

Title: A Randomized Controlled Trial of Behavioral Weight Loss and Stigma-Reduction for Long-Term Weight Loss

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1. STUDY OBJECTIVE

To evaluate, in a 72-week randomized controlled trial, the efficacy of a psychological intervention to reduce weight bias internalization (WBI) on enhancing long-term weight loss.

2. BACKGROUND

2.1 The Problem of Obesity

Obesity, defined by a BMI ≥ 30 kg/m² (or ≥ 27 kg/m² with a weight-related comorbidity), is the most common nutritional disease in the United States, affecting about 36% of adults age 20 years and over. An additional 33% of American adults are overweight, as judged by a BMI of 25.0-29.9 kg/m². Obesity is associated with a number of co-morbidities including type 2 diabetes (70% of people with type 2 diabetes have obesity) and cardiovascular disease. Losing as little as 5% of initial weight improves co-morbid conditions including insulin resistance, dyslipidemia, and hypertension.

A program of diet, physical activity and behavioral therapy is the first line treatment for obesity. This approach produces significant weight loss ($\geq 5\%$) but is often followed by weight gain. Patients regain about 35% of their initial weight loss in the first year and 50% or more have returned to their baseline weight by 5 yr. It is therefore, highly desirable to identify effective interventions, which would improve long-term maintenance of prior weight loss.

2.2 Benefits of Weight loss

A 5–10% reduction in body weight in obese individuals improves several risk factors for cardiovascular disease (CVD) including blood pressure, triglyceride levels, low-density-lipoprotein cholesterol, blood glucose, and sleep apnea.¹⁻³ The Diabetes Prevention Program (DPP) revealed that a 7% reduction in initial weight, combined with 150 minutes of activity, reduced the risk of developing type 2 diabetes by 58%, compared with placebo, in at-risk overweight/obese individuals at an average of 2.8 years follow-up.⁴ Losses $\geq 10\%$ are associated with greater improvements in CVD risk factors⁵ and are more consistent with obese individuals' desired weight loss goals.⁶

2.3 Current Status of Behavioral Weight Loss Treatment for Obesity

Behavioral weight loss (BWL) treatment is the cornerstone of treatment for most obese individuals, as recommended by the NHLBI's Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults.⁷ In trials conducted in academic medical centers, persons treated by a 1200-1500 kcal/d diet, combined with regular exercise and a comprehensive program of group or individual BWL, lose approximately 7-10% of initial weight in 20-26 weeks.^{4,8,9}

2.4. Role of Physical Activity in Facilitating Long-Term Weight Loss

Physical activity is the most reliable predictor of long-term weight loss.^{9,10} Studies consistently show that participants are more likely to achieve and maintain significant long-term weight loss (e.g., $\geq 10\%$) when they engage in high levels (e.g., ≥ 200 -250 minutes per week) of physical activity.¹⁰⁻¹⁵ For example, in secondary analyses of a randomized controlled trial evaluating the effects of different doses of exercise on weight loss, Jakicic et al showed that participants who reported exercising ≥ 200 min/wk had significantly greater weight loss at month 12 (by 6.3 kg) than participants who exercised < 150 min/wk.¹³ Another study found that participants who maintained a 10% weight loss 24 months after treatment reported engaging in an average of 275 min/wk of physical activity.¹² These observational data are supported by findings from some but not all randomized trials.^{12,16}

One pathway to increasing physical activity is by boosting exercise self-efficacy. Self-efficacy – which refers to individuals' confidence in their ability to engage in goal-directed behavior – robustly predicts initiation and maintenance of health behavior change,¹⁷ including weight-loss behaviors such as adherence to diet and physical activity recommendations.¹⁸⁻²⁰ Greater weight-related self-efficacy is associated with greater short- and long-term weight loss²⁰⁻²⁴ and, in comparison to dietary self-efficacy, self-efficacy to exercise is a stronger predictor of weight loss.²⁵ Self-efficacy may naturally decrease during long-term weight-loss maintenance.²³ A recent study found that an intervention designed to increase self-efficacy (combined with standard BWL) resulted in significantly less weight regain from months 12 to 18 of follow-up than BWL alone.²⁶

2.5 Weight Stigma as a Barrier to Weight Loss

2.5.1. Weight stigma is pervasive.

The term *weight stigma* refers to societal scorn and devaluation of individuals with overweight and obesity.²⁷ This includes discrimination (e.g., being denied employment), bullying/teasing, social exclusion and avoidance (e.g., rejection from peers), and other forms of unfair treatment due to excess weight. Common stereotypes and prejudicial (or *weight-biased*) beliefs include perceptions that persons with obesity are lazy, incompetent, weak, and lacking willpower.¹¹ These beliefs lead individuals with obesity to be mistreated across multiple settings in their daily lives, including: disparagement in educational settings from students and educators; discrimination in hiring, firing, and promotions; social avoidance (e.g., on public transportation); criticism from family members, spouses, and friends; and negative representation in media.²⁸⁻³²

The high rates of obesity and overweight in the US population are accompanied by high rates of weight-based stigmatization. Estimates indicate that rates of weight-based discrimination have increased by 66% from 1995 to 2006 and, among women, are comparable to rates of discrimination based on race and age.^{33,34} Due to the pervasiveness of weight bias in daily life, some individuals may internalize stigmatizing attitudes; this occurrence is referred to as weight bias internalization (WBI), or self-directed stigma.³⁵ Internalizing stigma involves: 1) awareness of and agreement with stereotypes; 2) applying of those stereotypes to oneself; and 3) devaluing oneself due to the stigmatized trait (i.e., weight).³⁶ For example, someone who is unable to successfully maintain weight loss may attribute weight regain to laziness and weakness, and have lower self-esteem due to assigning these stereotypical characteristics to oneself.

2.5.2. Weight stigma impedes weight control.

Individuals with obesity who experience and internalize weight stigma may benefit from weight loss to improve their health, yet may face stigma-specific barriers to weight loss. In two longitudinal studies, individuals who reported experiencing weight discrimination at baseline were three times more likely to remain obese³⁷ and gained 1.7 more kg than individuals who did not report weight discrimination.³⁸ Recent studies have also illustrated that patients who have experienced and/or internalized weight stigma, in comparison to those who have not, have poorer long-term weight loss outcomes with both behavioral and surgical weight loss interventions.³⁹⁻⁴² For example, in a study of 49 adults with BMI ≥ 27 kg/m² who received behavioral weight loss (BWL) treatment, higher frequency of receiving weight-stigmatizing comments from others was associated with less weight loss and less physical activity.³⁹ In another study, participants who consciously or unconsciously endorsed negative weight stereotypes (one aspect of WBI) also lost less weight and reported less physical activity.⁴⁶ Proposed pathways for these effects include a combination of physiological stress responses that increase inflammation and appetite, and maladaptive behavioral coping responses such as increased caloric intake and avoidance of physical activity.³⁴

Acute and long-term studies have shown that weight stigma (particularly WBI) is associated with reduced self-efficacy for dietary control,⁴³ with increased caloric consumption (particularly of unhealthy foods),⁴³⁻⁴⁵ and with worse dietary adherence following bariatric surgery.⁴⁶ In addition, individuals who experience weight stigma feel more self-conscious in fitness settings and are more prone to anticipating future stigmatization in these settings, thus increasing avoidance of physical activity.⁴⁷⁻⁴⁹ In prior work, my colleagues and I have also shown associations between WBI and reduced self-efficacy to engage in physical activity, along with reduced exercise motivation and engagement.⁵⁰ In other words, if individuals with obesity believe that they are lazy and lack willpower (internalized stereotypes), they lose confidence in their ability to follow through on their physical activity goals and are, thus, less likely to engage in their planned physical activity.^{50,51}

2.5.3. Addressing weight stigma in weight loss interventions

Weight stigma-specific barriers are not addressed in current weight loss programs. As stated above, cognitive-behavioral treatments for weight loss produce clinically meaningful losses in the short-term,⁵² which reduce cardiometabolic risk.⁵³⁻⁵⁵ However, these losses are not maintained, on average, in the long-term,^{52,56} highlighting the need to develop novel treatments to sustain weight loss. Adherence to high levels of physical activity predicts long-term weight loss.⁵⁷ Given the evidence reviewed that individuals who have experienced and/or internalized weight stigma have reduced self-efficacy for and engagement in physical activity, an intervention targeting weight stigma may improve long-term weight loss.

An intervention that combines traditional BWL with a program to reduce WBI could produce clinically meaningful short- and long-term weight losses, as well as reductions in self-stigmatization. The intervention to reduce WBI is expected to increase long-term exercise self-efficacy and adherence, thus, facilitating long-term weight loss. An intervention that incorporates elements from both approaches could provide patients with multifaceted health benefits.

3. SPECIFIC AIMS

Aim 1. To test, in a randomized controlled trial, the effects of a novel 29-session cognitive-behavioral weight stigma intervention, combined with BWL (in comparison to standard BWL alone), in producing long-term weight loss (at week 72) in a total of 104 individuals with obesity who have experienced weight stigma.

H1: Patients who receive the stigma + BWL intervention will achieve significantly greater weight loss at week 72 than patients assigned to standard BWL (9% and 5% of initial weight, respectively).

Aim 2. To assess whether the stigma + BWL intervention significantly increases physical activity and self-efficacy (as compared with BWL alone).

H2: Patients who receive the stigma + BWL intervention will achieve significantly greater levels of physical activity and exercise self-efficacy at weeks 20, 46, and 72 than patients assigned to standard BWL.

Secondary Aims

3. To compare changes in cardiometabolic risk factors (e.g., metabolic syndrome) in patients assigned to the stigma + BWL intervention versus BWL alone.

H3: Patients who receive the stigma + BWL intervention will achieve significantly greater reductions in cardiometabolic risk at week 72 than patients assigned to standard BWL.

4. To evaluate changes in psychological distress (e.g., WBI) in the stigma + BWL intervention compared to BWL alone.

H4: Participants who receive the stigma + BWL intervention will have greater reductions in WBI and psychological distress at weeks 20, 46, and 72 than participants receiving BWL alone.

5. To compare short-term weight change in patients assigned to the stigma + BWL intervention versus BWL alone.

H5: Participants who receive the stigma + BWL intervention will achieve significantly greater weight loss than patients assigned to standard BWL at weeks 20 and 46.

4. STUDY DESIGN

4.1 General Design

This is a randomized controlled trial to test the effects on long-term weight loss of a novel stigma-reduction intervention combined with standard BWL treatment, as compared to BWL alone. Participants will be a total of 104 men and women seeking weight loss, ages 18 years and older, with a body mass index (BMI) of 30 kg/m² or above (or 27 kg/m² or above with an obesity-related comorbidity), a history of experiencing weight bias, and elevated levels of WBI. Participants will attend a screening visit in which they will complete a behavioral evaluation with a psychologist and a medical history that will be reviewed by a nurse practitioner or physician. Questionnaires assessing experiences and internalization of weight bias, with confirmation by interviewer assessment during the behavioral evaluation, will be used to determine whether participants meet criteria for having high levels of WBI. Eligible consenting participants will be randomly assigned to the standard BWL intervention (n = 52) or the stigma + BWL intervention (n = 52). All participants will attend weekly, 90-minute group meetings for 20 weeks (20 visits). In the stigma + BWL treatment group, 60 minutes will be devoted to BWL and 30 minutes to weight stigma. In the standard BWL treatment group, the additional 30 minutes will be devoted to sharing recipes and food preparation tips. Following 20 weeks of weight loss treatment, participants will attend group meetings focused on weight loss maintenance, monthly from weeks 21-46 (6 visits), and every-other-month from weeks 47-72 (3 visits). Maintenance sessions in the stigma + BWL group will continue to incorporate discussion of WBI and stigma-related barriers to physical activity. Assessments – which include questionnaires, blood draws, and measurements of body weight and physical activity – will occur at baseline and weeks 20, 46 (no blood draw this week), and 72. Weight will be measured at every group meeting for clinical purposes.

Other Therapy:

Participants will be expected to use medications (prescribed by their primary care providers) to control traditional cardiometabolic risk factors (e.g., hypertension, hypercholesterolemia, etc) and other co-morbid conditions. Subjects will be asked at the study's outset to keep medication dose constant throughout the study, whenever possible. Participants will be expected to have been on their medication regimen (including the dose) for 3 months prior to entering the dietary group lifestyle modification program.

5. SUBJECT SELECTION

5.1 Subject Recruitment

Participants will be recruited from advertisements in local media outlets (newspapers, radio, television), as well as flyers and public transportation in the surrounding area. Online and print media outlets at the University (such as newsletters) will also be used to advertise the study. We also will advertise the study to health care providers who work in Penn's Clinical Care Associate practices, with whom we have collaborated previously.⁵⁸

5.2 Inclusion/Exclusion Criteria

Key Inclusion Criteria

Eligible participants will be men and women ages 18 years and older. Participants must have obesity, defined as a BMI ≥ 30 kg/m² or ≥ 27 kg/m² with an obesity-related comorbidity. Obesity-related comorbidities (which confer added CVD risk) will include: coronary heart disease; other atherosclerotic disease; sleep apnea; hypercholesteremia (i.e., high cholesterol, as diagnosed by doctor and/or if taking medication to lower cholesterol); and components of the metabolic syndrome, including hypertension (SBP ≥ 130 , DBP ≥ 80 mm Hg, diagnosed by doctor and/or if taking anti-hypertensive medication); fasting blood glucose of 100-125 mg/dL (or prediabetes, diagnosed by doctor); low HDL cholesterol (<40 mg/dL in men, <50 mg/dL in women), elevated triglycerides (>150 mg/dL, i.e., dyslipidemia diagnosed by doctor or taking medication to treat dyslipidemia), or elevated waist circumference (≥ 40 in for men, ≥ 35 in for women). Eligible participants must also report a history of experiencing weight bias as assessed by self-report questionnaire and in-person interview, and have elevated levels of WBI as indicated by an average score of 4 (midpoint) or above on the Weight Bias Internalization Scale (WBIS) and by in-person interview. Participants must be seeking weight loss. If currently taking medications, dosages must be stable for at least 3 months. Participants will be eligible to participate if they exhibit mild to moderate severity of depression, anxiety, or binge eating disorder, as determined by the behavioral evaluation and the screening measures (Beck Depression Inventory-II and Questionnaire for Eating and Weight Patterns; see below for details). Elevated WBIS scores are often associated with these variables.¹⁹ Participants taking anti-depressant medication will be eligible if their dose has been stable for a minimum of 3 months.

Eligible female patients will be:

- non-pregnant and non-lactating
- surgically sterile or postmenopausal, or they will agree to continue to use a method of birth control during the study

Participants must:

- have a PCP who is responsible for providing routine care
- have reliable telephone service and/or email access with which to be in contact with the study team
- understand and be willing to comply with all study-related procedures and agree to participate in the study by giving written informed consent

Key Exclusion Criteria:

Applicants will be excluded if they have: a diagnosis of type I or II diabetes (for type II diabetes, blood glucose ≥ 126 mg/dL or A1C ≥ 6.5); uncontrolled hypertension (blood pressure $\geq 160/100$ mm Hg); experienced a cardiovascular event (e.g., stroke, myocardial infarction) in the last 12 months; lost and maintained $\geq 5\%$ of their initial weight in the last 3 months or $\geq 10\%$ in the past 2 years; or have participated in individual or group psychotherapy related to weight in the last 3 months (due to the potentially confounding effects of receiving a simultaneous cognitive-behavioral intervention). Participants who have recently received or are currently receiving therapy for a pre-existing mental health issue unrelated to weight (e.g., psychotherapy for

depression or anxiety, or marriage, grief, or career counseling) may be eligible if the therapy is deemed by the Principal Investigator to be unlikely to affect weight, eating habits, or physical activity. Applicants with *severe* symptoms of mood (BDI-II score ≥ 29), anxiety, or binge eating disorder, and any severity of thought or substance use disorders will not be accepted into the study, as these symptoms may interfere with individuals' ability to adhere to a weight loss program. Clinician judgment will be used to determine severity of mood disorder symptoms independent from obesity-related concerns and complications (e.g., fatigue), and decisions about applicants' eligibility based on psychiatric symptoms will fall within the Principal Investigator's discretion. Individuals with bulimia nervosa will not be eligible to participate, because weight loss may be contraindicated. Applicants with current, active suicidal ideation, and/or a suicide attempt within the past year will be excluded from the study and referred to psychiatric treatment facilities in the greater Philadelphia area. Applicants will not be eligible if they have a history of bariatric surgery. Women who are nursing, pregnant, or planning to become pregnant in the next 16 months are not eligible to participate. Applicants who report obtaining 150 minutes or more of structured physical activity per week (e.g., 30 minutes 5 days per week) will not be eligible, as they will already be obtaining the recommended amount of physical activity and may not be able to further increase their activity as part of the study.

6. STUDY PROCEDURES

6.1 Screening Procedures

All applicants will be screened by phone to determine whether they potentially meet eligibility criteria. We will obtain a waiver of written documentation of consent for the telephone screen. Those who remain interested in the trial will be scheduled for an in-person interview. The Weight and Lifestyle Inventory (WALI), an assessment of general eating and lifestyle behaviors, the Weight Bias Internalization Scale (WBIS), and the Beck Depression Inventory (BDI) will be mailed or emailed to eligible participants following the phone screen and completed by them prior to their screening/informed consent visit. The in-person interview will be conducted by a psychologist, who will obtain informed consent and evaluate participants' behavioral eligibility (i.e., willingness and appropriateness to participate). This will include our assessment of the applicant's mood (as measured by interview and the BDI) and suicidality (including history of suicidal ideation and behavior).

Applicants who remain interested and pass this portion of the assessment will proceed to provide a medical history, which will be reviewed by the study physician or nurse practitioner to determine medical eligibility. Medical eligibility will be confirmed with blood test results. Applicants with a history of cardiac events or other significant CVD risk factors may also be asked to provide written verification from their primary care physician stating that they are healthy enough to participate in a weight loss program.

Following completion of the screening visit, applicants will be required to complete food records for one week. Applicants will be provided with booklets or assisted in downloading a free mobile app to monitor their food intake over the course of the week. Applicants must return their completed food records (via mail or email) before being provisionally accepted into the study.

Participants will be officially accepted into the study and randomized during a subsequent randomization visit that will occur within one month of beginning the study intervention.

6.2 Study Visits

Screening visit. The following procedures will be completed at the screening visit as discussed above: informed consent, medical history, weight, height, and meeting with psychologist whose assessment will be used as a part of determining the subject's eligibility for the study. This medical history will be reviewed by the study physician or nurse practitioner determine whether there are any contraindications to weight loss. These contraindications include but are not limited to: any major active kidney, liver, cardiovascular, or cerebrovascular disease; type 2 diabetes; or the use of any medications that significantly affect weight (weight loss or weight gain, including steroids). Female participants will be ineligible for the study if they are pregnant or nursing. Applicants with a history of cardiac events or other significant CVD risk factors may also be asked to supply a letter from their primary care physician providing medical clearance for them to participate in this study. Applicants will be required to monitor their food intake following the screening visit and return their food records before being provisionally accepted into the study.

Randomization visit. Within one month of the start of the group intervention, participants will attend a visit in which their weight will be measured and, if they still meet all study criteria, they will be randomized to their treatment group. Accelerometers will be given to participants to monitor their activity for 7-10 days. Participants will return their accelerometers in person, at which time their activity for the past week will be assessed with a structured interview.

BWL intervention. Participants in this group will be provided with 20 weekly BWL sessions, based on the Diabetes Prevention Program (DPP) manual,⁵⁹ followed by 6 monthly weight loss maintenance sessions and 3 every-other-month sessions (for a total of 29 visits over 72 weeks). A diet of 1200-1499 calories per day will be prescribed for participants < 250 lb, and 1500-1800 for those ≥ 250 lb.^{59,60} Participants will be instructed to eat a balanced deficit diet with approximately 15-20% of kcal from protein, 20-35% from fat (less than 10% from saturated fat), and the remainder from carbohydrates.⁵⁹ Session topics during the first 20 weeks will include self-monitoring, stimulus control, slowing eating, social support, cognitive restructuring, portion sizes, and goal-setting.⁵⁹ Those during weeks 21-72 will focus on continued self-monitoring and skills required for weight loss maintenance and relapse prevention. BWL sessions will last 60 minutes, with an additional 30 minutes devoted to discussing recipes and food preparation.

Physical activity will be prescribed at a level consistent with data showing that ≥250 min/wk is associated with improved long-term weight loss.^{12-14,61} Activity will begin at week 2 with 60 min/wk, and will gradually progress by 10 minutes over 2-4 week intervals until achieving 150 min/wk by week 20, 200 min/wk by week 46, and 250 min/wk by week 72. Participants will be instructed to spread the 150-250 minute doses of activity equally across at least 5 days, and to accumulate their structured physical activity in bouts that are ≥10 minutes in duration. Moderate intensity will be prescribed with an emphasis on walking; the vast majority of our research participants self-select this form of activity.

Stigma + BWL intervention. Participants in this group will receive the same BWL program described above, which will be combined with a stigma-reduction intervention. During the initial 20 weeks, the 60-minute BWL sessions will be followed by 30 minutes devoted to stigma-related content. Session topics will be based on those tested in a previous pilot study, including: psychoeducation about weight and weight stigma; challenging myths and cognitive distortions

related to weight; strategies for coping with instances of stigma; and increasing empowerment and body esteem. The effects of weight stigma on health behaviors will be discussed, and sessions will focus specifically on helping participants overcome stigma-related barriers to physical activity. For example, they will be given strategies to cope with anticipated stigma while exercising in public spaces (e.g., while walking), as well as to challenge self-critical beliefs (e.g., that they are lazy) which may otherwise lead them to avoid exercising. These concrete strategies, along with reducing WBI and improving self-confidence, are intended to increase participants' self-efficacy for and engagement in physical activity. In the monthly and every-other-month weight loss maintenance sessions from weeks 21-72, strategies for coping with weight stigma and challenging internalized beliefs will be reviewed, and participants will be encouraged to use these strategies specifically with physical activity.

Outcome assessment visits

Participants will be expected to attend 4 assessment visits throughout the course of the study: at baseline, week 20, and week 72. Three of these assessment visits (baseline, week 20, and week 72) will include a fasting blood test, which will include a complete blood count (CBC), comprehensive metabolic panel (CMP), thyroid-stimulating hormone (TSH), lipid panel, insulin, high sensitivity C-reactive protein (hs-CRP), and hemoglobin A_{1c}. These tests will require approximately 1 tablespoon (i.e., 15 mls) of blood. Blood pressure, pulse, and waist measurement will also be measured at these outcome assessment visits, and weight will be measured at all assessment visits.

Participants will also be asked to monitor their physical activity and complete questionnaires at baseline, week 20, week 46, and week 72. Questionnaires will be completed online or administered/returned via mail or at scheduled group sessions. Accelerometers will be administered at scheduled group sessions and returned in person, with an accompanying brief interview to assess activity over the past week.

6.3 Outcome Measures

Primary outcome. Percent weight loss from baseline to week 72 is the study's primary outcome. At week 72, participants in the stigma + BWL intervention are predicted to maintain their 9% reduction in initial weight, as compared to a significantly smaller 5% reduction in the BWL alone group. Duplicate measures of height (with a wall-mounted stadiometer; Veeder-Root, Elizabethtown, NC) will be obtained at screening, and weight (with a digital scale; Detecto, model 6800A) will be measured at screening, randomization (baseline), and at weeks 20, 46, and 72. Weight will also be measured at all group sessions. Percent weight loss from baseline to weeks 20 and week 46 will be assessed as secondary outcomes, along with categorical weight loss at weeks 72, 46, and 20 (loss of $\geq 5\%$ and $\geq 10\%$ of initial body weight at each time point). Participants in the BWL group are predicted to lose 8% of their initial weight at week 20. Participants in the stigma + BWL group are expected to lose 1% more of their initial weight (9%) at week 20 due to greater engagement in physical activity.

Secondary outcomes.

Physical activity. All participants will be given triaxial accelerometers (ActiGraph GT9X) to wear on their waist for a 1-week period within 2 weeks of each assessment period (baseline and weeks 20, 46, and 72). Accelerometry has been used in numerous clinical trials,⁶²⁻⁶⁵ and the ActiGraph to be used in this study was adopted in the 5-year extension of the Look AHEAD study. Established activity counts will be used to identify thresholds of physical activity (sedentary, light, moderate, vigorous).⁶⁶ Self-reported physical activity will be assessed with the Paffenbarger

Physical Activity Questionnaire⁶⁷ to obtain specific information on the types of activity participants engage in, and a brief questionnaire used in prior studies⁶⁸ to collect data on sedentary behavior. Self-efficacy will be assessed with the Self-Efficacy for Exercise Scale⁶⁹ Exercise Outcome Expectations and Barriers Scale (perceived barrier items only),⁷⁰ and Weight and Lifestyle Efficacy (WEL),⁷¹ which measure individuals' confidence in their ability to overcome barriers to exercising and controlling their weight. Greater physical activity by objective and self-report assessment is expected in the stigma + BWL intervention vs. BWL alone group at weeks 20, 46, and 72. Based on prior research,¹³ we predict that participants in the stigma + BWL group will engage in approximately 250 min/wk of physical activity at week 72, as compared to approximately 150 min/wk in the BWL alone group, thus contributing to the 4% difference in weight loss at week 72.

Cardiometabolic risk. Blood pressure, waist circumference, and blood samples (measures: triglycerides, cholesterol, and glucose) will be obtained at screening and weeks 20 and 72 to assess changes in cardiometabolic risk factors, particularly in the components and diagnosis of metabolic syndrome. Blood pressure will be measured using an automated Dinamap monitor (Johnson & Johnson, XL model 9300) at three, 1-minute intervals after ≥ 5 minute rest, using measures described previously.⁷² Waist circumference will be measured (to the nearest 0.1 cm) in duplicate with flexible tension-controlled measuring tape midway between the iliac crest and lowest rib. Blood samples will be drawn after an overnight fast to obtain plasma glucose levels and a lipid panel (triglycerides and HDL cholesterol), along with inflammatory markers of cardiometabolic risk (e.g., C-reactive proteins). Samples will be sent to Quest Diagnostics (Horsham, PA) for analysis, and duplicates will be stored in a -80°C freezer. Additionally, the study nurse practitioner or physician will review current medication use. Improvements in triglycerides, high density lipoprotein (HDL) cholesterol, and glucose are expected at week 20 in both treatment groups because of acute weight loss and calorie restriction. Due to higher levels of physical activity, greater weight loss, and reduced WBI, the magnitude of improvement is expected to be greater in the stigma + BWL intervention vs. BWL alone group at week 72.

Weight bias coping and internalization. Participants will complete the WBIS (described previously) at screening and weeks 20, 46, and 72. Participants will also complete additional measures of stigma, quality of life, stress, and depression at randomization and all subsequent assessment times. Stigma questionnaires will include the Weight Self-Stigma Questionnaire (WSSQ; an alternative measure of WBI),⁷³ Fat Phobia Scale (a measure of stereotype endorsement),⁷⁴ and the Everyday Discrimination Scale (an assessment of unfair treatment in daily life for a variety of reasons, including weight).⁷⁵ The WBIS, WSSQ, Fat Phobia Scale, and Everyday Discrimination Scale are widely used and well validated.^{37,76-81} Additionally, an assessment of weight stigma coping strategies⁸² will be completed to assess the frequency with which participants engage in adaptive and maladaptive behaviors (e.g., exercising more vs. avoiding physical activity) in response to weight stigma. At baseline only, participants will complete the Weight Stigma Timing of Life Questionnaire to assess their history of weight-stigmatizing experiences, and the Adverse Childhood Experience Questionnaire to assess experiences of childhood trauma.⁸³ Participants will also complete the Impact of Weight on Quality of Life Questionnaire-Lite (IWQOL),⁸⁴ which contains five subscales that include items assessing distress due to weight-stigmatizing situations and weight-based discrimination. Participants will complete the Perceived Stress Scale (PSS)⁸⁵ to determine self-reported daily stress, the Questionnaire for Eating and Weight Patterns (QEWP)⁸⁶ to assess disordered eating, and the Patient Health Questionnaire (PHQ-9)⁸⁷ to assess symptoms of depression. Participants will complete the Body Appreciation Scale⁸⁸ to assess changes in body positivity. Additionally, participants will complete a brief questionnaire assessing the frequency with which they self-monitor their weight and eating (along with food records which will be collected from participants at all group meetings to assess days of recorded food intake and activity). Participants in the stigma + BWL intervention group are predicted to show greater reductions in all measures of stigma and distress than participants in the BWL group at weeks 20, 46, and 72.

6.4 Safety Measures

Risks

The risk of adverse medical or psychiatric events should be minimized by the careful screening procedures to be used. The principal risks during the group lifestyle modification program include:

Risk of gallstones. Rapid weight loss may increase the risk of gallstones. The risk of gallbladder disease will be reduced by limiting weight loss to no more than 3 pounds per week for 4 consecutive weeks. Weight loss will be monitored at all group sessions. Patients will be asked to slow or stop their weight loss if there are concerns about the rate of their weight loss.

Blood draw. Risks of drawing blood include pain, bruising at the puncture site, swelling, feeling faint or lightheaded, and rarely infection.

Psychological distress. Participants may become distressed by learning about and discussing their experiences with weight-based discrimination and stigma.

Confidentiality and loss of privacy. All efforts will be made to protect participant confidentiality and privacy. We cannot guarantee total privacy. Personal information may be given out if required by law.

Ongoing medical visits and safety measures

A physician/nurse practitioner will be available if participants notice any side effects of weight loss. Participants who report significant depression or emotional distress will be evaluated by the study's psychologist or psychiatrist and referred to their PCP for further evaluation and treatment. Participants will be referred to their PCP if their mood is significantly disrupting their normal function (as reflected by symptoms that include feeling blue, not enjoying usual activities, trouble sleeping or concentrating, or having thoughts of dying or harming oneself).

7. STATISTICAL ANALYSIS

Sample size calculation

Using a sample size equation for longitudinal clustered samples,⁸⁴ a power analysis was conducted for the **primary outcome: percent weight change at week 72**. Estimated group means, attrition rate, intraclass correlation (ICC), and variances were derived from data from prior studies conducted at our Center.⁷² Specifically, we predict a 72-week weight loss of 9% in the stigma + BWL group and 5% in the BWL group, with expected standard deviations of 7%.⁷² Based on these estimates, a baseline sample size of 104 participants (52 per group), assuming a 20% attrition rate, an ICC of .80, and 4 assessment points, will give us 80% power to detect a between-treatment group difference at week 72 of 4% (effect size: 0.57) to be significant at $\alpha = 0.05$. The power analysis was conducted using PASS v14. All secondary outcomes will be considered exploratory and will provide valuable findings that will help to inform larger studies. This study has not been powered to detect differences in changes in physical activity, cardiometabolic outcomes, or psychosocial variables.

Analysis plan

Data quality and integrity will be checked by assessing the data for missing and out-of-range values with basic statistical procedures, including univariate statistics and visual graphical displays (e.g., scatter plots). We will investigate all questions of data quality and integrity prior to performing any statistical modeling. To test the adequacy of randomization, preliminary analyses will include a comparison of all participant demographic and baseline characteristics by randomized treatment groups (t-tests or Wilcoxon rank sum tests for continuous variables and Chi-Square test or Fisher's Exact test for categorical data). If imbalances are observed, the relevant variables will be included as covariates in the final analyses.

All data will be analyzed under the intention-to-treat principle. Analyses will be two-tailed with a significance level of 0.05, and will be conducted using SPSS version 24.0 or SAS version 9.4. To assess the primary outcome of percent weight change by treatment group, a mixed effects model will be fit with Treatment Group (*stigma+BWL*, *BWL*) as a between subjects factor and Time (*Weeks 20, 46, 72*) as a categorical within-subjects factor. We will use the group x time interactions with the time main effect to estimate and test treatment group differences at each time point, with the 72-week time point as our primary test. In fitting a mixed effects model with residual maximum likelihood (REML), a variance-covariance structure must be selected. The criteria for selecting the best form of the variance-covariance structure will be based on criteria such as the Akaike's Information Criterion (AIC). We will include as baseline covariates any variables that differ significantly between the treatment groups at baseline and show significant relationships with the outcome. The results from the mixed model will be summarized by mean(SE) for each treatment group at each time point. Residual analyses will be conducted to check for outliers and influential points and violations in the normality assumption. If violations are detected, variance-stabilizing transformations will be considered.

The second primary aim of assessing changes in physical activity and self-efficacy, and the secondary aims of comparing changes in cardiometabolic risk factors and psychological well-being (including WBI), will be analyzed using the same methods as described above for the mixed effects model used for the primary aim. Changes in all outcomes will be summarized by mean(SE) for each treatment group at each time point.

8. SAFETY AND ADVERSE EVENTS

At each contact with participants, the study personnel will seek information on adverse events by specific questioning and, as appropriate, by physical examination. Information on all adverse events will be recorded immediately in the source document, and also in the appropriate adverse event module of the case report form (CRF). All clearly related signs, symptoms, and abnormal diagnostic procedures results will be recorded in the source document, though should be grouped under one diagnosis.

All adverse events occurring during the study period will be recorded. The clinical course of each event will be followed until resolution, stabilization, or until it has been determined that the study treatment or participation is not the cause. Serious adverse events that are still ongoing at the end of the study period will be followed up to determine the final outcome. Any serious adverse event that occurs after the study period and is considered to be possibly related to the study treatment or study participation will be recorded and reported immediately. All serious adverse events will be reported to the IRB within 10 working days.

9. DATA HANDLING AND RECORD KEEPING

Information about study participants will be kept confidential and managed according to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Those regulations require a signed subject authorization informing the subject of the following:

- Protected health information (PHI) collected from subjects in this study
- Who will have access to that information and why
- Who will use or disclose that information
- The rights of research participants to revoke their authorization for use of their PHI
- View of PHI will be limited to individuals at the University of Pennsylvania directly involved in the study. The company donating the study product will not have access to PHI.

In the event that a participant revokes authorization to collect or use PHI, the investigator, by regulation, retains the ability to use all information collected prior to the revocation of subject authorization. For participants who have revoked authorization to collect or use PHI, attempts will be made to obtain permission to collect at least vital status (i.e. that the subject is alive) at the end of their scheduled study period.

10. STUDY MONITORING, AUDITING, AND INSPECTING

The investigator will permit study-related monitoring, audits, and inspections by the EC/IRB, government regulatory bodies, and University compliance and quality assurance groups of all study related documents (e.g. source documents, regulatory documents, data collection instruments, study data, etc.). The investigator will ensure the capability for inspections of applicable study-related facilities (e.g. pharmacy, diagnostic laboratory, etc.).

A Data Safety and Monitoring Board (DSMB) consisting of at least one external (non-Center) reviewer will be assembled to provide additional study oversight. Members of the DSMB will meet twice per year to review the study's progress, enrollment, and de-identified group-level data for differential rates in key outcomes and Adverse Events (AEs). This team will be responsible for monitoring the safety and efficacy of this trial, executing the data safety and monitoring (DSM) plan, and complying with Public Health Service (PHS) reporting requirements. Review of the rate of subject accrual and adherence to inclusion/exclusion criteria will occur at this time.

Participation as an investigator in this study implies acceptance of potential inspection by government regulatory authorities and applicable University compliance and quality assurance offices.

11. REFERENCES

1. Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults: executive summary. Expert Panel on the Identification, Evaluation, and Treatment of Overweight in Adults. The American journal of clinical nutrition 1998;68:899-917.
2. The Diabetes Prevention Program (DPP): description of lifestyle intervention. Diabetes care 2002;25:2165-71.

3. Obesity: preventing and managing the global epidemic. World Health Organization. 2000.
4. Knowler WC, Barrett-Connor E, Fowler SE, et al. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *The New England journal of medicine* 2002;346:393-403.
5. Wing RR, Lang W, Wadden TA, et al. Benefits of modest weight loss in improving cardiovascular risk factors in overweight and obese individuals with type 2 diabetes. *Diabetes care* 2011;34:1481-6.
6. Wadden TA, Womble LG, Sarwer DB, Berkowitz RI, Clark VL, Foster GD. Great expectations: "I'm losing 25% of my weight no matter what you say". *Journal of consulting and clinical psychology* 2003;71:1084-9.
7. Jensen MD, Ryan DH, Apovian CM, et al. 2013 AHA/ACC/TOS guidelines for the management of overweight and obesity in adults. A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society. *Circulation* 2014;129:S102-S38.
8. Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults--The Evidence Report. National Institutes of Health. *Obesity research* 1998;6 Suppl 2:51s-209s.
9. Wadden TA, Webb VL, Moran CH, Bailer BA. Lifestyle modification for obesity: new developments in diet, physical activity, and behavior therapy. *Circulation* 2012;125:1157-70.
10. Jakicic JM, Otto AD. Physical activity considerations for the treatment and prevention of obesity. *American Journal of Clinical Nutrition* 2005;82:226S-9S.
11. Anderson RE, Wadden TA, Bartlett SJ, Zemel B, Verde TJ, Franckowiak SC. Effects of a lifestyle activity vs structured aerobic exercise in obese women. *JAMA* 1999;281:335-40.
12. Jakicic JM, Marcus BH, Lang W, Janney C. Effect of exercise on 24-month weight loss maintenance in overweight women. *Archives of Internal Medicine* 2008;168:1550-9.
13. Jakicic JM, Marcus BH, Gallagher KI, Napolitano M, Lang W. Effect of exercise duration and intensity on weight loss in overweight, sedentary women. *JAMA* 2003;290:1323-30.
14. Jakicic JM, Winters C, Lang W, Wing RR. Effects of intermittent exercise and use of home exercise equipment on adherence, weight loss, and fitness in overweight women: A randomized trial. *JAMA* 1999;282:1554-60.
15. Donnelly JE, Blair SN, Jakicic JM, Manore MM, Rankin JW, Smith BK. Appropriate physical activity intervention strategies for weight loss and prevention of weight regain for adults. *Medicine & Science in Sports & Exercise* 2009;41:459-71.
16. Jeffery R, Wing R, Sherwood N, Tate D. Physical activity and weight loss: Does prescribing higher physical activity goals improve outcome? *American Journal of Clinical Nutrition* 2003;78:684-9.
17. Strecher VJ, DeVellis BM, Becker MH, Rosenstock IM. The role of self-efficacy in achieving health behavior change. *Health Education Quarterly* 1986;13:73-92.
18. Linde JA, Rothman AJ, Baldwin AS, Jeffery RW. The impact of self-efficacy on behavior change and weight change among overweight participants in a weight loss trial. *Health Psychology* 2006;25:282-91.
19. Schwarzer R, Renner B. Social-cognitive predictors of health behavior: Action self-efficacy and coping self-efficacy. *Health Psychology* 2000;19:487-95.
20. Roach JB, Yadrick K, Johnson JT, Boudreaux J, Forsythe WA, Billon W. Using self-efficacy to predict weight loss among young adults. *Journal of the American Dietetic Association* 2003;103:1357-9.
21. Edell BH, Edington S, Herd B, O'Brien RM, Witkin G. Self-efficacy and self-motivation as predictors of weight loss. *Addictive Behaviors* 1987;12:63-6.
22. Dennis KE, Goldberg AP. Weight control self-efficacy types and transitions affect weight-loss outcomes in obese women. *Addictive Behaviors* 1997;21:103-16.
23. Warziski MT, Sereika SM, Styn MA, Music E, Burke LE. Changes in self-efficacy and dietary adherence: The impact on weight loss in the PREFER study. *J Behav Med* 2008;31:81-92.
24. Jeffery RW, Bjornson-Benson WM, Rosenthal BS, Lindquist RA, Kurth CL, Johnson SL. Correlates of weight loss and its maintenance over two years of follow-up among middle-aged men. *Prev Med* 1984;13:155-68.
25. Byrne S, Barry D, Petry NM. Predictors of weight loss success. Exercise vs. dietary self-efficacy and treatment attendance. *Appetite* 2012;58:695-8.
26. Burke LE, Ewing LJ, Ye L, et al. The SELF trial: A self-efficacy-based behavioral intervention trial for weight loss maintenance. *Obesity* 2015;23:2175-82.
27. Puhl RM, Brownell KD. Psychosocial origins of obesity stigma: Toward changing a powerful and pervasive bias. *Obesity Reviews* 2003;4:213-27.
28. Ata RN, Thompson JK. Weight Bias in the Media: A Review of Recent Research. *Obesity Facts* 2010;3:41-6.
29. Gortmaker SL, Must A, Perrin JD, Sobol AM, Dietz WH. Social and economic consequences of overweight in adolescence and young adulthood. *The New England Journal of Medicine* 1993;329:1008-12.

30. Puhl RM, Heuer CA. The stigma of obesity: A review and update. *Obesity* 2009;17:941-64.
31. Puhl R, Brownell KD. Bias, discrimination, and obesity. *Obesity Research* 2001;9:788-805.
32. Puhl RM, Brownell KD. Confronting and Coping with Weight Stigma: An Investigation of Overweight and Obese Adults. *Obesity* 2006;14:1802-15.
33. Andreyeva T, Puhl RM, Brownell KD. Changes in Perceived Weight Discrimination Among Americans, 1995-1996 Through 2004-2006. *Obesity* 2008;16:1129-34.
34. Puhl RM, Andreyeva T, Brownell KD. Perceptions of weight discrimination: Prevalence and comparison to race and gender discrimination in America. *International Journal of Obesity* 2008;32:992-1000.
35. Durso LE, Latner JD. Understanding self-directed stigma: Development of the Weight Bias Internalization Scale *Obesity* 2008;16:S80-S6.
36. Corrigan PW, Watson AC, Barr L. The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology* 2006;25:875-84.
37. Sutin AR, Terracciano A. Perceived Weight Discrimination and Obesity. *PLoS ONE* 2013;8.
38. Jackson SE, Beeken RJ, Wardle J. Perceived weight discrimination and changes in weight, waist circumference, and weight status. *Obesity* 2014;22:2485-8.
39. Wott CB, Carels RA. Overt Weight Stigma, Psychological Distress and Weight Loss Treatment Outcomes. *Journal of Health Psychology* 2010;15:608-14.
40. Gudzone KA, Bennett WL, Cooper LA, Bleich SN. Perceived judgment about weight can negatively influence weight loss: A cross-sectional study of overweight and obese patients. *Prev Med* 2014;62:103-7.
41. Lent MR, Napolitano MA, Wood GC, et al. Internalized weight bias in weight-loss surgery patients: psychosocial correlates and weight loss outcomes. *Obesity Surgery* 2014;24:2195-59.
42. Carels RA, Young KM, Wott CB, et al. Weight Bias and Weight Loss Treatment Outcomes in Treatment-Seeking Adults. *Annals of Behavioral Medicine* 2009;37.
43. Major B, Hunger JM, Bunyan DP, Miller CT. The ironic effects of weight stigma. *Journal of Experimental Social Psychology* 2014;51:74-80.
44. Schvey NA, Puhl RM, Brownell KD. The Impact of Weight Stigma on Caloric Consumption. *Obesity* 2011;19:1957-62.
45. Durso LE, Latner JD, Hayashi K. Perceived Discrimination is Associated with Binge Eating in a Community Sample of Non-Overweight, Overweight, and Obese Adults. *Obesity Facts* 2012;5:869-80.
46. Raves DM, Brewis A, Trainer S, Han S, Wutich A. Bariatric surgery patients' perceptions of weight-related stigma in healthcare settings impair post-surgery dietary adherence. *Frontiers in Psychology* 2016;7:1497.
47. Seacat JD, Mickelson KD. Stereotype threat and the exercise/dietary health intentions of overweight women. *Journal of Health Psychology* 2009;14:556-67.
48. Vartanian LR, Shaprow JG. Effects of weight stigma on exercise motivation and behavior: a preliminary investigation among college-aged females. *Journal of Health Psychology* 2008;13:131-8.
49. Vartanian LR, Novak SA. Internalized societal attitudes moderate the impact of weight stigma on avoidance of exercise. *Obesity* 2011;19:757-62.
50. Pearl RL, Puhl RM, Dovidio JF. Differential effects of weight bias experiences and internalization on exercise among women with overweight and obesity. *Journal of Health Psychology* 2015;20:1626-32.
51. Hubner C, Baldofski S, Zenger M, et al. Influences of general self-efficacy and weight bias internalization on physical activity in bariatric surgery candidates. *Surgery for Obesity and Related Disorders* 2015;11:1371-6.
52. Wadden TA, Cramer CE, Brock J. Behavioral Treatment of Obesity. *Psychiatric Clinics of North America* 2005;28:151-70.
53. Wing RR, Lang W, Wadden TA, et al. Benefits of modest weight loss in improving cardiovascular risk factors in overweight and obese individuals with Type 2 Diabetes. *Diabetes Care* 2011;34:1481-6.
54. Lavie CJ, Milani RV, Ventura HO. Obesity and cardiovascular disease: Risk factor, paradox, and impact of weight loss. *Journal of the American College of Cardiology* 2009;53:1925-32.
55. Group TLAR. Long term effects of a lifestyle intervention on weight and cardiovascular risk factors in individuals with type 2 diabetes: Four year results of the Look AHEAD trial. *Archives of Internal Medicine* 2010;170:1566-75.
56. Jeffery RW, Epstein LH, Wilson GT, et al. Long-term maintenance of weight loss: Current status. *Health Psychology* 2010;19:5-16.
57. Wing RR, Phelan S. Long-term weight loss maintenance. *The American Journal of Clinical Nutrition* 2005;82:2225-55.
58. Wadden TA, Volger S, Sarwer DB, et al. A two-year randomized trial of obesity treatment in primary care practice. *The New England journal of medicine* 2011;365:1969-79.

59. TheDiabetesPreventionProgram(DPP)ResearchGroup. The Diabetes Prevention Program (DPP). *Diabetes Care* 2002;25:2165-71.
60. Wadden T, West D, Delahanty L, et al. The Look AHEAD study: A description of the lifestyle intervention and the evidence supporting it. *Obesity* 2006;14:737-52.
61. Jakicic J, Tate D, Lang W, et al. Dose and pattern of objectively measured physical activity on long-term weight loss in adults: Results from the Step-Up Study. *Obesity*;In Review.
62. Jakicic JM, Gregg E, Knowler W, et al. Physical activity patterns of overweight and obese individuals with type 2 diabetes in the Look AHEAD Study. *Med Sci Sports Exerc* 2010;42:1995-2005.
63. Miller GD, Jakicic JM, Rejeski WJ, et al. Effect of varying accelerometry criteria on physical activity: the Look AHEAD Study. *Obesity* 2013;21:32-44.
64. Napolitano MA, Borradaile KE, Lewis BA, et al. Accelerometry use in a physical activity intervention trial. *Contemporary clinical trials* 2010;31:514-23.
65. Pahor M, Guralnik JM, Ambrosius WT, et al. Effect of structured physical activity on prevention of major mobility disability in older adults. The LIFE Study Randomized Clinical Trial. *JAMA* 2014;311:2387-96.
66. Freedson PS, Melanson E, Sirard J. Calibration of the Computer Science and Applications, Inc. accelerometer. *Med Sci Sports Exerc* 1998;30:777-81.
67. Paffenbarger RS, Wing AL, Hyde RT. Physical activity as an index of heart attack risk in college alumni. *American Journal of Epidemiology* 1978;108:161-75.
68. Gibbs BB, King WC, Davis KK, et al. Objective versus self-reported sedentary behavior in overweight and obese young adults. *J Phys Act Health* 2015 Feb 24. [Epub ahead of print].
69. Resnick B, Jenkins L. Testing the reliability and validity of the Self-Efficacy for Exercise scale. *Nursing Research* 2000;49:154-9.
70. Steinhart MA, Dishman RK. Reliability and validity of expected outcomes and barriers for habitual physical activity. *Journal of Occupational Medicine* 1989;31:536-46.
71. Clark MM, Abrams DB, Niaura RS, Eaton CA, Rossi JS. Self-efficacy in weight management. *Journal of Consulting and Clinical Psychology* 1991;59:739-44.
72. Wadden TA, Berkowitz RI, Womble LG, et al. Randomized trial of lifestyle modification and pharmacotherapy for obesity. *The New England Journal of Medicine* 2005;353:2111-20.
73. Lillis J, Luoma JB, Levin ME, Hayes SC. Measuring weight self-stigma: The Weight Self-Stigma Questionnaire. *Obesity* 2010;18:971-6.
74. Bacon JG, Scheltema KE, Robinson BE. Fat phobia scale revisited: the short form. *International Journal of Obesity* 2001;25:252-7.
75. Williams DR, Yu Y, Jackson JS, Anderson NB. Racial differences in physical and mental health: Socioeconomic status, stress, and discrimination. *Journal of Health Psychology* 1997;2:335-51.
76. Durso LE, Latner JD, Ciao AC. Weight bias internalization in treatment-seeking overweight adults: Psychometric validation and associations with self-esteem, body image, and mood symptoms. *Eating Behaviors* 2016;21:104-8.
77. Lee MS, Dedrick RF. Weight Bias Internalization Scale: Psychometric properties using alternative weight status classification. *Body Image* 2016;17:25-9.
78. Hubner C, Schmidt R, Selle J, et al. Comparing self-report measures of internalized weight stigma: The Weight Self-Stigma Questionnaire versus the Weight Bias Internalization Scale. *PLoS ONE* 2016;11:e0165566.
79. Puhl RM, Latner JD, O'Brien K, Luedicke J, Danielsdottir S, Forhan M. A multinational examination of weight bias: Predictors of anti-fat attitudes across four countries. *International Journal of Obesity* 2015;39:1166-73.
80. Sutin AR, Stephan Y, Terracciano A. Weight discrimination and mortality. *Psychological Science* 2015.
81. Krieger N, Smith K, Naishadham D, Hartman C, Barbeau EM. Experiences of discrimination: Validity and reliability of a self-report measure for population health research on racism and health. *Social Science & Medicine* 2005;61:1576-96.
82. Puhl RM, Luedicke J. Weight-Based Victimization Among Adolescents in the School Setting: Emotional Reactions and Coping Behaviors. *Journal of Youth and Adolescence* 2012;41:27-40.
83. Anda RF, Felitti VJ, Bremner JD, et al. The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience* 2006;256:174-86.
84. Kolotkin RL, Crosby RD, Williams GR. Assessing weight-related quality of life in obese persons with type 2 diabetes. *Diabetes Research and Clinical Practice* 2003;61:125-32.
85. Cohen S, Kamarck T, Mermelstein R. A global measure of perceived stress. *Journal of Health and Social Behavior* 1983;24:385-96.

86. Yanovski SZ, Marcus MD, Wadden TA, Walsh BT. The Questionnaire on Eating and Weight Patterns-5: An updated screening instrument for binge eating disorder. *International Journal of Eating Disorders* 2015;48:259-61.
87. Kroenke K, Spitzer RL. The PHQ-9: A new depression diagnostic severity measures. *Psychiatric Annals* 2002;32:1-7.
88. Avalos L, Tylka TL, Wood-Barcalow N. The Body Appreciation Scale: Development and psychometric evaluation. *Body Image* 2005;2:285-97.
84. Diggle PJ, Heagerty PJ, Liang K, Zeger SL. *Analysis of longitudinal data*. 2nd ed. New York: Oxford University Press; 2002.