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Patient-Centered Care for Obesity: How We Can Treat Obesity While Actively Fighting Weight Stigma and Eating Disorder Risk

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In the nutrition, obesity, and eating disorder (ED) fields, polarizing discourse exists around whether treating obesity and reducing weight stigma and ED psychopathology are mutually exclusive.^{1,2,3,4,5,6,7} The objective of this commentary was to examine and synthesize evidence surrounding the relationship between obesity treatment and weight stigma and ED risk to combat the false dichotomy that exists between treating obesity and reducing weight stigma and ED risk. First, an overview of obesity, weight stigma, and ED are introduced, followed by discussion of self-directed dieting vs evidence-based obesity treatments and their relation to factors that influence ED risk. The commentary ends with a call to action for all clinicians to promote access to evidence-based care, combat weight stigma and minimize the risk of ED development.

Obesity

Traditionally, obesity has been defined as a body mass index (BMI; calculated as kg/m^2) of >30 .^{2,8} Using this definition, obesity prevalence is high and has been rising; as of 2018, 42% of US adults are living with obesity.⁹ Disproportionate prevalence is observed among traditionally marginalized groups, including Black and Hispanic/Latinx populations and those with lower socioeconomic status (SES).^{10,11,12} Obesity is associated with adverse health outcomes, including impaired daily functioning, decreased health-related quality of life, increased stress,^{4,13} and increased risks of cardiometabolic disease and cancer.^{14,15,16,17} Additionally, as severity of obesity increases, so does the severity of health problems.¹⁸

BMI serves as a screening tool and not a diagnostic tool, as a patient's BMI does not distinguish between lean and fat mass.¹⁹ Moreover, the association between BMI and health outcomes can differ by racial and ethnic groups.¹⁹ Based on these discrepancies, a new definition has been proposed with Canadian guidelines, and the World Health Organization, defining *obesity* as the state of excess adiposity that is associated with adverse impacts to quality of life or physical health (Figure 1).^{8,20} This new definition takes a health-focused rather than a weight-focused approach, allowing for improved sensitivity to the nuance of the relationship between weight and health status. From a clinical perspective, BMI can still be a complementary piece of data when assessing whether someone has obesity, but these data alone are not enough to define obesity at the individual level. Importantly, obesity should be treated like other chronic conditions and afforded access to evidence-based and effective treatment options to improve health-related outcomes.²¹

There is debate surrounding whether obesity or weight stigma might be the true cause of adverse outcomes related to obesity,⁴ and that the previous definition of obesity erroneously prioritized BMI and weight status alone as the diagnostic criteria for obesity. Further research is needed to better understand how to operationalize this new definition of obesity when doing population level research and to examine whether this revised definition facilitates a decrease in weight stigma and bias.

Weight Stigma

Weight stigma, defined as devaluation of a person based on weight, is pervasive (Figure 1).²² Twenty-five to fifty percent of youth experience bullying due to their weight, and 13 to 32% have been discriminated against based on their weight.^{23,24,25,26,27,28,29} Among adults, estimates of weight stigma prevalence have ranged from 44% to 57%.^{30,31}

Weight stigma increases the risk of high allostatic load, psychiatric and substance use disorders, and suicidality.^{32,33,34,35} Complicating these risks, more than one-half of healthcare providers attribute overweight and obesity to a lack of willpower, reinforcing negative stereotypes³³ and dissuading people with obesity across the globe from seeking medical care.³⁶ Rather than motivating healthy behaviors, weight stigma contributes to avoidance of healthcare, healthcare inequities, increased weight gain, and EDs.^{4,22,37,38,39} Therefore, preventing weight stigma should be prioritized in health-care settings.

EDs

EDs are serious psychiatric disorders that occur across the body weight and size spectrum and include anorexia nervosa, bulimia nervosa, and binge ED (Figure 1).⁴⁰ EDs affect 8.6% of girls and women and 4.1% of boys and men at some point in their lives⁴¹ and occur across diverse racial and ethnic groups and the socioeconomic spectrum.⁴² Adverse consequences of EDs include premature death (particularly by suicide), osteoporosis, gastrointestinal issues, liver and kidney damage, hypo- and hypertension, dyslipidemia, and glucose dysregulation.^{40,43,44,45,46,47,48} A childhood history of overweight or obesity and substantial weight gain during adolescence increase risk for EDs, with increased weight concerns as a mechanism.^{49,50,51}

It is also important to note that weight stigma is a known risk factor for disordered eating.⁵² Both children and adults who experience weight stigma have an increased risk of low self-esteem and poor body image.^{52,53,54,55,56,57} The impact of weight stigma on disordered eating can be seen in children as early as elementary school.⁵⁸ Internalization of the thin ideal can moderate the relationship between experiencing weight stigma and disordered eating behavior.⁵⁹ However, more work remains to be done to establish the link between weight stigma and anorexia nervosa, bulimia nervosa, and binge ED.⁵²

Dieting VS Supervised Treatment for Obesity

Self-Directed Diets

The word *diet* has been used counterintuitively. In colloquial use, it describes self-directed efforts to lose weight by restricting the amount and/or types of food consumed. Fad diets, often oriented toward achieving appearance ideals rather than improving physical health, are often promoted in media. Cyclical in nature, these diets promise unrealistic benefits and may promote disordered eating behaviors. Early studies indicated self-directed dieting and EDs were associated; whether this relationship was causal, however, became controversial almost 2 decades ago.^{60,61,62} Strict rules about avoiding certain foods, common in self-directed diets, can lead to alternating between severe restriction and excessive food intake, promoting

subsequent weight gain after weight loss.^{63,64} These practices can result in low self-worth and stricter rules about calorie restriction.⁶⁴ This pattern mirrors symptoms observed in bulimia nervosa, some forms of anorexia nervosa, and many cases of binge ED. Thus, self-directed dieting itself can be a gateway to EDs.^{60,65,66}

Currently, self-directed dieting among patients with obesity has been implicated in increasing disordered eating behaviors and promoting development of EDs. Figure 2 presents clear distinctions between self-directed diets and supervised evidence-based obesity treatment (i.e. diets monitored and administered by health professionals) that have significant implications for increasing vs decreasing ED risk.^{7,16,17,20,60,61,62,63,64,65,66,67,68,69,70,71,72,73,74,75,76,77,78,79,80,81,82,83,84,85,86,87} Clear overlap in core features of evidence-based obesity and ED treatment in improving nutrition and body image lead to the following conclusion: treating obesity and reducing weight stigma and ED psychopathology are not mutually exclusive.

Supervised evidence-based Obesity Treatment

In contrast to self-directed diets, which often promote reaching an “ideal” body size by implementing overly restrictive changes, supervised evidence-based behavioral weight management encourages sustainable changes to promote long-term health.⁶⁷ These multicomponent interventions are based on several theories^{68,69} and incorporate dietary, activity, and behavior change strategy components. Treatment also focuses on modifying socioenvironmental factors, including stimulus control in the home environment, seeking out support networks, and active problem-solving skill development. Current behavioral treatments for obesity typically produce weight losses of 5% to 10% of initial body weight,^{21,88} and improvements are observed regarding quality of life, body image, daily functioning and mobility, and modest reductions in depression and anxiety.^{7,16,17,70,71} This level of weight loss may result in a state of weight suppression, which can increase the risk of EDs.^{89,90,91} Notably, the link between weight suppression and ED risk is mediated by increased drive for thinness, and interventions that increase body acceptance may prevent negative consequences of weight loss.^{65,92,93} Rarely, evidence-based obesity treatment can lead to, or exacerbate, pre-existing distorted or obsessive thoughts and behaviors around weight and food, which potentially increase risk of EDs (Figure 1).^{7,94} Overall, however, participation in treatment for obesity has been associated with reductions in disordered eating behaviors.^{7,71,72} Evidence-based obesity treatment is compatible with a patient-centered treatment approach as these treatments focus on improving overall health, rather than weight loss alone, and can reduce ED risk.^{20,73,74,75}

Many individuals regain weight after obesity treatment,^{95,96} leading to concern about weight cycling.^{75,97} Early research indicated patterns of weight loss and regain are associated with higher all-cause mortality and morbidity from cardiovascular disease; however, much of this research did not control for unintentional weight loss from underlying health conditions.^{98,99,100,101} More recent findings support that treatments for obesity produce significant and sustained physical and mental health improvements, despite potential weight regain, and challenge the notion that losing and regaining causes more harm

than never losing weight. ^{76,77,78,79,80,81} In fact, increased frequency of weight loss attempts when at least 5 lb were lost is associated with lower mortality than no attempt. ⁸⁰

Compatibility between Obesity Treatment and ED Treatment and Prevention

Robust analyses have demonstrated that treatment for obesity may reduce ED prevalence and risk. ^{7,72} Supervised behavioral childhood obesity treatment may have a protective effect via treatment carryover by addressing emotional eating. ^{7,71} Both meal planning and regular eating are components of obesity treatment that overlap with cognitive behavioral therapy (CBT) for EDs. ⁸² Meal planning ensures nutrient-rich foods are available when it is time to eat, mirroring efforts to identify and reduce triggers for disordered eating. Regular eating is prescribed to prevent excessive hunger, which contributes to dysregulated eating. ¹⁰²

Regular weigh-ins represent another component shared between supervised evidence-based obesity treatments and CBT for EDs. Weekly weighing replaces too frequent or complete avoidance of weighing, either of which can perpetuate disordered eating. ^{83,84,103} In individuals without EDs, self-weighing helps facilitate clinically significant weight loss without leading to ED symptoms. ^{83,84,103} Among those with EDs, being aware of weight can counteract irrational beliefs that can motivate disordered behaviors or create ambivalence about treatment. ^{102,104,105}

Treatments for obesity also emphasize improving diet quality, ^{86,87} suggesting a flexible eating style in which more nutrient-dense foods and fewer nutrient-poor, energy-dense foods are consumed, while moderately restricting caloric intake. No foods are prohibited and a balanced dietary pattern is recommended. This avoids triggering cognitive distortions linked to EDs, such as dividing foods into “good” vs. “bad.” ¹⁰⁶ This approach is identical to that used in CBT for EDs.

The few studies examining obesity treatments that assess weight stigma have all shown modest yet significant short- and long-term reductions in weight stigma. ^{59,107,108,109,110} Behavioral and CBT interventions for weight often address negative cognitions that affect self-esteem and body image, which may minimize internalized weight stigma. ^{81,111,112} For example, increasing self-efficacy by meeting behavioral goals enables a person to challenge and reject negative beliefs about one’s capabilities. ^{113,114} Furthermore, group interventions or interactions with others with similar experiences engenders camaraderie, which decreases loneliness, increases a sense of belonging (counteracting stigma), and may provide validation and support not otherwise available. ^{110,114,115,116} A recent randomized controlled trial compared changes in internalized weight stigma between a standard group weight management treatment and one that also included a weight stigma reduction intervention in a diverse sample of adults with obesity who reported a high level of weight stigma at baseline. Participants who received the weight stigma intervention reported greater reductions in aspects of weight self-stigma (i.e. self-devaluation), but internalized weight stigma was significantly reduced in both groups. ¹¹⁴ Further study of mechanisms for stigma-reduction are needed; still, these findings reveal internalized weight stigma reduces, rather than increases, with behavioral weight management treatment alone.

Summary

Shared components between supervised evidence-based obesity treatment mirror interventions for ED by including overall concepts of diet quality vs quantity, physical activity/sedentary activity, self-monitoring, and building a healthy body image. Specifically, evidence-based obesity treatments focus on improving overall diet quality and increasing the consumption of nutrient dense foods.¹¹¹ This is similar to ED interventions that promote a flexible eating style and challenge avoidance of “forbidden” foods.^{111,117} Physical activity goals in obesity treatment include increasing enjoyable activities and reducing sedentary time, which parallels recommendations in ED treatment.^{118,119} Regular self-weighing is a mainstay of evidence-based ED treatment and replaces too frequent or avoidance of weighing, either of which can perpetuate disordered eating thoughts and behaviors.^{83,84,103} Self-weighing as part of obesity treatment leads to clinically significant weight loss without resulting in adverse psychological outcomes.^{83,84,85} Finally, evidence-based obesity treatment encourages patients to participate in activities to reduce the overvaluation of weight and shape and promote self-efficacy, similar to ED interventions that promote these activities to reduce the risk of relapse.^{111,120} Thus, there are several similarities between evidence-based obesity treatment and interventions for disordered eating, dispelling the commonly believed narrative that obesity treatments can increase ED risk.

In summary, self-directed diets can promote unhealthy practices (eg, fasting or rigid food restriction) that can cause great harm.^{60,63,64,65,66} Conversely, supervised evidence-based obesity treatment improves health and reduces ED symptoms without increasing internalized weight stigma.^{7,59,77,107,108,109,110}

Call to Action

It is critical that evidence-based and compassionate care be accessible for individuals seeking treatment for obesity, EDs, and comorbid obesity and EDs. Given existing debate between obesity treatment advocates and advocates for Health at Every Size (HAES), a call to action for clinicians is issued in this section of the commentary. Suggestions described herein are guided by the Belmont principles of beneficence (ie, maximize benefits while minimizing risks) and justice (ie, equitable distribution of care).¹²¹ Health professionals should acknowledge what an intervention entails, and its range of outcomes, while respecting patients’ decisions, whether that includes a weight-related goal or not. Health professionals on both sides of the debate should aim to improve access to compassionate, evidence-based, and patient-centered care, to actively fight weight stigma, and to end diet culture by placing emphasis on health rather than weight.

Focus on Patient-centered Approaches in Obesity Treatment

Given the multiple complications of obesity, withholding evidence-based obesity treatment from patients for whom it is medically indicated and who desire it is unethical.^{122,123} A respectful, compassionate, and patient-centered approach requires a thorough review of treatment options. Treatment should be based on weight history, family history, comorbidities, ED risk, psychosocial factors, and prognosis.²⁰

A fully informed treatment decision may require conversations that reframe expectations. Due to stigma, many patients may erroneously believe that, regardless of their starting weight, they must achieve a BMI < 25 through behavioral strategies alone. Therefore, it is critical to explain the limitations of BMI as a measure of health, that some weight regain is normal after treatment for obesity if treatment is discontinued, and that long-term maintenance of reduced weight requires more effort than expended by those who have never experienced overweight and obesity. A metaphor for this pattern is the role of diet and exercise in treatment of type 2 diabetes. If patients with type 2 diabetes discontinue exercise and/or increase consumption of simple carbohydrates, an increase in blood glucose will be observed. Similarly, if behaviors incorporated in obesity treatments are stopped, weight regain is likely. Therefore, it is important for individuals to modify their shared home environment and social-environmental contextual cues to support eating, activity, and behavior changes that can be sustained in the long term.

If a patient with obesity does not wish to discuss weight status or pursue treatments for obesity, healthcare providers should respect this decision without judgment. Many other behavioral changes can improve health in the absence of weight loss, such as increases in physical activity and consumption of fruits and vegetables, and improvements in sleep and stress management. These factors can also be beneficial in prevention of future excess weight gain. Improved body image has numerous positive consequences and should be pursued regardless of body size or decisions about weight loss.

Misinformation about the nature of evidence-based obesity treatment has fueled the debate between the obesity and ED fields, largely due to limited access to treatment for each. To reduce misinformation and utilization of fad diets and other potentially dangerous weight loss strategies, evidence-based treatments for obesity need to be accessible, effective, and affordable. Despite the U.S. Preventive Services Task Force recommendation to provide behavioral treatment to youth and adults with obesity, access remains limited.^{123,124,125} Indeed, 96.4% of US adults with obesity have an unmet need for obesity care, with most individuals attempting to lose weight through self-directed dieting.¹²⁶ Furthermore, few persons with EDs receive evidence-based care.¹²⁷

Barriers to ED treatment include misperception of the severity of disorder, lack of insurance, physicians not recognizing EDs, stigma surrounding mental health, and geographical proximity to treatment.¹²⁸ Also, persons with EDs are more likely to seek and receive treatment for obesity than for EDs,¹²⁹ illustrating a clear need for providers of obesity treatment to screen for EDs and make referrals for ED treatment as needed.¹²⁹

Despite Medicaid coverage of US Preventive Services Task Force recommendations for adults, insurance coverage remains a primary barrier to treatments for both obesity and EDs.¹³⁰ The Centers for Medicare and Medicaid Services have made provisions for reimbursing obesity treatment in primary care; however, additional focus on translation to clinical care is needed^{118,131} as utilization of the benefit remains low. Moreover, little treatment guidance exists, only certain types of providers can offer services, and interpretation and implementation of Centers for Medicare and Medicaid Service guidelines vary by state.^{118,130,131,132,133} In addition, insurance coverage for childhood obesity

is lacking.¹³⁴ Access to care for obesity and EDs is especially problematic among marginalized populations. This is particularly concerning given higher obesity prevalence among Black, Hispanic, and Latinx patients and those with lower SES,¹³⁵ and that EDs do not discriminate on the basis of race or SES.^{10,41} Traditionally marginalized racial and ethnic groups and those with lower SES may receive differential treatment, have different cultural perspectives on eating and weight, and face other barriers including transportation and language.^{136,137} Furthermore, availability of weight loss information via the internet can lead to further disparities in treatment; for example, web searches done in Spanish have been found to contain more misinformation than those in English.¹³⁸ Technology, financial incentives, and cultural tailoring may improve access to evidence-based treatment.^{136,137}

Weight-based stigma and discrimination remain pervasive^{139,140,141} and highly prevalent in healthcare settings.¹⁴² Efforts to reduce weight stigma should be data-driven and initiated through broad policies such as laws against weight-based discrimination in all 50 states. A multifaceted approach to reduce weight stigma in health care provider education is essential^{143,144} to develop an understanding within health care and the general public that numerous factors beyond “self-control” affect weight. For example, training for health care providers should include nonstereotypical case examples and information about uncontrollable causes of obesity and biological and physiological challenges to weight loss and weight regain.¹⁴³ During training, contact with patients with obesity sharing their lived experience can evoke empathy.¹⁴⁵ Most of the techniques tested to reduce weight bias have been marginally effective in the short-term, so new strategies to eradicate this form of prejudice in health care are still needed. Overall, public health and clinical messages that frame weight loss as solely a matter of willpower, promote extreme dietary or exercise behaviors, or encourage weight loss for the primary purpose of changing appearance do a significant disservice to advancing effective care.

Embracing body diversity as a movement has gained widespread recognition through fat-acceptance and Health at Every Size efforts, bringing weight stigma to the forefront of the conversation.^{146,147} Respect for a diversity of body shapes and sizes by healthcare providers and society at large is needed and, for those seeking obesity treatment, conversations with health care providers should emphasize overall health rather than weight alone. This is not a new concept; as early as 1982, *The Dieter’s Dilemma: Eating Less and Weighing More* argued for replacing weight goals with health goals.¹⁴⁸ However, it clearly bears repeating given ongoing discrimination against those living in larger bodies and promotion of “quick fixes.” Rejecting diet culture may prevent internalization of unhealthy, aesthetic, Western, thin ideals and will discourage disordered behaviors.

Conclusions

Providers and researchers need to present a united front to eliminate the false dichotomy between prevention and treatment of obesity and EDs.¹⁴⁹ Using a patient-centered approach, public health complications associated with obesity and EDs can be reduced while actively fighting weight stigma at the individual and population levels. All conversations on obesity, EDs, and weight stigma should utilize person-first, compassionate, and non-stigmatizing language. The scientific community should highlight complex systems that

contribute to obesity, advocate for patients' rights to choose or refuse treatment for obesity, and promote access to evidence-based treatments.¹⁵⁰ Moreover, addressing social determinants that create barriers to care is also high priority in implementing behavioral treatments for obesity and EDs.¹⁵¹ Successful development and implementation of evidence-based behavioral obesity interventions that assess and mitigate ED prevalence and risk, while combating weight stigma, can be achieved when health care providers from the obesity and ED fields work together for the benefit of patients.

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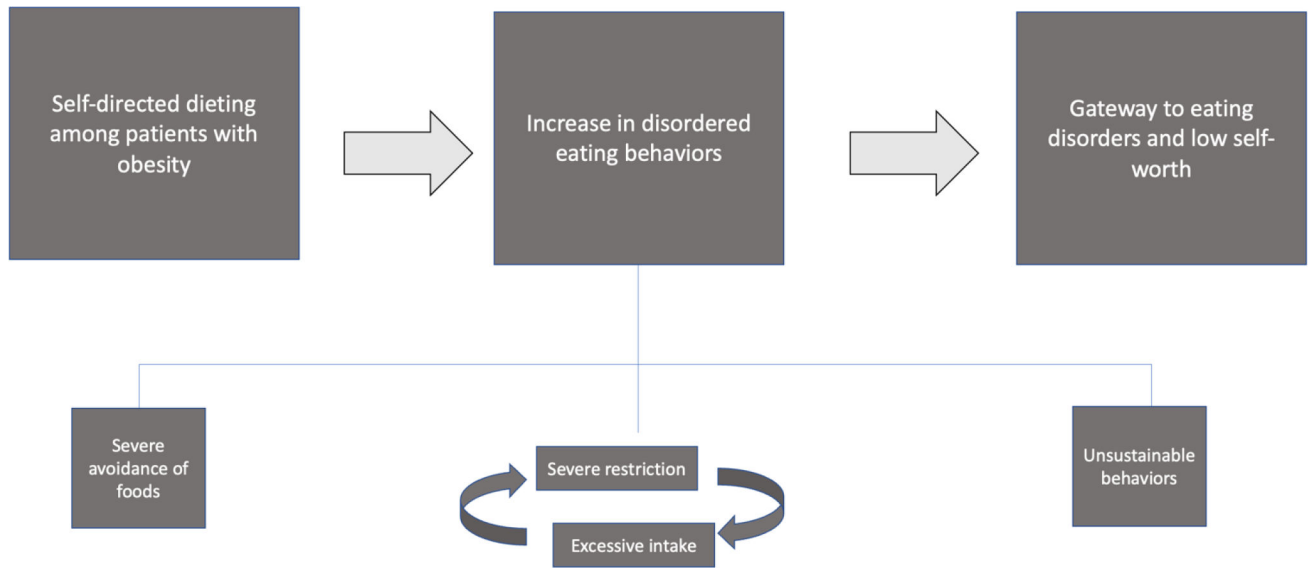


Figure 1a. The Relationship between Self-Directed Dieting and Health-Related Outcomes⁶⁰⁻⁶⁶

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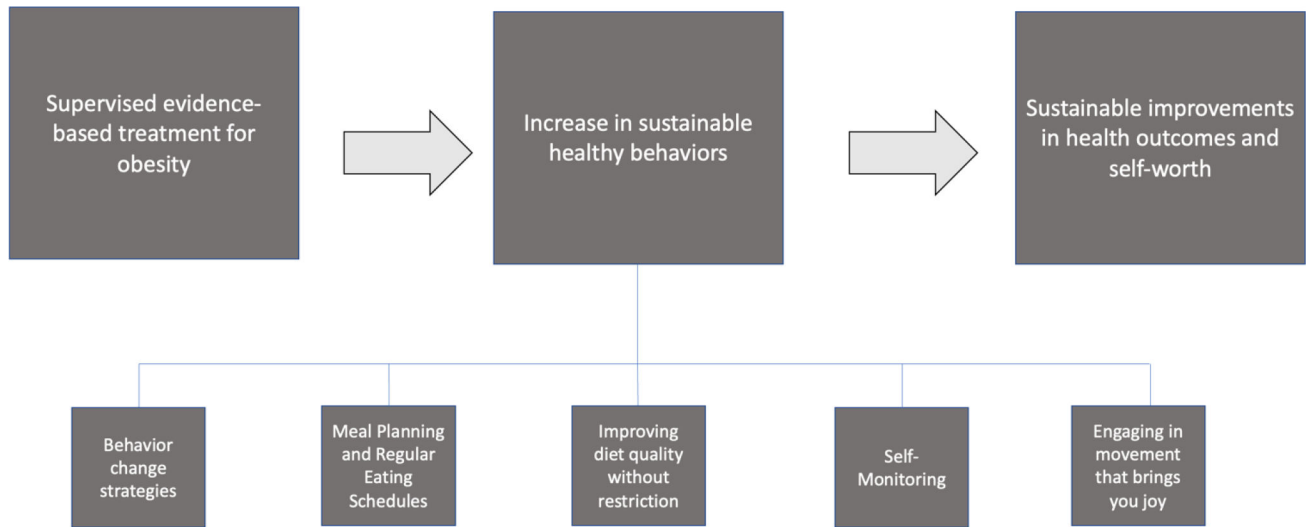


Figure 1b. The Relationship between Supervised, Evidence-based Obesity Treatment and Health-Related Outcomes^{7,16,17,20,67-87}

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Table 1:

Definitions, Comorbidities, and High-risk Populations Associated with Obesity, Weight Stigma, and Eating Disorders

	Definition	Prevalent Health Concerns ^{152,153,154}	High-Risk Populations ^{153,155,156}
Obesity	A disease defined by excess adipose tissue that is associated with adverse impacts to quality of life or physical health. ^{8,9}	<ul style="list-style-type: none"> • Cancer • Cardiovascular disease • Chronic kidney disease • Dementia • Dyslipidemia • Gastroesophageal reflux disease • Hepatobiliary disease • Hypertension • Infection • Osteoarthritis • Psychological illnesses (e.g., anxiety and depression) • Stroke • Type 2 diabetes 	<ul style="list-style-type: none"> • Individuals from lower socioeconomic status backgrounds • Middle-aged adults (i.e., 40–59 years) • Traditionally marginalized racial/ethnic groups (e.g., Non-Hispanic Black adults and Hispanic adults)
Weight Stigma	Devaluation of a person due to their body weight, shape, or size, including discriminatory attitudes, actions, or policies. ¹⁵⁷	<ul style="list-style-type: none"> • Anxiety • Depression • Eating disorders • Cardiometabolic disease risk factors (e.g., heightened inflammation)^{158,159} • Suicidal ideation 	<ul style="list-style-type: none"> • People with overweight/obesity, especially those with severe obesity (BMI of 40 kg/m²) • Women and minoritized genders
Eating Disorders	A variety of behavioral illnesses marked by frequent, extreme, unhealthy eating patterns to compensate for difficult feelings. Examples include anorexia nervosa, bulimia nervosa, and binge eating disorder. ¹⁶⁰	<ul style="list-style-type: none"> • Alcohol use disorder • Chronic pain • Generalized anxiety disorder • Hypertension • Obsessive-compulsive disorder • Phobia (e.g., social phobia) • Post-traumatic stress disorder • Type 2 diabetes • Unipolar major depression 	<ul style="list-style-type: none"> • Adolescents • People focused on body image (e.g., athletes, models, and those partaking in diet culture) • People with overweight/obesity • Women and minoritized genders

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