

5-1-2006

## Nurse Practitioners' Attitudes Toward Obesity

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### Recommended Citation

Dionne, Teresa Cueba, "Nurse Practitioners' Attitudes Toward Obesity" (2006). *Master's Projects*. 758.  
DOI: <https://doi.org/10.31979/etd.5vfq-82vr>  
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SAN JOSE STATE UNIVERSITY  
SCHOOL OF NURSING

MASTER'S PROGRAM PROJECT OPTION (PLAN B)  
PROJECT SIGNATURE FORM

STUDENT NAME Teresa Cuesta Dionne

SEMESTER ENROLLED Spring 2006

TITLE OF PROJECT Nurse Practitioner Attitudes  
Toward Obesity

NAME OF JOURNAL Journal of the American Academy  
of Nurse Practitioners

The project and manuscript have been successfully completed and meet the standards of the School of Nursing at San Jose State University. The project demonstrates the application of professional knowledge, clinical expertise, and scholarly thinking. An abstract of the project and two copies of the manuscript are attached.

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Running head: NURSE PRACTITIONERS' ATTITUDES TOWARD OBESITY

Nurse Practitioners' Attitudes Toward Obesity

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## Nurse Practitioners' Attitudes Toward Obesity

### **Keywords**

**Attitude:** A mental position with regard to a fact or state (Merriam-Websters' Dictionary, 2006)

**Overweight individuals:** Defined by the National Institute of Health as individuals with a body mass index between 25kg/m<sup>2</sup> and 29.9kg/m<sup>2</sup>.

**Obese individuals:** Defined as having a body mass index of 30 kg/m<sup>2</sup> or greater.

**Morbidly obese individuals:** Defined as having a body mass index of 40 kg/m<sup>2</sup> or greater or 100 pounds or more over their ideal body weight (National Institute of Health, 2006).

### **Abstract**

**Purpose:** The purpose of this study was to explore if negative attitudes exist among nurse practitioners toward obese clients.

**Data Sources:** Data sources included responses to a 23 item questionnaire and a 7 item demographic survey completed anonymously through the mail. 104 Nurse practitioner members of the American Academy of Nurse Practitioners (21% response rate) participated in the study. Participants were asked to respond to questions related to attitudes about obese persons and weight management.

**Conclusions:** Respondents did not exhibit a total attitude toward obese persons score consistent with a negative attitude toward obese persons. The majority of respondents (84%) felt comfortable discussing weight with their clients. While 96% of participants include diet and exercise as a regular part of the health maintenance and health promotion education they provide.

**Implications for practice:** This study provides insight into NP practice regarding overweight and obese clients, and adds to the limited knowledge of NP attitudes. Findings of this study may guide strategies to enhance the delivery of care for overweight and obese individuals.

## Introduction

The incidence of overweight and obesity has almost tripled in the last twenty years. In a 2002 survey by the Centers for Disease Control (United States Department of Health and Human Services Centers for Disease Control and Prevention, 2006) 65% of Americans were found to be overweight or obese. Obesity has become an epidemic in the United States.

The reasons why Americans are becoming increasingly obese are multifactorial. Increased consumption of processed and fast foods, a more sedentary lifestyle, and genetic factors impact weight and weight gain. The US Department of Health Services (United States Department of Health and Human Services, 2005) found that less than one third of adults engage in the recommended amount of daily physical activity. Ludwig and Pereira studied obesity in relation to fast food habits and identified a direct correlation between frequency of fast food consumption, obesity, and insulin resistance (Ludwig & Pereira, 2005).

The US department of health services (2005) reports that there are over 300,000 deaths each year related to obesity. Overweight and obese individuals are at increased risk of hypertension, diabetes, coronary artery disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, depression, and cancer. According to the Surgeon General's report: A call to action to prevent and decrease overweight and obesity (United States Department of Health and Human Services, 2005) obesity related health care costs in the year 2000 alone was greater than 117 billion dollars.

The large health care costs associated with obesity are related to the many morbidities and mortalities associated with obesity. Another factor that contributes to the increased health care costs is that obese clients delay seeking medical care. This is often due to the stigma of

obesity and the negative bias obese clients feel healthcare workers have towards them (Drury & Louis, 2002).

Primary care providers have the potential to act as a valuable resource for overweight and obese clients for health information and weight management. Unfortunately, the stigma of obesity, and a negative bias towards the obese by healthcare workers frequently dissuade them from seeking healthcare (Drury & Louis, 2002). Nurse Practitioners have been studied in conjunction with other healthcare professionals regarding weight bias, but have not been studied to determine whether their attitudes and beliefs differ from those of other healthcare providers.

In a study of nurse practitioner practice by the American Academy of Nurse Practitioners (American Academy of Nurse Practitioners [AANP], n.d.) found that nurse practitioner primary provider clients have lower average emergency room admissions and lower average hospital length of stay. Nurse Practitioners were also found to suggest therapeutic approaches that reduce healthcare costs and provide clients with information to make healthy lifestyle choices. Nurse practitioners in comparison with physicians were found to spend an average of 31 percent more time with their clients (AANP, 2005).

Currently there are approximately 106,000 Nurse Practitioners practicing in the United States. Nurse Practitioners are becoming a vital asset to primary care practices, with more than 30 percent of primary care physicians approaching the retirement age and a shortage of primary care physicians to take their place (AANP, n.d.). According to a study by the University of California, Berkeley from the Petris Center on Health Care Markets and Consumer Welfare nurse practitioners are improving access to critical health services (Kirby, Spez, Mairuro, & Scheffler, 2005).

The increase in nurse practitioners as primary care providers, combined with the epidemic of obesity necessitates the evaluation of nurse practitioner attitudes and beliefs about obesity. Current provider practice is not adequately dealing with the issue of obesity. It is necessary to analyze nurse practitioners' attitudes and practice to see if they are consistent with previous research of health professionals and to identify areas for change. The purpose of this study is to identify nurse practitioners' attitudes toward obesity and opinions about weight management.

### Literature Review

Stigma is one of the most harmful and hurtful effects of obesity. Obese individuals feel prejudice and discrimination in many of their everyday interactions. Unfortunately, obese individuals also experience a negative bias from the medical community (Foster et al., 2003).

Drury and Louis (Drury & Louis, 2002) studied 216 women to determine if health care was delayed or avoided because of weight. The women were recruited from Las Vegas area Churches and given a self administered questionnaire. The correlational survey examined the body mass index (BMI), self-esteem, attribution for weight, and satisfaction with medical care in relation to the delay or avoidance in seeking medical care (Drury & Louis, 2002).

In their research Drury and Louis (2002) found that weight related issues are a common reason for the delay or avoidance of health care. Participant reasons including a weight gain since last visit, not wanting to be weighted at the physician's office and being told to lose weight were found to be related to a delay and avoidance of health care. Those who were morbidly obese reported slightly different reasoning for the delay and avoidance of seeking healthcare. Twenty-five percent of the morbidly obese in this study cited undressing in the physicians office as a reason they avoided seeking healthcare and 60 percent of the morbidly obese individuals



reported that being told to lose weight was a reason they avoided seeking healthcare (Drury & Louis, 2002).

Drury and Louis (2002) identified a positive correlation between BMI and delay and avoidance of healthcare. Drury and Louis (2002) also found that despite being satisfied with the healthcare obese women often delay seeking healthcare for weight related reasons. Drury and Louis' (2002) research strengthened the need not only for clinicians to be aware of their own bias concerning weight, but recognizing clients at risk for avoidance of healthcare for weight related reasons. Replication of this study with individuals with nurse practitioners as primary care provider was recommended for future research by Drury and Louis (2002) to compare findings with physicians.

Six hundred and twenty primary care physicians were studied by Foster, Wadden, Makris, Davidson, Sanderson, Allison and Kessler (Foster et al., 2003) about their attitudes toward obese clients and the causes and treatment of obesity. Foster et al (2003) assessed the beliefs about obesity by rating the importance of 11 biological and behavioral factors. Participants completed a likert survey that assessed perceived attributes of obese individuals. Foster et al (2003) found physicians attribute negative stereotypes toward obese clients. More than 50% of the primary care physicians surveyed viewed obese clients as awkward, unattractive, ugly and noncompliant. Thirty seven percent of participants reported experiencing negative reactions toward the appearance of obese clients. One third of the physicians characterized obese clients as weak willed, sloppy and lazy (Foster et al., 2003).

The results of Foster et al's (2003) research indicate that physicians view obesity as a behavioral problem, with lack of motivation and physical activity as the primary causes for obesity. Almost half of the physicians surveyed indicated that psychological problems were an

extremely important cause of obesity. The high percentage of physicians who attribute negative qualities to obese individuals, confirms the assumption that the medical community has a negative bias towards obese individuals.

In a study of obese women, Wadden, Anderson, Foster, Bennett, Steinburg and Sarwer (Wadden et al., 2000) surveyed obese women participating in obesity trials about their opinions of weight control management by their primary care provider. A total of 259 women completed the questionnaires. Half of the women reported that their primary care provider had not recommended any of the ten most common weight loss methods (Wadden et al., 2000). Thirty percent of clients surveyed reported that their primary care physician never discussed weight management with them. Wadden et al (2000) identified the need to do further research into primary care physician's weight management practices, such as a chart review to determine if there is a discrepancy between advice physicians are giving and client perceptions.

Timmerman, Reifsnider, and Allan (Timmerman, Reifsnider, & Allan, 2000) surveyed 17 nurse practitioners and 15 physicians about weight management practices. Items were assessed utilizing a likert style survey, and measured practices related to weight management including assessment, intervention, and perceived barriers to implementing interventions. Timmerman, Reifsnider, and Allan (2000) found that over 75% of the clinicians surveyed did not use measurements of body fat, waist to hip ratios, or body mass index in their assessment.

Nurse practitioners and physicians routinely advised weight management interventions for over 60% of clients (Timmerman et al., 2000). The weight management interventions include increased activity, low fat diets, healthy eating and weight loss benefits. Over 85% of participants indicated that they made referrals to commercial weight loss programs, support groups and medically supervised weight loss programs (Timmerman et al., 2000).

Timmerman, Reifsnider, and Allan (2000) also analyzed the responses to find the differences between nurse practitioner and physician practice regarding weight management practices. Physicians were more likely to advise aerobic weight loss, nurse practitioners were more likely to obtain nutritional assessments. The greatest difference between nurse practitioner and physicians was that physicians were more likely to indicate a lack of enjoyment in working with weight problems and clients' lack of interest in changing as a barrier to weight management (Timmerman et al., 2000).

### Conceptual Framework

Social interactionism is the theoretical framework and foundation of the Labeling theory. The Labeling theory focuses on the relativity of deviance, social reaction or labeling of deviance and outcomes of being labeled (DeMelo, 2005). Obese individuals often feel stigmatized by the label of obesity they face in society.

Primary care providers have the potential to act as a *moral entrepreneur* which is defined as an individual who has the potential to apply a label that will have detrimental effects on the individual labeled (DeMelo, 2005). This can be very detrimental to the obese individual, who may be devastated by being thus labeled by a *moral entrepreneur*.

Obese individuals wear their deviance. Social reaction and labeling are often inevitable every day occurrences for overweight and obese individuals. The stereotyping associated with labeling is often debilitating for obese individuals, and could lead feeling uncomfortable performing everyday activities like eating in a restaurant or buying clothes.

Outcomes of the Labeling theory are possibly the most dangerous component of labeling. According to the Labeling theory individuals begin to believe and act out the stereotypes related

to their label. For obese clients this could have a tremendous negative impact on their health and perpetuate further stigma and increased obesity.

As primary care providers nurse practitioners are in a position to provide a positive impact on client health and weight management. If nurse practitioners are not aware of negative attitudes toward obese individuals they could unknowingly act as a moral entrepreneur and apply a deviant label that will have a detrimental effect on the client.

## Methods

### Design

The purpose of this study was to explore if negative attitudes exist among nurse practitioners toward obese clients. This descriptive study used a quantitative design, and a sample of American Academy of Nurse Practitioners members. Participants were asked to complete the Attitudes Toward Obese Persons Scale (ATOPS) and demographic data questionnaires. Randomly selected members of AANP were mailed both questionnaires. Data collection tools contained no identifying information, and participant's responses remained anonymous. ATOPS and demographic questionnaire were mailed to participants along with a letter explaining the study and a request for participation, and a self addressed stamped envelope for return of the survey to the researcher. No additional incentives were provided. Participants were asked to return their surveys within a three week period of time.

### Sample

Following the Institutional Review Board (IRB) approval, the ATOPS and demographic data questionnaires were sent to 500 American Academy of Nurse Practitioners (AANP) members. AANP members were randomly selected from the AANP database. AANP members who were not currently practicing as nurse practitioners were excluded from the study. The 500

AANP members consisted of six different types of nurse practitioner specialties (see Figure 1.).

A total of 104 completed surveys were returned (21% response rate) and an additional 10 incomplete surveys were received and excluded from analysis.

### Measures

#### Demographic data

Demographic data collected consisted of age, gender, years of practice as a nurse practitioner, area of specialty, body mass index, experience with obese clients and weight loss management. The demographic data was used to identify correlation between years of practice, area of specialty, BMI and a negative attitude towards obese persons.

#### Instruments

The Attitudes Toward Obese Persons Scale is a 23 item modified version of an instrument used by Bray (1972). The survey was designed to assess social attitudes toward obesity using a six point likert response scale. 1= strongly disagree, 2= moderately disagree, 3= slightly disagree, 4= slightly agree, 5= moderately agree and 6= strongly agree. The ATOPS was designed and modified to measure 5 themes: Self esteem, Personality, Emotions, Lifestyle, and Practitioner view. The greater the ATOPS score the greater the negative view of obese persons. ATOPS scores of greater than 80 depicted strong negative attitudes toward obese persons. The ATOPS does not measure positive attitudes toward obese persons, therefore an ATOPS score of less than 80 is not indicative of a positive attitude. The second survey included 7 demographic questions including age, gender, experience, specialty, BMI and experience with obese clients.

## Data Analysis

Descriptive statistics were used to analyze the data received from the Attitudes Toward Obese Persons Scale and demographic data questionnaires. Frequency and summary statistics were calculated for the 23 questions in the Attitudes Toward Obese Persons Scale and demographic data. An Analysis of Variance (ANOVA) was used to reveal any correlations between, the ATOPS score and, years of experience as a nurse practitioner. In addition, the ATOPS score was compared to NP's reported BMI and to the percentage of clients the nurse practitioner cares for who are overweight or obese (Figure 4 & Figure 6). Lastly, ATOPS scores were compared to NP's area of specialty.

## Results

### Demographics

One hundred and four (n=104) nurse practitioners completed the survey. Over 86% of the NPs were female, and the majority of the nurses practitioners ranged in age between 45 and 57 years of age (see Figures 1 and 2). More than 39% of the NPs were Family Nurse Practitioners (see Figure 3), and the majority of the respondents had less than five years of experience in working as a nurse practitioner (see Figure 4). The nurse practitioner respondents reported that over 52% of their clients were over weight or obese (see Figure 5) and that they frequently consult with their clients about weight loss see Figure 6).

### Self Esteem and Emotions

Nurse practitioner participants had a mean ATOPS score of 63.11 with a standard deviation of 16.06. Seventy three per cent (n = 76) of participants felt that obese people were *more* self conscious than other people. More than 80% (n = 84) of nurse practitioner respondents felt that obese people *were* ashamed of their weight, however, they (73%, n=76) *did not feel* that

obese persons resented those who were of normal weight. In addition, ninety four per cent (n=98) of participants did not feel that obese persons were *more* emotional than nonobese persons.

Half (50%, n=52) of nurse practitioner respondents believed that obese people *are not* as happy as nonobese people. Respondents (55%, n=57) also felt than obese people *were* dissatisfied with themselves, however, almost 54% (n=56) of respondents believed that obese people *were* as self confident as other people. Respondents also reported (56%, n=58) a belief that obese people felt that they *were* as good as others.

### Personality

Most respondents (83%, n=86) feel that obese workers *are* as successful as nonobese workers. Fifty seven per cent (n=60) of nurse practitioner respondents felt that obesity *did not* effect desirability for marriage. Over 78% (n=81) of survey participants *did not* feel that obesity had an effect on neatness, while over 80% (n=84) of respondents *did not* view obesity as having a relationship to aggressive behavior or lack of aggression. Over 87% (n=91) of respondents *did not* view obesity as having an effect on personality. Respondents also reported (56%, n=58) a belief that obese people feel they *are* as good as others.

### Lifestyle

Over 89% (n=93) of nurse practitioners surveyed felt that obese people *would* expect to lead normal lives and over 88% (n=92) of respondents felt that obesity and family problems *were not* related. Nurse practitioner respondents (54%, n=56) felt that obese people *were not* as sexually attractive, and 73% (n=76) agree that obese persons *are not* as healthy as nonobese people.

### Nurse Practitioner Practice Views

Seventy two per cent (n=75) of participants *did not* list obesity as one of the worst fates a person could have, and 74% (n=77) *did not* view obese clients as noncompliant. Almost 84% (n=87) of nurse practitioners reported feeling comfortable discussing weight with their clients, and over 96% (n=100) included diet and exercise as an important part of health care maintenance education. Over 94% (n=98) of respondents *disagreed* with the statement "I dislike having obese people as clients".

An analysis of variance (ANOVA) was used to reveal the relationships between the ATOPS and the participant nurse practitioners specialty and years of experiences as a nurse practitioner. There was no statistically significant correlation between the ATOPS and the specialty of nurse practitioners. No correlation was found between the ATOPS and the years of experience as a nurse practitioner.

There was, 21% (n=22) of participants refused to indicate their own BMI. The mean ATOPS scores of participants who did not report their BMI were compared with those who did report their BMI. Participants who *did not* had a mean TAS score of 60.67 while participants who did report their BMI had a slightly higher mean score of 63.12. In other words, Participants that did indicate their own BMI had a slightly more negative view of obese persons than those who refused to indicate their own BMI.

### Discussion

Overall, the data from this study found no statistically significant correlation between the total attitude scale score (TAS score) of nurse practitioners and a negative attitude toward obese persons. Nurse practitioner participants had a mean TAS score of 63.11 with a standard



deviation of 16.06. Nurse Practitioners did not demonstrate negative attitudes toward obese persons. The total attitude scores did not change in relation to age, gender, years in practice, area of specialty or BMI.

The self reported BMI was not completed by all participants. Participants, who did not report their BMI, might have done so for many reasons. Participants may have had an inadequate knowledge of BMI calculation. Another factor for refusal to report their BMI may have been the sensitive nature of weight; especially overweight and obesity. Sensitivity is complicated by the fear of stigma of overweight and obesity conflicting with participants professional knowledge of health maintenance and health promotion.

Eight of the participants who did not report their BMI did use alternative answers. These answers included a generalization of their BMI such as, less than 20, less than 30, normal, and within normal limits. Others indicated their previous BMI in relation to their current BMI to show their progress: "was 35, now is 26." Some respondents used humor, but still refused to report their BMI; these respondents used comments to refer to their BMI as "too much", and "beats me, but I'm obese".

Another surprising finding was in the number of respondents who reported a BMI greater than 30. Only 8% (n=13) of nurse practitioner respondents reported a BMI of 30kg/m<sup>2</sup> or greater, this is in stark contrast to the estimated 65% of Americans that have a BMI of 30kg/m<sup>2</sup> or greater (United States Department of Health and Human Services Centers for Disease Control and Prevention, 2006).

Nurse practitioner participants did report feeling comfortable discussing weight and weight loss with their clients. Participants also reported discussing diet and exercise as part of their regular health maintenance education with clients.

### Limitations

Study limitations include factors such as sensitivity to the discussions about overweight and obesity. Another study limitation was the limited data collection time of three weeks. Apparently not enough time was allotted as an additional 30 surveys were received after data collection had been terminated. The print out quality of the questionnaires was also a limitation because during the printing process, the response ovals became distorted, and that apparently confused some participants. The accuracy of *self-reported* BMI was also a study limitation. In future studies it would be important to provide a BMI formula or table for participants. Hence, the small sample size might also have hampered the generalizability of the findings to the entire nurse practitioner population.

In future studies, ethnicity reporting as part of the demographic information would be important information. Qualitative open ended questions on the survey may be able to differentiate between NP's personal and professional feelings toward obese persons. Lastly, the Attitudes Toward Obese Persons Scale may not be sensitive enough to differentiate between a negative perception of obese persons, and whether this results in obese clients being treated differently by nurse practitioners.

### Implications for Practice

This study adds insight into NP practice regarding overweight and obese clients, and adds to the limited knowledge of NP attitudes. Findings of this study may guide strategies to enhance the delivery of appropriate care for overweight and obese individuals.

### Conclusions

Nurse practitioners did not exhibit a negative attitude towards obese persons. Nurse practitioner participants indicate that they feel comfortable discussing weight and weight loss with their clients. Nurse practitioners also reported including diet and exercise as part of their regular health maintenance and health promotion education.

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Figure 1 Gender of Nurse Practitioner Respondents (n=104)

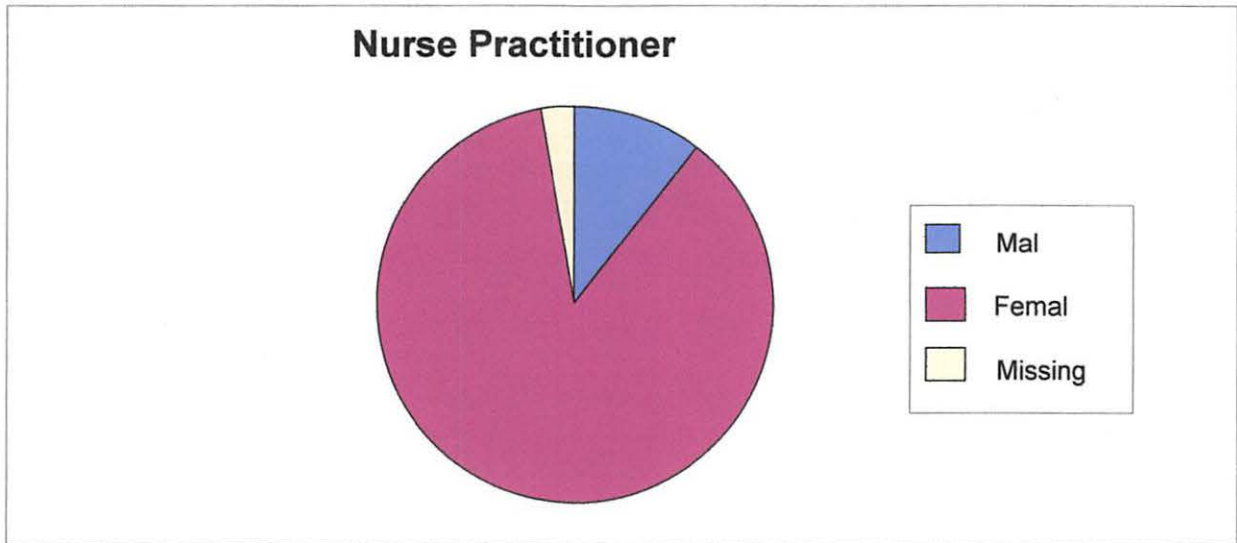


Figure 2 Age of Nurse Practitioner Respondents (n=104)

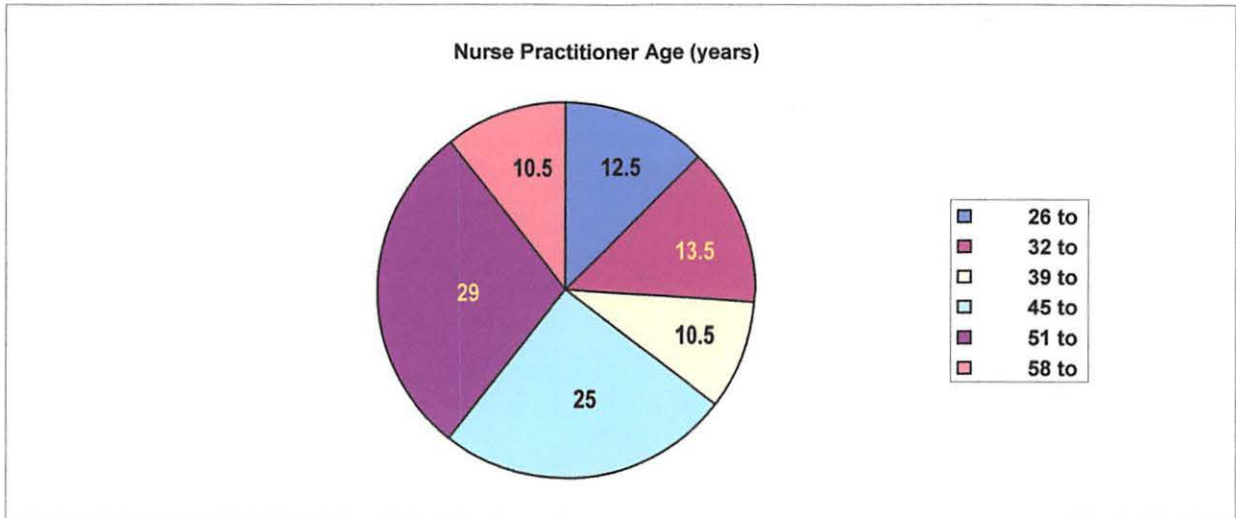


Figure 3 Area of Specialty of Nurse Practitioner Respondents (n=104)

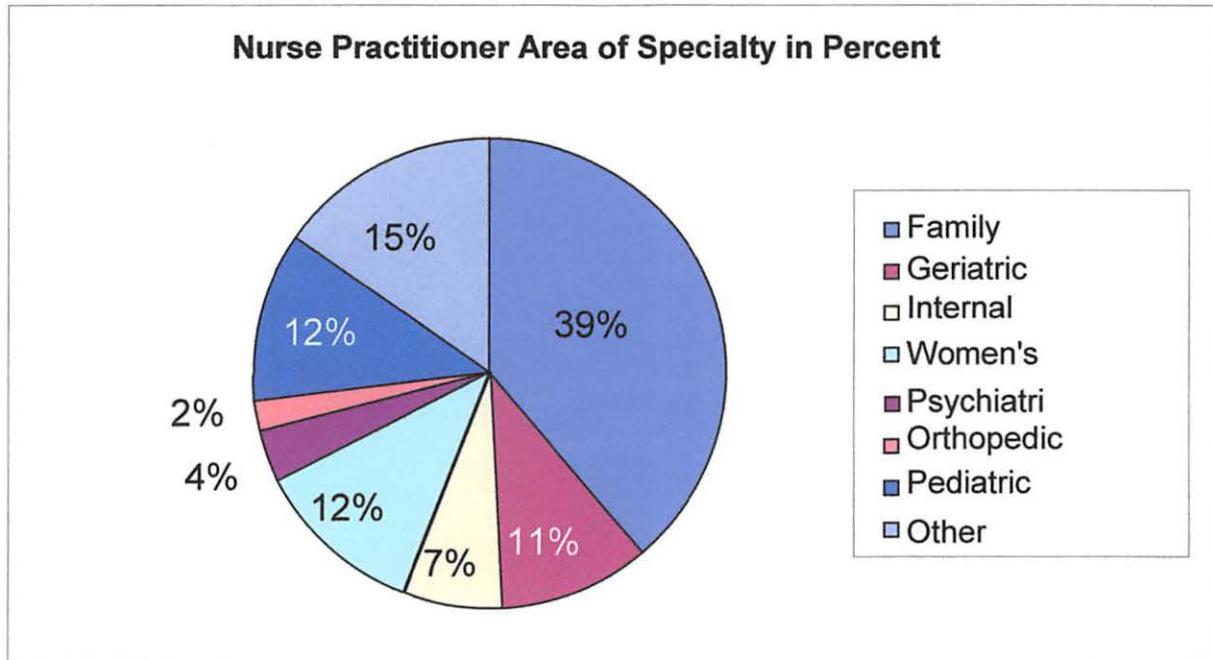




Figure 4 Years of Practice As a Nurse Practitioner (n=104)

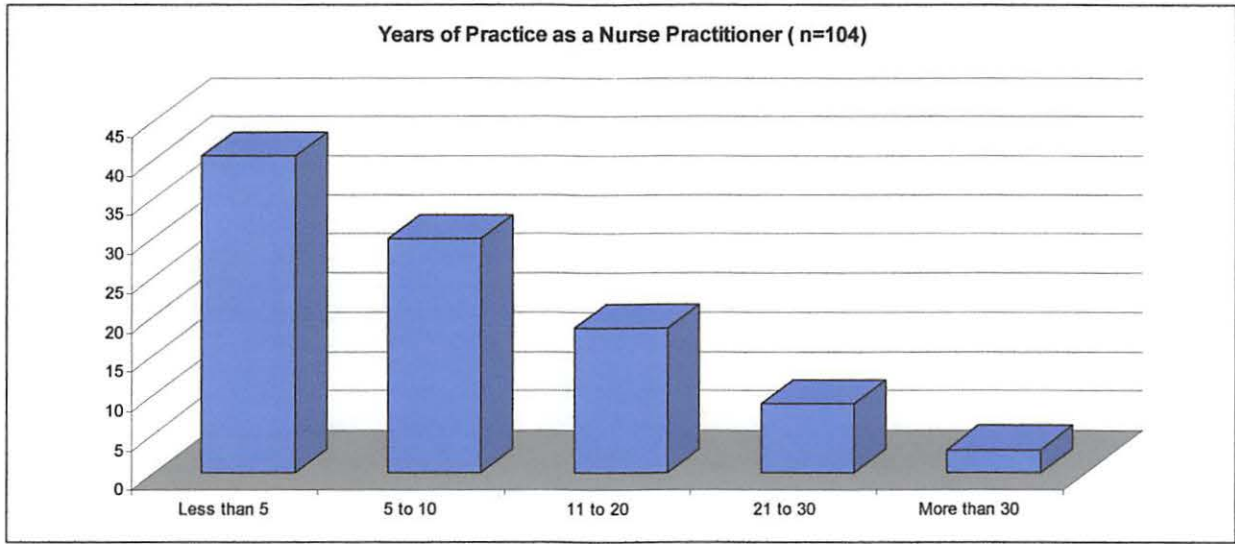


Figure 5 Percent of Nurse Practitioners Who Consult With Their Clients About Weight Loss

(n=104)

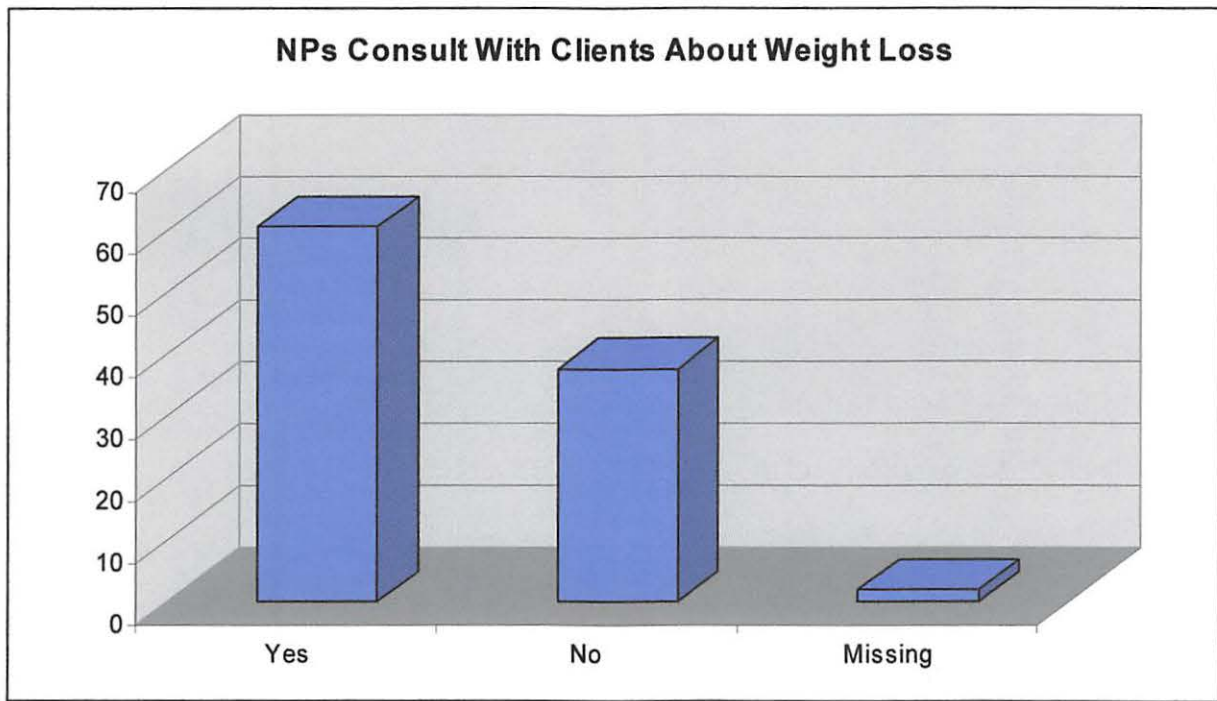


Figure 6 Percent of Overweight Patients Seen By Nurse Practitioners (n=104)

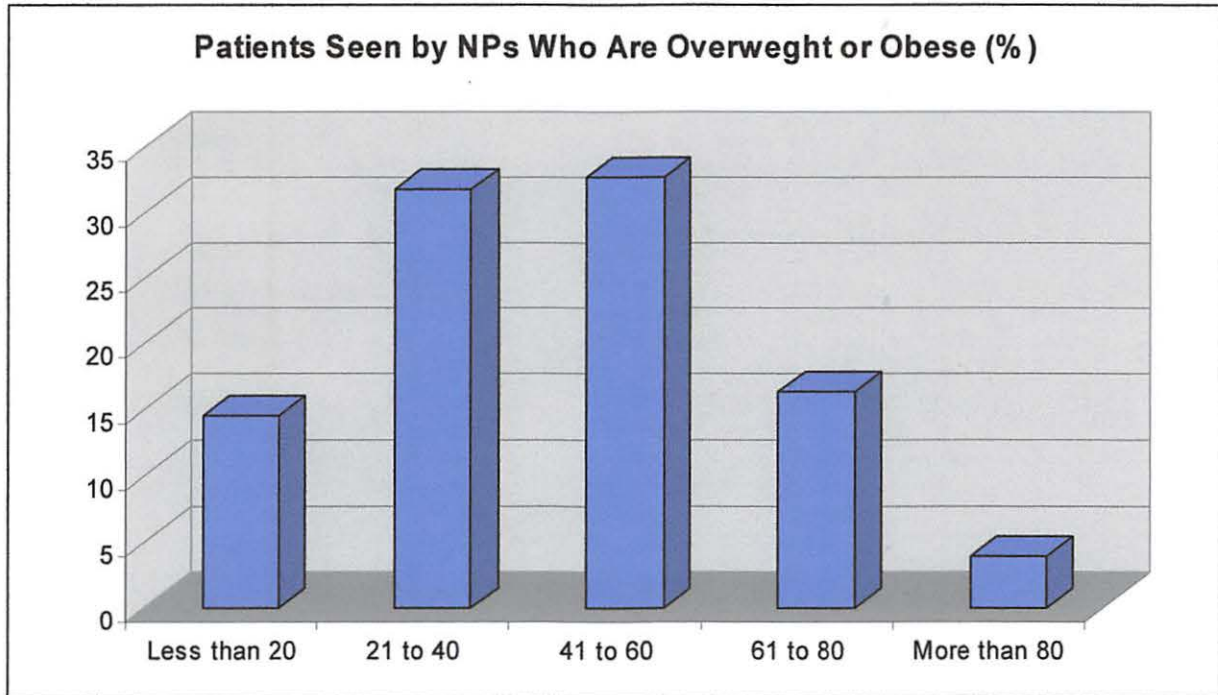


Table 1 Self Esteem and Emotions (n=104)

Target Phrase	n	%
<b>... not as happy as ...</b>		
SD	17	16.3
MD	24	23.1
SLD	10	9.6
SLA	31	29.8
MA	15	14.4
SA	6	5.8
<b>...not as good as...</b>		
SD	20	19.2
MD	19	18.3
SLD	19	18.3
SLA	24	23.1
MA	19	18.3
SA	2	1.9
<b>...more self-conscious...</b>		
SD	6	5.8
MD	13	12.5
SLD	9	8.7
SLA	35	33.7
MA	30	28.8
SA	11	10.6
<b>...dissatisfied with themselves</b>		
SD	11	10.6
MD	21	20.2
SLD	14	13.5
SLA	34	32.7
MA	21	20.2
SA	2	1.9
<b>...not as self-confident...</b>		
SD	16	15.4
MD	25	24
SLD	15	14.4
SLA	24	23.1
MA	18	17.3
SA	6	5.8
<b>Very few... are ashamed of their weight</b>		
SD	18	17.3
MD	42	40.4
SLD	24	23.1
SLA	10	9.6
MA	6	5.8
SA	4	3.8

**...more emotional**

SD	37	35.9
MD	35	33.7
SLD	26	25
SLA	4	3.8
MA	1	1
SA	0	0

Note. SD=Strongly Disagree, MD=Moderately Disagree, SLD= Slightly Disagree, SLA=Slight

Agree, MA= Moderately Agree, Strongly Agree.

Table 2 Personality (n=104)

Target Phrase	n	%
<b>...cannot be as successful...</b>		
SD	46	44
MD	25	24
SLD	15	14
SLA	14	13
MA	2	2
SA	2	2
<b>...non-obese not marrying obese...</b>		
SD	11	11
MD	18	17
SLD	31	30
SLA	23	22
MA	15	14
SA	6	6
<b>...severely obese are untidy...</b>		
SD	42	40
MD	31	30
SLD	8	8
SLA	15	14
MA	7	7
SA	1	1
<b>...obese less aggressive than non-obese</b>		
SD	30	29
MD	26	25
SLD	28	27
SLA	13	12
MA	6	6
SA	1	1
<b>...obese have different personalities than non-obese...</b>		
SD	52	50
MD	22	21
SLD	17	16
SLA	10	10
MA	6	6
SA	1	1

Note. SD=Strongly Disagree, MD=Moderately Disagree, SLD= Slightly Disagree, SLA=Slight

Agree, MA= Moderately Agree, Strongly Agree

Table 3 Lifestyle (n=104)

Target Phrase	n	%
<b>...obese not to expect normal life...</b>		
SD	51	49
MD	26	25
SLD	16	15
SLA	7	7
MA	3	3
SA	1	1
<b>...obese not as healthy as...</b>		
SD	8	8
MD	14	13
SLD	6	6
SLA	8	8
MA	34	33
SA	34	33
<b>...obese not as sexually attractive as...</b>		
SD	10	10
MD	17	16
SLD	18	17
SLA	24	23
MA	19	18
SA	13	12
<b>...obese tend to have family problems</b>		
SD	36	35
MD	34	33
SLD	22	21
SLA	9	9
MA	2	2
SA	0	0

Note. SD=Strongly Disagree, MD=Moderately Disagree, SLD= Slightly Disagree, SLA=Slight

Agree, MA= Moderately Agree, Strongly Agree

Table 4 Nurse Practitioner Views as Part of Their Practice (n=104)

Target Phrase	n	%
<b>...worst... is to become obese...</b>		
SD	35	34
MD	28	27
SLD	12	11
SLA	18	17
MA	8	8
SA	3	3
<b>...obese are non-compliant...</b>		
SD	25	24
MD	32	31
SLD	20	19
SLA	14	13
MA	8	8
SA	3	3
<b>...feel comfortable discussing weight...</b>		
SD	8	8
MD	4	4
SLD	5	5
SLA	10	10
MA	33	32
SA	44	43
<b>...dislike having obese clients</b>		
SD	64	62
MD	23	22
SLD	11	11
SLA	4	4
MA	1	1
SA	1	1
<b>...not an important part of *HCM education provided...</b>		
SD	87	84
MD	11	11
SLD	2	2
SLA	1	1
MA	2	2
SA	1	1

Note. SD=Strongly Disagree, MD=Moderately Disagree, SLD= Slightly Disagree, SLA=Slight

Agree, MA= Moderately Agree, Strongly Agree, \*HCM=Health Care Maintenance



Table 5 Analysis of Variance for The Total Attitude Scale Score in relation to the Area of Specialty and Years of Experience

Variable	F	p
NP Specialty	0.604	0.614
Years of Experience as NP	0.897	0.411

Note. NP is Nurse Practitioner