able to fix everything, right? So the idea is to use the power, privilege and leverage that we personally have to fix the things that we can and then to work together in groups to make larger changes.

Reference: Chastain, R. (2021, December 18). Creating A Size-Inclusive Healthcare Office. Weight and Healthcare. https://weightandhealthcare.substack.com/p/creating-a-size-inclusive-healthcare

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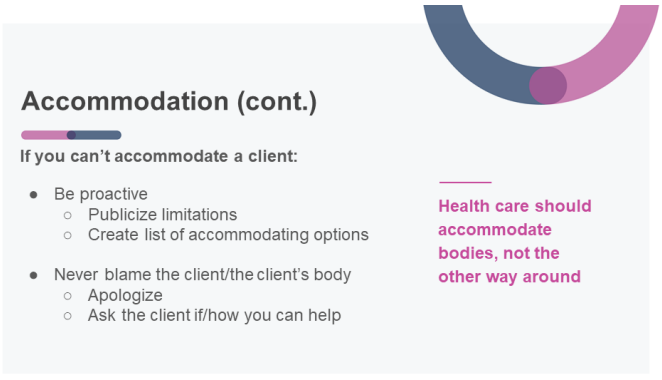

If you aren't able to accommodate, be proactive. My thing is always, if you can't be accommodating, be honest. The goal should be that you communicate things in such a way that no one ever arrives at your office to find that they can't be accommodated. So if there are things

that you have diagnostic tools that are weight rated, put that on your website. Have pictures of the waiting room, make sure people can see whether or not they're going to be accommodated. And in the event of a lack of accommodation, never blame the client or the client's body. It's not that the gown is, that the patient is too big, it's that the gown is too small, right? So we want to make sure that we're not further stigmatizing someone who's experiencing weight stigma. And often the lack of accommodation is not the fault of the person who is client facing, but that doesn't change the fact that they're experiencing weight discrimination like in your hands. And so when we can be really sensitive to that, when we can apologize, I'm so sorry, we don't have the proper size gown, I'm going to work on that. For now, here's what we can do. And ask the client, you know, can you help them, how can you help them and move forward based on their wishes to try to minimize the problem. Always remembering health care should accommodate the bodies that exist. We shouldn't have to change our bodies to fit into health care.

Reference: Chastain, R. (2021, December 18). Creating A Size-Inclusive Healthcare Office. Weight and Healthcare. https://weightandhealthcare.substack.com/p/creating-a-size-inclusive-healthcare

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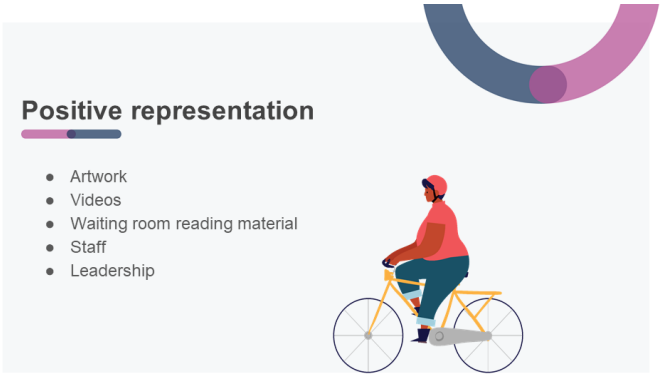

Positive representation. Everybody deserves them to see themselves positively represented. So when you look around the artwork that you have, any videos that might be playing, waiting room reading material, the staff, the leadership, do we see higher-weight people positively represented or do we see them as sort of cautionary tales or before and after pictures? So, we want people to come in and see themselves. And this doesn't just go for higher-weight people of course, it goes for people of all marginalized identities. And having those folks in staff and leadership means that there's some lived experience in the room to help create environments and spaces and make decisions that are inclusive of higher-weight people.

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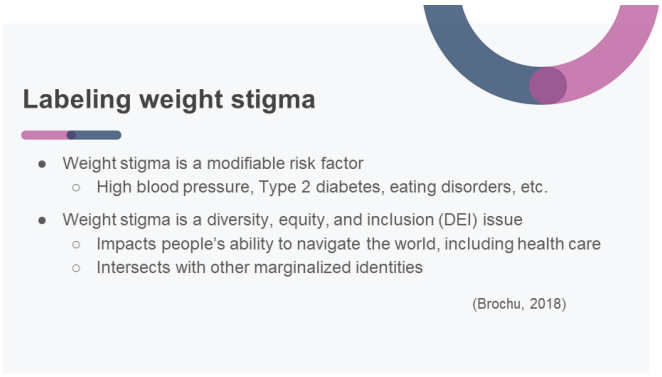

So, then there's the way that we talk about weight stigma. So weight stigma is an independent risk factor for high blood pressure, for type 2 diabetes, for eating disorders. And so when we see it that way, we can see that weight stigma itself is a risk factor that is modifiable. By reducing weight stigma, we can perhaps reduce the risk for these health issues for higher-weight people. Beyond that weight stigma is also a diversity, equity and inclusion issue. It impacts people's ability to navigate the world, including health care in equal ways. And it again, it intersects with other marginalized identities in a lot of different ways. So most importantly here I think is to have an unwavering attitude of stigma eradication.

Reference: Brochu, P. M. (2018). Weight Stigma Is a Modifiable Risk Factor. Journal of Adolescent Health, 63(3), 267–268. https://doi.org/10.1016/j.jadohealth.2018.06.016

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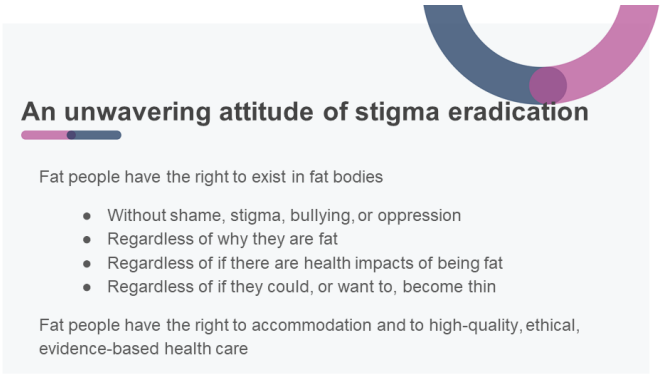

And so, that starts with understanding that fat people have the right to exist in fat bodies without shame, bullying, stigma or oppression regardless of why they might be fat, regardless of if there are health impacts of being fat, regardless of if they could or want to become thin. Fat people have the right to accommodation and to high-quality, ethical, evidence-based health care period. And this is really an important understanding. In terms of stigma, regardless of what someone believes about being higher-weight and health, people who are experiencing stigma should never be asked to change themselves to suit their oppressors as a way to escape stigma. That's wrong regardless. So regardless of what impact somebody thinks being fat might have on someone's health, that person still deserves to exist without shame, stigma, bullying or oppression. And this is also important in the way that stigma research is conceptualized. So

you'll see a lot of stigma research, weight stigma research that starts with a sentence like the obesity epidemic is rampant and shows no signs of relenting. Yikes. That's a stigmatizing point of view, right? And so what we have here is because a lot of people who do weight stigma research, obviously not Dr. Hunger, but a lot of people who do this research are invested in anti-fatness. And so we've got this idea going that you can think that higher-weight people should be eradicated, future higher-weight people should be prevented from existing. We should eradicate fatness from the earth. But you know, like in a non-stigmatizing way. And that's not actually an anti weight stigma position. Right, when we believe that the eradication of fatness would be a good thing for society, then we're inherently stigmatizing folks. And when our weight stigma research gets based on that, then people get this misunderstanding that it's appropriate to say, you know, I think the world would be better if people like you didn't exist, but I don't want to stigmatize you while I say that. And that's simply not a possible thing to do because it's an anti-fat is an inherently stigmatizing point of view. All right, so that is the end of mine. And again, I know that this has been a lot in a short amount of time, so I know Dr. Hunger and I are both super excited about the Q&A. Thanks for having us, thanks for listening, and thanks for engaging with this.

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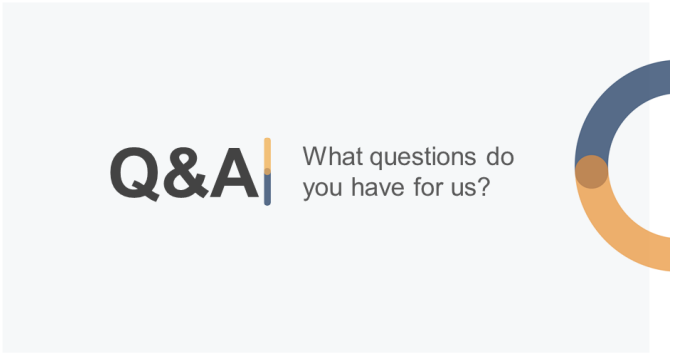

- [Amanda] Thank you, Jeff. Thank you, Ragen. I am glad that we have about 10 minutes for Q&A, so please do feel free to pop any questions you have in the chat. I have to call out that you've gotten snaps, you've gotten fire, you've got some starry eyes in the chat. So thanks, everyone for that feedback. We do have a question that I like to start with and I'll just read it aloud, and then see which one of you would like to take the first pass at it. Often I hear stories from heavier people being falsely accused of being pregnant or when a larger bodied person is pregnant but is not pregnant, is pregnant, excuse me. And there are comments like, "Oh, I couldn't even tell." In your opinion, is this a form of fat shaming or stigmatizing or language?

- [Ragen] I'm happy to start unless you'd rather, Jeff. So, I do think this is stigmatizing in the sense that people are being treated differently. I also think that the way that we talk to people who are pregnant or who we think might be pregnant is often problematic in general, right? The idea of assuming someone is pregnant of commenting on that, they may or may not want those comments. And so anytime we're doing unsolicited comments about something like that, I think we're probably starting from a bad place. And then when we're talking about a higher-weight person, it can be so fraught the idea of being pregnant. Marilyn Wann gave me my favorite response to being asked if you're pregnant. Often people will just say, not pregnant, just fat. But her favorite response is, "No, but the night is young." So there are options for responding to this

for higher-weight people. But I do think it's a form of discrimination and I do think it makes it more difficult for people in a range of sizes who are or want to be or are not pregnant.

- [Dr. Hunger] Yeah, and just to add on a little bit to Ragen's point, I think sort of an adjacent comment is that we should never be even like interacting with folks who may or may not be pregnant and feeling like any sort of freedom or comfortability with like just throwing out these weight-related comments ever. Pregnant or not, fat or not, it's just like we don't need to, they serve no function in our conversations with folks. And so, I think in general the default should be to just like zip it when it comes to if that thing springs to mind, just like override a little bit and just zip it shut.

- [Amanda] Next question, how can nursing home residents who are also medically obese advocate to get the exams that they need? Ragen, do you want to start with this one?

- [Ragen] Sure. So just can be really rough, especially if people don't have as much agency. So asking for what you need is the first step and then if you're denied asking them to chart that immediately can be really helpful. Hey, while I wait, can you chart that I ask for this exam or diagnostic and you declined on the basis of my weight? Sometimes you can bypass a lot of it by saying, well, what would you do for a thinner person with these symptoms? And using that as a way to kind of bypass weight stigma and get answers as to what diagnostics or exams somebody might need. And finally having an advocate. It doesn't have to be a professional advocate, just having like your kind niece or nephew or someone else in the room has been shown to help people get better health care even if they're not an expert in health care. So, those are my initial tips.

- [Amanda] I'm going to move on to the next question just so 'cause I do see them starting to come in now. And, Jeff, feel free to add in thoughts as well if you want to circle back to that at any point. But I do have a question around language. What language should my nursing staff be using when requesting patient weigh-ins during check-in?

- [Dr. Hunger] I mean, I guess my gut, and I'm curious to hear your thoughts on this, Ragen would be walking in and just if it's acceptable within your specific office of just making it optional, asking, you know, presenting them with the option like, would you like to get weighed today? If it is, in that specific clinic is an option because giving folks the sort of the autonomy and the power over that decision is huge, especially in that environment where a lot of folks from marginalized communities, fat folks, queer folks, Brown folks feel like there's no power there. There's a gigantic power differential. So, any small ways in which we can reestablish self-advocacy and power from the patient perspective, like giving them the option to be weighed or not is huge. And I think that if for whatever reason, 'cause I realize that there are a lot of complicated reasons related to insurance that you may have to weigh your patients. I think one strategy can be to move towards blind weighing and taking strategies to, although it's going to be not quite as impactful as just giving them the option, they're at least not sort of hit with weight as the first thing that they encounter when they walk through that sort of clinical encounter door.

- [Ragen] I definitely agree with all that. I also would point out that if you're worried about mixed reimbursement, that if the patient declines weigh-in, the patient is removed from both the numerator and the denominator, so they don't impact future compensation. So, that's a way to kind of bypass some of the insurance issues. And yeah, even in medically necessary weigh-ins, I think blind weigh-ins can be incredibly important. And also pointing out something like, we just need this for anesthesia or we need this to see about your heart failure and any kind of edema

you're experiencing to be clear that you're not judging their weight, you need it for a medically necessary reason. And then absolutely agree with giving patients an option to opt out in routine weights.

- [Amanda] I think that got it. The next question I was going to go to, so I'll just read it aloud and see if you'd have anything to add to that. How should providers approach a client that is of a higher-weight in regards to the fact that it's a risk factor for high blood pressure and other health issues? The provider doesn't want to offend the client but still wants to address the weight.

- [Dr. Hunger] Ragen, do you want to take that or would you like me to?

- [Ragen] Go ahead. You kick it off.

- [Dr. Hunger] Yeah, so in this context I guess I would recommend that the provider shift a little bit of the focus of the conversation. I think that we know that a lot of the health behaviors that I covered in my section of the webinar today are incredibly impactful for blood pressure and other health related issues. We see changes in blood pressure with an increase in physical activity, even if we don't see changes in weight, we see improvements in HbA1c with improve with, you know, having a more intuitive eating style and more physical activity even if we don't see changes in weight. And so I think that there's got to be a little bit of an orientation or a paradigm shift to think more through the lens of what is something that I as a provider can help my patient with that is achievable and sustainable. And more often than not, when you looked at the data, weight loss is a strategy to improve things like biomarkers, like blood pressure, HbA1c. Lipid profiles aren't really as reliable of an indicator or reliable predictor of change in those things as sustainable changes in health behaviors are. And so I think it's going to, and I think that the challenge there is that patients might also walk in and assume that the only solution that I have to this is changing a number on a scale, they might not know that you can see improvements in these things by just making some modifiable sustainable health behavior changes. And so, that would be where I would want to land that one.

- [Ragen] 100% Agree. I think it's important to understand that while being higher-weight is correlated with health issues, so is the experience of weight stigma, so is the experience of weight cycling or yo-yo dieting, which is the most common outcome of weight loss attempts. And so as Jeff said, going to that health supporting behavior options, thinking to yourself, what would I do for a thin person with these health issues. And then looking at those interventions can be a really helpful way to mitigate any weight bias that can be not just from the practitioner but from the practitioner's training.

- [Dr. Hunger] I was just going to say like when we look at in any of the literature that likes to claim that weight loss is the driver of these changes is like, and guess what, they lost 3% of their weight and that is clinically significant and that was what was driving their changes in blood pressure when they made radical changes to their engagement with physical activity and their relationship with food. I'm not a betting man, but I would be much more likely to assume that those changes in health behavior as opposed to a 3% change in weight loss are really the integral driver of those improvements.

- [Ragen] And if you want to look into that, for those who are listening, Mann, Ahlstrom and Tomiyama, 2013 looks at exactly that question and finds that in fact in correlational analysis, they could not correlate the weight loss to the health changes and it was much more likely the behavior changes.

- [Amanda] Great. Let's try to get one more question. And this was about birth control pills. So the question reads, many birth control pills have not been tested with fat people. I have known doctors to not prescribe oral contraception because of the quote weight limit. How do we move pharmaceutical companies or other sexual health care practices to include fat people in their trials as a category?

- [Ragen] Jeff, I feel like you're the best source for this.

- [Dr. Hunger] I apologize, I was answering a question in the chat. Can you say the question again, Amanda?

- [Amanda] Sure. How do we, so many pills have not been tested with fat people, providers may not prescribe oral contraception because of the weight limit. How do we move pharmaceutical companies or other sexual health care practices to include fat people in their trials?

- [Dr. Hunger] Yeah, I mean that a really important question and a challenging one because I think that especially when we live in this world right now that is dominated by drug trials that are designed to just sort of target weight as the primary predictor of health change, whether it be through ozempic or mounjaro and all those different things. I think we as researchers need to be leading the way. So I think a part of it is getting folks like myself on the inside, if you will, to be more invested in these things. Like I have spent the past 10 or 12 years really working to forge collaborations and find clinical trial experts that are actually interested in thinking about testing these things among fat patients or are really interested in adopting a weight neutral lens to thinking about diabetes care, for example. And thinking about including folks across the weight spectrum, even if they may not like benefit the trial. Because oftentimes folks when may think about enrolling folks in their clinical trials are thinking about, well, who's going to be the most advantageous to my numbers because I want to eventually sell my drug. And so, I think about a lot of it starts sort of this sort of grassroots. I mean there's folks in this call that are probably equally in positions where they can be the advocate for this in their respective organizations to really be thinking about pushing folks to not only be size inclusive in their tare, or size inclusive in their thinking, but also size inclusive in their research because that's a big part of this. I think someone else mentioned in one of the chats, like we know very little about, for example, the ways in which birth controls do do not work for fat people because so many trials exclude fat people from them as like from the get-go. And so we just need to be doing our best as advocates in these spaces as researchers and as clinicians to sort of push that forward as much as possible. I know that was a little bit of a punt because I don't have a solid answer for it, but I think that's us as grassroots folks can be sort of that voice.

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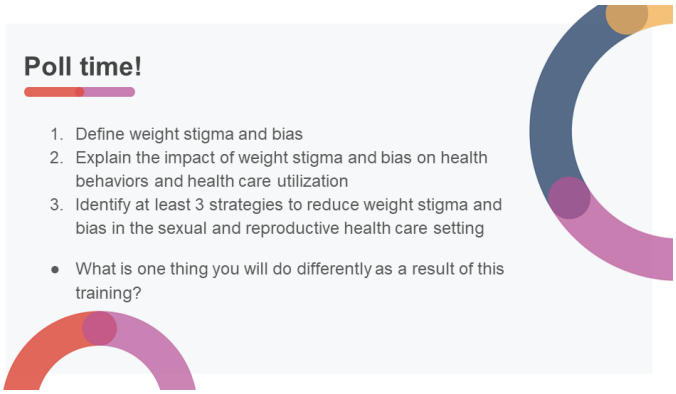

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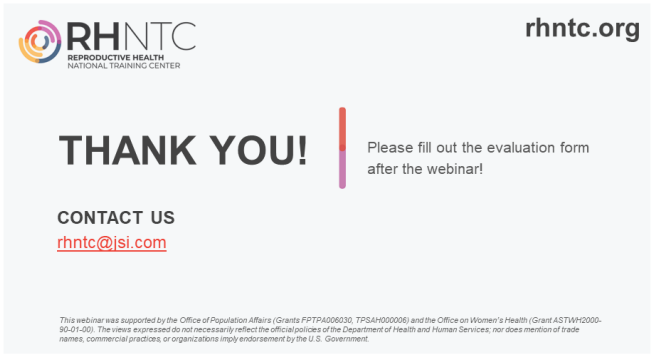

- [Amanda] Great. Thank you so much. In our last two minutes, I did just want to revisit the poll with the objectives that we set at the beginning of the session and see how if at all the group's confidence has changed. On the slide you'll see the session objectives again, and you should have seen the poll pop up. So we are asking again, using that one to five scale your confidence as it relates to each of the session objectives. And you'll also notice an additional open-ended question at the bottom, question four. We want to know how you're thinking of putting into action what you learned today. So, please respond to the poll questions that you see. We're going to leave that poll open. I know it might take some time, particularly for the open-ended question. And as you are continuing to weigh in via the poll, I want to thank you all so very much for joining us today and I hope you will thank me through emojis or virtual reactions in thanking our speakers, Ragen and Jeff. As a reminder, we'll have the materials from today's session available within the next few days.

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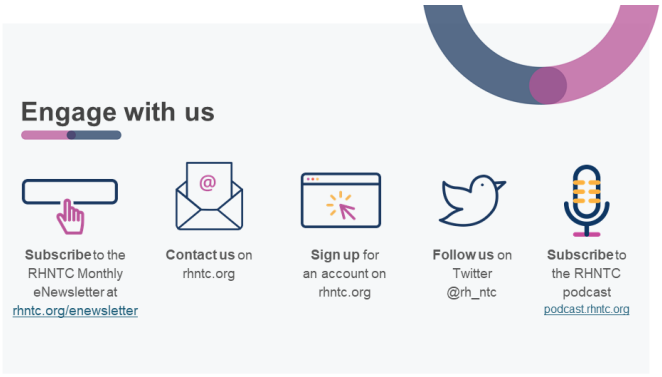

If you do have additional questions for the RHNTC on this topic, please don't hesitate to email us at rhntc@jsi.com. We have one more ask of you, and again, we had chatted the evaluation link at the beginning of the session and we will chat it again now. Please complete this evaluation with, or sorry, the evaluation will appear when you leave the webinar. My apologies. The evaluation link will also be emailed to you after the webinar. We love getting your feedback and we use it to inform future sessions. In order to obtain a certificate of completion for attending this webinar, you do have to be logged in to rhntc.org when you complete the evaluation. And lastly, to stay in touch, subscribe to our newsletter by visiting rhntc.org/newsletter. Contact us through our website, sign up for an account on our website, follow us on Twitter. And finally subscribe to our podcast at podcast.rhntc.org in your favorite podcast app. Whew. I think we can go and end the poll and take a quick peek. I know we're at the top of the hour, so I do want to thank you all again. And just a quick scroll does seem like confidence to define the topics shows an improvement since the beginning of the session, as well as confidence explaining the impact, and it looks like folks are walking away with some strategies that they can identify. So again, thank you all for joining. Thank you to our presenters. And we will hope to see you soon at the RHNTC.