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Language Matters: Patients' Preferred Terms for Discussing Obesity and Disordered Eating with Health Care Providers After Bariatric Surgery

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Abstract

Objective—Patients who seek or undergo bariatric surgery are likely to experience pervasive societal biases regarding weight and eating behaviors in the health care system. This cross-sectional study examined patient preferences for desired weight and eating-related terms for health care providers among individuals with loss-of-control eating after bariatric surgery.

Method—168 adults who underwent bariatric surgery approximately 1.5 years prior and were in the follow-up stage of a controlled treatment trial testing behavioral treatments.

Results—Of the 11 terms used to describe weight, only two were viewed neutrally: *weight* and *BMI*. All other terms, including *obesity*, were rated negatively and many were rated extremely negatively. *Fatness* was the least desirable term. Of the 18 terms used to describe loss-of-control eating, one (“ate until uncomfortably full”) was rated positively and several were rated neutrally. On average, none of the weight or loss-of-control eating terms was rated as “desirable” or “very desirable.” Analyses revealed few gender and racial differences in language preferences.

Conclusions—Many weight-related and loss-of-control eating terms are viewed as undesirable. Health care providers should begin with neutrally-rated terms and ask patients about their language preferences when speaking with individuals before/after bariatric surgery to improve patient-centered care and reduce perceived weight bias.

Keywords

Weight stigma; bariatric surgery; obesity; weight bias

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Introduction

By 2030, over 51% of adults in the US are expected to have obesity with a 130% increase in severe obesity (1, 2). With severe obesity rates on the rise, utilization of bariatric surgery – the most effective treatment for severe obesity and comorbid conditions – is expected to increase in the US and worldwide (3, 4). Patients who seek or undergo bariatric surgery are at risk of experiencing pervasive societal biases surrounding weight (e.g., “anti-fat” stigma such as being blamed or viewed negatively for having excess weight and/or stigma for using the procedure for weight loss) and disordered eating behaviors such as binge eating (5, 6). Pervasive weight biases are ingrained in our society including the healthcare system (5). Health care providers and even obesity specialists are susceptible to holding negative weight biases towards individuals with obesity, including their own patients, which has the potential to negatively impact patient care (7) and medical conditions (8). For example, perceived weight discrimination is associated with significantly elevated risk for obesity-related medical conditions even after adjusting for excess weight. Patients who perceive weight biases from their health care providers are more likely to engage in maladaptive eating behaviors that promote further weight gain (6, 9), report less motivation to lose weight (10), switch health care providers (10), and avoid future appointments (10). After bariatric surgery, negative weight biases perceived in the provider were associated significantly with poorer dietary adherence (6). Thus, understanding how to communicate effectively about weight and overeating in an unbiased manner is critically important, particularly when caring for the patients most susceptible to weight biases.

To date, researchers have asked individuals with overweight/obesity to identify appropriate or acceptable terminology for discussing weight and obesity. Available data based on survey and qualitative methods, although relatively limited (10–20), suggest common themes. Terms such as “*fat/fatness*” and “*obesity/obese*” have been rated as undesirable, while “*weight*” has been rated as the most preferable term. Similar results were found when examining desirability of weight terms in a high-risk obesity subgroup of individuals with binge-eating disorder (BED) (17), an eating disorder associated strongly with obesity (21) and characterized by recurrent binge-eating episodes, associated distress, and several associated symptoms related to loss-of-control (LOC) eating, without regular compensatory behaviors (22). Importantly, desirability of weight terms did not vary much as a function of BED status, although women rated weight terms as less desirable, on average, than men (16). Taken together, individuals struggling with weight do not identify many desirable terms when discussing weight with health care providers.

Discussing eating behaviors including LOC eating may hold more promise in reducing perceived weight stigma than discussing weight (16, 17). Contrary to findings on the desirability of various weight terms, most of the LOC-eating terms were rated positively or neutrally among treatment-seeking individuals with obesity and BED (17). The four most positively rated terms, on average, were “*loss of control*,” “*ate until you were uncomfortably full*,” “*kept eating even though you were not physically hungry*,” and “*driven or compelled to keep eating even though you wanted to stop*.” The undesirable phrases were “*like you knew you were going to eat a large amount of food, so you didn’t even consider stopping*” and “*addicted to the food you were eating*” (17). These findings were consistent with a study

that examined preferred terms for LOC eating among an online community sample with and without binge-eating (16).

To date, only one study has examined weight-related language preferences within a bariatric population. Pearl and colleagues examined the acceptability of person-first obesity language among individuals seeking bariatric surgery (18). Overall, using person-first obesity language (“*persons with obesity*”) was more acceptable to individuals seeking bariatric surgery than using obesity as an adjective (“*obese person*”). Furthermore, nearly half reported they would feel more understood (50%) and comfortable (40%) with their health care providers if weight stigma was discussed (18). No study has yet to focus on patient preferences for weight and eating terms *following* bariatric surgery, a high-risk period when weight biases may manifest.

Individuals who have undergone bariatric surgery may be particularly vulnerable to experiencing weight biases for several reasons including the decision to undergo bariatric surgery. One study found that individuals who lost weight via bariatric surgery were rated significantly more negatively (lazier, less competent and attractive, and having less healthy eating habits) relative to their counterparts who lost weight via diet and exercise (23). Given that individuals with a history of bariatric surgery may be susceptible to weight biases as a function of having undergone the surgery, it is imperative to understand how to communicate in a way that will not be perceived as biased and not be detrimental to physical and psychological outcomes. Individuals who have had bariatric surgery are subject to repeated assessments of weight and eating by health care providers to determine post-operative outcomes. Therefore, sensitive discussions about weight and eating are needed to reduce perceived weight stigma. Finally, LOC eating has emerged as a consistent predictor of poorer outcomes after bariatric surgery (24, 25). Thus, discussing LOC eating in a sensitive manner will be important to identify at-risk individuals following bariatric surgery.

This study examined patient preferences of desired weight and LOC-eating terms when speaking with health care providers after bariatric surgery. Consistent with previous literature (16, 17), it was hypothesized that few weight-related terms would be viewed positively, while several LOC-eating terms would be rated neutrally.

Methods

Participants were 140 adults (Age: $M=45.6$, $SD=10.9$ years; BMI: $M=37.0$, $SD=6.6$ kg/m²) who underwent bariatric surgery approximately 1.5 years prior at an institution’s bariatric center of excellence and were in the follow-up stage of a randomized controlled treatment trial testing treatments for LOC eating following bariatric surgery. Participants sought psychological/behavioral treatment for eating and weight concerns and experienced regular LOC eating, defined as at least once weekly during the prior 28 days, about six months following laparoscopic sleeve gastrectomy ($n=123$) or Roux-en-Y gastric bypass ($n=17$) surgeries. Treatment duration was three months followed by a six-month follow-up assessment where participants completed surveys for the present study. Retention was good, with 81.4% (114/140) completing surveys at the six-month follow-up. Participants were primarily female ($n=119$; 85%) with relatively diverse racial identities: $n=79$ (56.4%)

identified as White, $n=44$ (31.4%) as Black or African American, $n=2$ (1.4%) as American Indian or Alaska Native, $n=1$ (0.7%) as Native Hawaiian or Other Pacific Islander, $n=3$ (2.1%) as Bi/Multiracial, and $n=11$ (7.9%) as other. Nearly 11% ($n=15$, 10.7%) identified as Latinx or Hispanic.

Procedures

All participants completed self-report surveys which assessed preferences for weight and LOC eating terminology and had weight measured during study evaluations.

Weight Preference Questionnaire

Participants completed the weight preference questionnaire (11), which asked individuals to imagine meeting with a health care provider who would tell them they were 50 pounds overweight and to indicate the desirability of 11 “weight” terms if used by their provider: “weight,” “heaviness,” “BMI,” “obesity,” “excess weight,” “fatness,” “excess fat,” “large size,” “unhealthy body weight,” “weight problem,” and “unhealthy BMI,” using a 5-point likert-type scale: -2 (very undesirable), -1 (undesirable), 0 (neutral), +1 (desirable), +2 (very desirable). The terms were presented in random order to prevent bias in preferences based on order. These terms have been used in several studies assessing weight preferences among clinical and nonclinical samples (11–13, 16, 17).

Preferred Terms for LOC eating Questionnaire

Participants were also asked to imagine meeting with a health care provider to discuss their binge eating after bariatric surgery and to determine the desirability of different terms for LOC eating, the salient feature of binge eating. Eighteen terms presented in random order were used in the present study including “a lack of control,” “a loss of control,” “out of control,” “addicted to the food you were eating,” “helpless to control your eating,” “had to keep eating even though you wanted to stop,” “you were giving into an urge to eat,” “you ate until you were uncomfortably full,” “you kept eating even though you were physically hungry,” “you ate more rapidly than normal,” “you ate alone because you were embarrassed about how much you were eating,” “you felt disgusted, depressed, or very guilty about eating,” “driven or compelled to keep eating even though you wanted to stop,” “you couldn’t stop eating once you started,” “you were on automatic pilot, or detached from what you were doing,” “you knew you were going to eat a large amount of food so you didn’t even consider stopping,” “a loss of willpower,” and “not in control of your eating”. The same 5-point likert-type scale as the weight preferences was used: -2 (very undesirable), -1 (undesirable), 0 (neutral), +1 (desirable), +2 (very desirable). These LOC-eating terms were used in previous studies (16, 17) and based on LOC-eating measures (i.e., Eating Loss of Control Scale (26)) and the *Diagnostic and Statistical Manual of Mental Disorders* (22).

Statistical Analyses

To examine participants’ preferences for weight- and eating-related terminology, one-way t-tests first examined whether mean ratings differed significantly from zero (i.e., neutral). Within-subjects ANOVAs compared terms to detect significant pairwise comparisons. Z-tests compared proportions of participants reporting that each term was “very undesirable”

compared with “very desirable.” Independent t-tests examined differences by gender (men and women) and race (White and Black individuals). Analyses were performed on data obtained from a consecutive series of study participants enrolled in a randomized controlled trial. Study size was determined based on power analyses for the original randomized controlled trial.

Results

Preferred Terms for Weight

Figure 1 depicts the desirability of weight-related terms with significant pairwise comparisons starred. Out of the 11 terms that could be used to describe weight, only two were viewed neutrally (non-significantly different from zero): *weight* and *BMI*. These terms were significantly more desirable than all other terms and did not differ significantly from each other. The remaining terms were viewed negatively. *Fatness* was rated as significantly less desirable than all other terms. *Heaviness*, *excess fat*, and *large size* were all significantly less desirable than other terms, but more desirable than *fatness*. *Unhealthy body weight*, *excess weight*, *unhealthy BMI*, and *weight problem* were undesirable, but more desirable than *obesity*, *heaviness*, *excess fat*, *large size*, and *fatness*.

Table 1 summarizes the proportion of participants who rated each term as “very undesirable” or “very desirable.” Several terms had significantly higher proportions of patients rating the term as “very undesirable” compared with “very desirable”: *heaviness*, *obesity*, *excess weight*, *fatness*, *excess fat*, *large size*, *weight problem*, and *unhealthy BMI*. *Weight*, *BMI*, and *unhealthy body weight* did not differ significantly. Refer to supplementary results for parallel analyses comparing the proportion of participants who rated each weight term as “very undesirable” or “undesirable” with those who rated each weight term as “very desirable” or “desirable”. Overall, a relatively similar pattern emerged.

Preferred Terms for Loss-of-Control

Figure 2 depicts the desirability of descriptions of loss of control. Out of the 18 descriptions of the feeling of loss of control, only 1 was rated positively (significantly greater than zero): *ate until uncomfortably full*. Many terms were rated neutrally (non-significantly different from zero): *kept eating though not physically hungry*, *not in control*, *loss of control*, *ate more rapidly than normal*, *driven or compelled to eat but wanted to stop*, *lack of control*, *giving into an urge*, *had to keep eating but wanted to stop*, *couldn't stop once started*, *helpless to control eating*, *out of control*, and *on auto-pilot*.

Ate until uncomfortably full, *kept eating though not physically hungry*, *not in control*, and *loss of control* were significantly more desirable than the majority of other descriptions: *had to keep eating but wanted to stop*, *couldn't stop once started*, *helpless to control eating*, *out of control*, *on auto-pilot*, *loss of willpower*, *ate alone because embarrassed about how much*, *disgusted*, *depressed*, or *very guilty*, *addicted to the food*, and *knew large amount but didn't consider stopping*. The most undesirable term was *knew large amount but didn't consider stopping*, which was significantly less desirable than all other terms except *addicted to the food*.

Table 2 summarizes the proportion of participants who rated each term as “very undesirable” or “very desirable.” Several terms had significantly higher proportions of patients rating the term as “very undesirable” compared with “very desirable”: *addicted to the food*, *ate alone because embarrassed about how much*, *disgusted*, *depressed*, or *very guilty*, *knew large amount but didn’t consider stopping*, and *loss of willpower*. Refer to supplementary results for parallel analyses comparing the proportion of participants who rated each loss-of-control term as “very undesirable” or “undesirable” with those who rated each loss-of-control term as “very desirable” or “desirable”. Overall, a relatively similar pattern emerged.

Gender Differences in Preferred Weight and Loss-of-Control Terms

Men and women’s language preferences significantly differed for four of eleven weight terms, all of which were less desirable to women than to men: *obesity* (men $M=0.25$, $SD=1.29$; women $M=-0.85$, $SD=1.09$, $t(112)=-3.64$, $p<.001$), *excess fat* (men $M=-0.38$, $SD=1.15$; women $M=-1.04$, $SD=1.00$, $t(112)=-2.41$, $p=.018$), *large size* (men $M=-0.38$, $SD=1.09$; women $M=-1.07$, $SD=1.02$, $t(112)=-2.51$, $p=.013$), and *unhealthy body weight* (men $M=0.31$, $SD=1.14$; women $M=-0.34$, $SD=1.13$, $t(112)=-2.13$, $p=.035$).

There were also gender differences in preference for terms describing loss-of-control eating, again with women rating two of nineteen terms as less desirable than they were rated by men: *on auto-pilot* (men $M=0.38$, $SD=0.81$; women $M=-0.22$, $SD=1.19$, $t(27.01)=-2.56$, $p=.017$), and *knew large amount but didn’t consider stopping* (men $M=0.06$, $SD=0.93$; women $M=-0.59$, $SD=1.15$, $t(23.18)=-2.52$, $p=.019$).

Race Differences in Preferred Weight and Loss-of-Control Terms

Preferences for weight-related terms only differed significantly between White and Black participants on one term: *excess weight* was less desirable to Black participants ($M=-0.64$, $SD=1.07$) than White participants ($M=-0.10$, $SD=1.20$, $t(96)=2.04$, $p=.044$).

Black and White participants’ language preferences differed significantly for four terms describing loss-of control eating, all of which were less desirable to Black participants than White participants: *ate more rapidly than normal* (Black $M=-0.19$, $SD=1.05$; White $M=0.27$, $SD=1.04$, $t(95)=2.09$, $p=.039$), *disgusted*, *depressed*, or *very guilty* (Black $M=-0.57$, $SD=1.09$; White $M=-0.10$, $SD=1.12$, $t(95)=2.02$, $p=.046$), *couldn’t stop once started* (Black $M=-0.32$, $SD=1.03$; White $M=0.18$, $SD=1.04$, $t(96)=2.34$, $p=.022$), and *not in control* (Black $M=-0.08$, $SD=0.98$; White $M=0.39$, $SD=1.02$, $t(96)=2.26$, $p=.026$).

Discussion

Individuals who undergo bariatric surgery may be vulnerable to experiences of negative biases regarding their weight and eating behaviors in the healthcare system. Our study examined patient preferences of several weight and LOC-eating terms that could be used by health care providers after bariatric surgery. Overall, our findings among post-operative bariatric patients replicate previous studies examining language preferences for weight and eating terms (16, 17), and extend previous research in this area by focusing on a patient population at-risk for experiencing stigma based on weight or eating experiences after bariatric surgery. Consistent with previous research (11, 16, 17), our findings suggest that

many weight-related terms are viewed as undesirable with “*fatness*” as the least desirable term. Only two weight-related terms, “*weight*” and “*BMI*,” were rated neutrally, and no terms were rated positively on average. A greater proportion of participants rated all terms, except for “*weight*” and “*BMI*,” as “very undesirable” compared to “very desirable.” In fact, very few individuals rated weight terms as “very desirable” and none of the average ratings reached “desirable.” Conversely, most of the LOC-eating terms were rated in the neutral range. The most desirable terms were “*ate until uncomfortably full*,” “*kept eating even though not physically hungry*,” “*not in control*,” “*loss of control*,” “*ate more rapidly than normal*,” and “*driven or compelled to eat*.” A greater number of participants viewed the following LOC-eating terms as “very undesirable” compared to “very desirable”: “*addicted to the food*,” “*ate alone because embarrassed by how much you were eating*,” “*feeling disgusted, depressed or very guilty*,” “*knew you ate a large amount of food, but didn’t consider stopping*,” and “*loss of willpower*”. Very few gender and racial differences in language preferences for either weight or LOC-eating terms emerged. Women and Black patients found some terms significantly more undesirable than did men and White patients, respectively; however, many of the terms were rated similarly across groups. Taken together, our findings suggest that choosing the appropriate language to use with each patient might be difficult, especially given that discussing weight and eating behaviors with health care providers is not desired among individuals with LOC eating and weight concerns after bariatric surgery. While discussing weight may be particularly sensitive, discussing eating behaviors might be a less stigmatizing way of approaching weight-related health concerns.

The present findings should be considered within the context of the study strengths and limitations. Participants in this study were treatment-seeking adults with LOC eating and weight concerns following bariatric surgery. These findings represent rich clinical data on a subgroup of patients who struggled with LOC eating and weight after bariatric surgery and were susceptible to negative weight biases, making their preferences particularly important. While it is plausible that this participant group was more sensitive to weight and eating terminology as a function of experiencing disordered eating, our findings largely parallel the broader literature (16, 17) and previous research suggesting desirability of weight and LOC-eating terms did not differ much based on BED status (16). Nonetheless, these findings may not generalize to those with similar concerns who opted out of research or to those with other eating concerns. In addition, our findings may not generalize to subgroups not represented well here such as Hispanic or Latinx individuals. Notably, our findings are cross-sectional; future research should examine whether perceived weight biases and clinical outcomes change when health care providers use more desired terminology. Finally, future research using qualitative methods with adults and adolescents might elucidate preferred weight and eating terms after bariatric surgery.

With these considerations in mind, we offer the following clinical recommendations. Consistent with previous research, variants of “*fatness*” are considered the least desirable when discussing weight after bariatric surgery; however, our findings broadly support the use of terms such as “*weight*” and “*BMI*” after bariatric surgery. Further, our findings support the use of several LOC-eating terms with the following terms rated as the most desirable on average: *ate until uncomfortably full*,” “*kept eating even though not physically hungry*,” “*ate more rapidly than normal*,” “*driven or compelled to eat*,” “*not in control*,” and

“*loss of control*.” Importantly, however, there is heterogeneity in patient preferences (20). For instance, although individuals in our study were significantly more likely to rate “*addicted to food*” as “very undesirable,” some individuals considered this terminology as “very desirable,” suggesting individual variations in preferences. Therefore, asking patients about their language preferences and mirroring patient language (unless the patient uses derogatory terms that are self-shaming) may be useful..

It is also noteworthy that all five of the *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5)* associated features of LOC/binge eating (“*ate more rapidly than normal*,” “*ate until uncomfortably full*,” “*kept eating but not physically hungry*,” “*ate alone because embarrassed by how much you were eating*,” and “*feeling disgusted, depressed, or very guilty*”) (22) were included in the LOC-eating language preference measure. “*Ate until uncomfortably full*”, a *DSM-5* associated feature, was the only positively rated LOC eating term. Two *DSM-5* LOC-eating features, “*ate until uncomfortably full*” and “*kept eating when not physically hungry*” were significantly more desirable than most other LOC-eating terms. On average, “*ate more rapidly than normal*” and “*kept eating but not physically hungry*” were rated as neutral. A significantly greater number of participants reported that two of the *DSM-5* associated features, “*ate alone because embarrassed by how much you were eating*” and “*feeling disgusted, depressed or very guilty*”, were “very undesirable” compared to “very desirable”. Interestingly, the most undesirable *DSM-5* features are both affective (e.g., feeling-based) as opposed to the other associated features which are behavioral features (i.e., *eating rapidly, eating when uncomfortably full, eating when not physically hungry*). These findings on the *DSM-5* features lend further support to the notion that patients might be more accepting of discussing eating behaviors with health care providers.

In conclusion, among individuals who experience disordered eating (specifically, LOC eating) following bariatric surgery, language that focuses on behaviors rather than weight may be perceived as preferable when used by health care providers. Notwithstanding, discussing weight and eating with health care providers was not generally desired. Health care providers should default to positive or neutral terms about weight and LOC eating and ask patients about their language preferences when speaking with individuals before/after bariatric surgery as this may reduce perceived weight bias and improve patient-centered care.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Study Importance Questions

What is already known about this subject?

- Patients may perceive weight stigma by health care providers when certain language is used to query about weight concerns.
- Previous research has examined language preferences for weight and eating terminology among individuals with obesity, but little is known about language preferences after bariatric surgery.

What are the new findings in your manuscript?

- Most terms used to describe weight were rated as undesirable, with “fatness” as the least desirable, by patients who had undergone bariatric surgery.
- Of the weight terms, “weight” and “BMI” were rated neutrally.
- Most loss-of-control eating terms were rated neutrally, and one (“*ate until uncomfortably full*”) was rated positively.

How might your results change the direction of research or the focus of clinical practice?

- Discussing eating behaviors may be more desirable than discussing weight after bariatric surgery.
- Health care providers should use neutral terms and ask patients what terms they prefer to use as this may improve patient-centered care for individuals after bariatric surgery.

Figure 1.
Preferences for Weight-related Terms

Figure 2.
Preferences for Terms Describing Loss-of-Control Eating

Table 1.

Proportions of participants rating weight-related terms as very undesirable and very desirable

Very Undesirable <i>n</i> (%)	Term	Very Desirable <i>n</i> (%)	<i>Z</i>	<i>p</i>
14 (12.3%)	weight	16(14.0%)	-0.39	0.696
35 (30.7%)	heaviness	2(1.8%)	5.93	<0.0001
16 (14.0%)	BMI	16(14.0%)	0.00	1.000
37 (32.5%)	obesity	6 (5.3%)	5.24	<0.0001
22 (19.3%)	excess weight	7(6.1%)	2.98	0.004
64 (56.1%)	fatness	1 (0.9%)	9.24	<0.0001
43 (37.7%)	excess fat	3 (2.6%)	6.60	<0.0001
45 (39.5%)	large size	4 (3.5%)	6.61	<0.0001
17 (14.9%)	unhealthy body weight	9 (7.9%)	1.67	0.098
28 (24.6%)	weight problem	11 (9.6%)	2.99	0.003
22 (19.3%)	unhealthy BMI	4 (3.5%)	3.75	<0.001

Table 2.

Proportions of participants rating terms that describe loss-of-control eating as very undesirable and very desirable

Very Undesirable <i>n</i> (%)	Term	Very Desirable <i>n</i> (%)	<i>Z</i>	<i>p</i>
12 (10.5%)	lack of control	9 (7.9%)	0.69	0.493
15 (13.2%)	loss of control	14 (12.3%)	0.20	0.843
17 (14.9%)	out of control	12 (10.5%)	0.99	0.322
20 (17.5%)	addicted to the food	4 (3.5%)	3.45	0.001
18 (15.8%)	helpless to control your eating	10 (8.8%)	1.61	0.109
15 (13.2%)	had to keep eating, wanted to stop	9 (7.9%)	1.29	0.198
14 (12.3%)	giving in to an urge	10 (8.8%)	0.86	0.390
13 (11.4%)	ate until uncomfortably full	13 (11.4%)	0.00	1.000
13 (11.4%)	kept eating, not physically hungry	14 (12.3%)	-0.21	0.838
14 (12.3%)	ate more rapidly than normal	10 (8.8%)	0.86	0.390
18 (15.8%)	ate alone, embarrassed about how much	5 (4.4%)	2.86	0.005
21 (18.4%)	disgusted, depressed, or very guilty	7 (6.1%)	2.82	0.006
13 (11.4%)	driven or compelled, wanted to stop	11 (9.6%)	0.43	0.667
15 (13.2%)	couldn't stop once started	8 (7.0%)	1.54	0.127
16 (14.0%)	on auto-pilot	11 (9.6%)	1.02	0.308
30 (26.3%)	knew large amount, didn't consider stopping	5 (4.4%)	4.59	<0.0001
24 (21.1%)	loss of willpower	9 (7.9%)	2.82	0.006
11 (9.6%)	not in control	12 (10.5%)	-0.22	0.826