



An examination of weight bias among treatment-seeking obese patients with and without binge eating disorder[☆]

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ABSTRACT

Objective: The objective was to compare weight-bias attitudes among treatment-seeking obese patients with and without binge eating disorder (BED vs. NBO) and to explore racial and sex differences and correlates of weight-bias attitudes.

Method: Participants included 221 obese patients (169 female, 52 male) seeking treatment for weight and eating, recruited through primary care settings; of these, 168 patients met BED criteria. Patients completed semi-structured interviews and psychometrically established self-report measures of attitudes about obesity, eating pathology and depression.

Results: Main effects for group (BED vs. NBO) and race (White vs. African American) were significant. Patients with BED had significantly higher levels of negative attitudes towards obesity than NBO patients, while African American patients had significantly lower levels of weight bias than did White patients. Greater negative attitudes towards obesity were significantly correlated with higher levels of depression and eating pathology for all patients.

Conclusions: Endorsement of negative weight bias was related to binge eating status, race, disordered eating, and depression. Primary care providers should be aware of weight biases among their patients.

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1. Introduction

Obesity rates have dramatically risen to epidemic proportions in the United States [1] and globally [2]. In addition to being at heightened risk for numerous medical [3] and psychological [4] comorbidities, obese individuals also face pronounced weight bias in multiple life domains [5]. A considerable research literature documents the pervasiveness of negative weight bias across areas including, but not limited to, education, workplace, and even health care settings [5,6]. For example, among health care providers, nurses [7], primary care physicians [8], mental health professionals [9], family physicians [10] and even those specializing in obesity treatment and research [11] demonstrate negative weight bias towards obese patients.

Such widespread stigma is concerning as experiencing weight bias from others is related to a number of negative psychological outcomes, such as greater depression, body image dissatisfaction, general psychiatric symptoms, poorer self-esteem and eating distur-

bances such as binge eating behaviors [12,13]. Recently, more attention has been devoted to examining weight-bias attitudes specifically within groups of obese persons. Contrary to theories postulating that individuals perceive their in-group with positive regard [14], those who are obese tend to report negative weight bias towards other obese individuals as well [15]. Interestingly, obese individuals who endorse negative weight bias about other obese people also report greater general psychiatric symptoms [12]. Due to widespread, commonly accepted stigma towards obesity, it has been speculated that some obese individuals may internalize weight biases, potentially leading to adverse sequelae [16], including binge eating [17].

It may be important to investigate negative weight bias on the subgroup of obese individuals who also have binge eating disorder (BED). BED, a formal diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* [18], is defined by recurrent binge eating (eating unusually large amounts of food while experiencing a sense of loss of control), marked distress and the absence of inappropriate weight compensatory behaviors (such as self-induced vomiting) that characterize bulimia nervosa. BED is a prevalent problem associated with obesity and increased medical and psychiatric comorbidity and psychosocial impairment relative to obese persons without BED [19,20] and with increased health care utilization particularly in generalist medical settings [21,22]. Little is known about weight-bias attitudes among obese patients with BED, including whether they differ from obese patients who do not binge

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eat. The heightened distress and body image concerns characteristic of obese patients with BED relative to non-binge-eating obese patients [19] suggests the logic of examining their attitudes regarding obesity.

To date, only a few studies have examined weight bias in association with BED [16,23,24]. Greater internalized weight bias was associated with greater fat phobia, depression, eating disorder pathology and lower self-esteem among obese treatment-seeking patients with BED [16]. Only two small studies, however, have specifically compared negative attitudes towards obesity between obese individuals with and without BED [23,24]. Findings from a preliminary study suggested that treatment-seeking obese patients with BED and age-matched and body mass index (BMI)-matched obese persons without BED recruited from a non-commercial weight loss support group organization did not differ significantly in their attitudes towards obesity [23]. Puhl et al. [23] also reported that negative attitudes towards obesity were not significantly associated with eating disorder pathology although they were negatively associated with self-esteem and positively associated with depression. Similar findings were reported for a treatment-seeking sample of obese Hispanic patients with and without BED [24]. The small sample sizes and the different recruitment methods used to obtain the treatment-seeking BED and non-BED obese controls [23] limit generalizability of the findings and indicate the need for larger studies that utilize similar recruitment methods.

Even less is known about sex and racial differences in weight bias among obese individuals who binge eat despite high rates of obesity and binge eating among both men and women [25] and across minority groups [22,26]. As noted above, Puhl et al. [24] compared attitudes towards obesity in BED and non-BED within Latinos but could not address sex or ethnic/racial variation. Puhl et al. [23] observed no significant differences in anti-obesity attitudes by ethnicity/race within the small BED group and could not examine this in their non-BED group that was primarily White. Examining weight bias by race and sex is important, given the well-established ethnic/racial and sex differences [27,28] in body image, which may influence attitudes towards obesity. Although it is recognized that weight bias is associated with a number of adverse sequelae [12], it is unknown whether this relationship is exacerbated for women, men or those who identify with particular racial groups. As such, further investigation of both sex and ethnic/racial variations in weight-related bias is indicated.

Overall, major gaps in the literature include the scarcity of research on weight bias, race and sex among obese individuals with BED. Research with larger samples and more relevant comparison groups is needed to explore further whether weight bias differs as a function of disordered eating pathology among treatment-seeking obese individuals. If weight biases are stronger among those with BED, this may have important implications for BED prevention and treatment interventions. Thus, the purpose of the present study was to examine weight bias in a diverse sample of treatment-seeking obese men and women with and without BED.

2. Methods

2.1. Participants

Participants included 221 obese (BMI \geq 30) treatment-seeking patients with and without BED, recruited similarly using flyers placed in local primary care offices in an urban setting. The flyers recruiting individuals with BED included advertisements offering treatment for binge eating or compulsive eating and weight loss; the flyers recruiting obese individuals without BED included advertisements offering treatment for weight loss. The BED group consisted of individuals who met DSM-5 criteria for BED except that the stricter duration criteria of 6 months from the *Diagnostic and Statistical*

Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) were used. The BED group ($n=168$) consisted of 126 (75%) women and 42 (25%) men, with an average age of 46.57 years (S.D.=10.61) and BMI of 37.85 (S.D.=5.12). They identified themselves as the following races: 45.2% ($n=76$) White, not Hispanic; 13.7% ($n=23$) White, Hispanic; 32.1% ($n=54$) African American, not Hispanic; 1.8% ($n=3$) African American, Hispanic; 2.4% ($n=4$) Asian American; 0.6% ($n=1$) American Indian/Native Alaskan; 0.6% ($n=1$) Indian Caribbean; 1.2% ($n=2$) multiracial; 1.8% ($n=3$) considered themselves “other”; and 0.6% ($n=1$) was missing information. The comparison group consisted of 53 obese individuals who did not regularly binge eat and comprised 43 (81%) women and 10 (19%) men, with an average age of 49.66 years (S.D.=9.95) and BMI of 35.88 (S.D.=5.20). They identified themselves ethnically/racially as follows: 66.0% ($n=33$) White, not Hispanic; 5.7% ($n=3$) White, Hispanic; 26.4% ($n=14$) African American, not Hispanic; 1.9% ($n=1$) African American, Hispanic; 1.9% ($n=1$) Asian American; and 1.9% ($n=1$) bi/multiracial.

2.2. Procedures

Assessment procedures were performed by trained master- and doctoral-level research clinicians. Exclusion criteria included pregnancy or breastfeeding, current anti-depressant therapy (for the BED patients only), medical conditions (heart disease, liver disease, uncontrolled hypertension, hypothyroidism or diabetes) or certain severe psychiatric illnesses (e.g., bipolar disorder) requiring alternative treatments. BED diagnosis was based on the Structured Clinical Interview for DSM-IV Axis I Disorders, Patient Edition [29] and the Eating Disorder Examination (EDE) [30]. Participants' height was measured using a tape measure, and weight was measured using a high-capacity digital scale. Study procedures were approved by the institutional review board and all participants provided written informed consent. Participants completed the interview and self-report measures described below.

2.3. Measures

The *Eating Disorder Examination (EDE)* [30] is a semi-structured investigator-based interview for assessing eating disorders. The EDE focuses on the previous 28 days, except for the diagnostic items that are rated per durations stipulated in the *DSM-IV-TR*. The EDE assesses the frequency of different forms of overeating, including objective bulimic episodes (defined as unusually large quantities of food with a sense of loss of control) that correspond to the *DSM*-based definition of binge eating episodes. The EDE also comprises four subscales: Dietary restraint, Eating concern, Weight concern, Shape concern and an overall Global score. The items for the four EDE subscales are rated on a seven-point forced-choice format (0–6), with higher scores reflecting greater severity or frequency. The EDE has demonstrated good inter-rater and test-retest reliability in diverse groups, including BED [31].

Attitudes Towards Obese People (ATOP) [32] Scale is a 20-item measure that assesses individuals' stereotypical views regarding obese people. Patients responded to questions such as, “Most obese people are more self-conscious than other people” on a Likert scale ranging from -3 (*I strongly disagree*) to $+3$ (*I strongly agree*). Scores range from 0 to 120, with higher scores indicating more positive views of obese individuals. The ATOP has been found to be reliable in similar groups [33].

The Beck Depression Inventory-II (BDI) [34] is a 21-item version that assesses current depression level and symptoms of depression. It is a widely used and a well-established measure with excellent reliability and validity [35]. Higher scores reflect higher levels of depression and, more broadly, negative affect and are an efficient marker for broad psychopathology [36].

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