Addressing Weight Bias in a Clinical Psychology Training Program

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INTRODUCTION

• The prevalence of weight discrimination has increased by 66% over recent decades (Andreyeva et al., 2008)
• Comparable to discrimination based on race and age (Puhl et al., 2008)
• Weight stigma is an almost daily experience for many higher body-weight people (Vartanian et al., 2014)
• Influences experiences and outcomes across a range of life domains, including health care (Phelan et al., 2015; Puhl & Heuer, 2009; Spahihloz et al., 2016)
INTRODUCTION

• Medical doctors and medical students exhibit implicit and explicit weight prejudice (Phelan et al., 2014; Sabin et al., 2012)

• Experience negative emotional reactions (e.g., disgust) to the appearance of higher body-weight patients (Foster et al., 2003)

• Clinical psychologists assign more negative psychological symptoms, diagnostic judgments, and prognoses to higher body-weight patients (Davis-Coelho et al., 2000; Young & Powell, 1985)

• Among eating disorder specialists, weight bias is associated with expressing negative attitudes and frustrations about treating higher body-weight patients (Puhl et al., 2014)

INTRODUCTION

• Weight bias is a neglected issue in mental health training

• Weight bias is difficult to reduce (Danielsdottir et al., 2010; et al., 2014)

• Only a few studies have examined the efficacy of educational weight bias reduction interventions among health professionals or trainees (e.g., Kushner et al., 2014; Poutschi et al., 2013; Swift et al., 2013)

• To my knowledge, none have focused on mental health specialists

• However, training activities that provide information about weight bias, emphasize the complexity of weight, and include intergroup exposure may help to reduce weight bias among mental health professionals
PURPOSE OF STUDY

• Unique opportunity to integrate teaching and research interests

• What is the efficacy of a weight bias seminar taught to clinical psychology graduate students, interns, and postdocs?

• Expect that the weight bias seminar would influence trainees’ weight and health beliefs and anti-fat attitudes in less stigmatizing ways

METHOD

• Participants: 45 clinical psychology trainees (28 women; 28 White/Caucasian; M age 28 years; 12 self-perceived higher body-weight)

• Completed surveys one week before and one week after the weight bias seminar
METHOD: WEIGHT BIAS SEMINAR

1. What is ‘obesity’? Objective: Challenge assumptions
2. What is weight bias? Objective: Demonstrate pervasiveness and harm
3. What can we do about it? Objective: Shift from weight to well-being

METHOD: MEASURES

1. Causes of Obesity (Foster et al., 2003)
   • 15 items, 1 (not at all important) to 5 (extremely important)
   • Eating and exercise (e.g., physical inactivity, overeating, high fat diet)
   • Other (e.g., genetic factors, psychological stress, insufficient sleep, weight bias)
2. Weight and Health Beliefs (developed for purpose of study)
   • 11 items, 1 (disagree strongly) to 7 (agree strongly)
   • e.g., The so-called obesity epidemic is overstated; Dieting is effective for long-term weight loss (R); Obesity causes health problems and death (R); Higher body-weight people can be healthy, and lower body-weight people can be unhealthy
3. Anti-fat Attitudes Questionnaire (Crandall, 1994; Quinn & Crocker, 1999)
   - 18 items, 1 (disagree strongly) to 9 (agree strongly)
   - Dislike (e.g., I really don’t like fat people much)
   - Willpower (e.g., Some people are fat because they have no willpower)

4. Universal Measure of Bias (Latner et al., 2008)
   - 10 items, 1 (strongly disagree) to 7 (strongly agree)
   - Social Distance (e.g., I would not want to have a fat person as a roommate)
   - Equal Rights (e.g., Special effort should be taken to make sure that fat people have the same rights and privileges as other people (R))

5. Attitudes about Treating Obese Patients (Puhl et al., 2014)
   - 16 items, 1 (strongly disagree) to 5 (strongly agree)
   - e.g., I often feel frustrated with obese patients (R)
RESULTS

**Causes of Obesity**

- **Eating and Exercise**
  - Pre-Test: *t*(44) = 3.24, *p* = .002, *d* = 0.48
  - Post-Test: *t*(44) = 2.81, *p* = .007, *d* = 0.42

- **Other Factors**
  - Pre-Test: *t*(44) = 8.70, *p* < .001, *d* = 1.35

*Photo Credit: Rudd Center Image Library*

**Weight and Health Beliefs**

- **Pre-Test**
- **Post-Test**

*Photo Credit: Stocky Bodies*
RESULTS

Anti-Fat Attitudes

<table>
<thead>
<tr>
<th></th>
<th>Pre-Test</th>
<th>Post-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dislike</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Willpower</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
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$t(44) = 2.27, p = .028, d = 0.37$
$t(44) = 5.57, p < .001, d = 0.83$

Universal Measure of Bias

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<tr>
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$t(44) = 0.44, p = .67, d = 0.07$
$t(44) = 0.97, p = .34, d = 0.15$
RESULTS

Attitudes about Treating Obese Patients

\[ t(44) = 2.82, \ p = .007, \ d = 0.44 \]

RESULTS: MEDIATION

Using MEMORE macro (Montoya & Hayes, 2017)

-1.07*

Change in Willpower

Weight Bias Seminar

-.26* (-.02)

Change in Dislike

95% CI (.0734, .3868)

\[ R^2 = .32 \]
RESULTS: MEDIATION

Using MEMORE macro (Montoya & Hayes, 2017)

Weight Bias Seminar

-1.07*

Change in Willpower

.20* (.08)

95% CI (-.2194,-.0076)

Change in Attitudes about Treating Obese Patients

R² = .15

TAKE-AWAY MESSAGE

• This study is a first attempt to bridge the divide between weight bias research and clinical psychology training
• There is a need for weight bias to be covered in mental health programs to produce culturally competent psychologists who are aware of diversity issues
• Without this knowledge, programs run the risk of training psychologists who perpetuate weight stigma and ultimately cause harm to patients
REFERENCES


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