



# Weight acceptance versus body dissatisfaction: Effects on stigma, perceived self-esteem, and perceived psychopathology



Jessica M. Murakami \*, Janet D. Latner

University of Hawaii at Manoa, Department of Psychology, 2530 Dole Street, Sakamaki C400, Honolulu, HI 96822, USA

## ARTICLE INFO

### Article history:

Received 19 May 2015

Received in revised form 11 August 2015

Accepted 17 September 2015

Available online 24 September 2015

### Keywords:

Weight acceptance

Weight bias

Stigma

Body dissatisfaction

## ABSTRACT

**Objective:** It is unknown whether weight acceptance or body dissatisfaction impact anti-fat stigma. Therefore, this study utilized a  $2 \times 2$  between-subject experimental design to examine of the relationship between body acceptance and stigmatization.

**Method:** Participants were university undergraduates ( $N = 394$ , 70% women, mean age = 20.8 years, mean BMI = 23.61 kg/m<sup>2</sup>) who were randomly assigned to read vignettes describing an obese or normal-weight target described as either accepting or not accepting of her weight. Participants completed measures of stigma (the Fat Phobia Scale (FPS), the modified Anti-fat Attitudes Scale (AFA)), perceived self-esteem (assessed with the modified Rosenberg Self-Esteem Scale (RSE)), and perceived psychopathology.

**Results:** Analyses revealed significant main effects for acceptance. Notably, targets who accepted their weight were less stigmatized on the FPS ( $F(1, 354) = 66.82, p < .001$ ) and the AFA willpower subscale ( $F(1, 373) = 37.90, p < .001$ ), and they were perceived as having better self esteem ( $F(1, 371) = 166.16, p < .001$ ) and fewer psychological problems ( $F(1, 381) = 123.19, p < .001$ ) than those who did not accept their weight.

**Conclusion:** Results from this study suggest that size acceptance, even when practiced by obese targets, was significantly less stigmatized than body dissatisfaction and associated with better perceived self esteem and mental health.

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## 1. Introduction

The widespread stigmatization of obesity has many negative repercussions, such as increased vulnerability to low self-esteem, depression, and anxiety, lower educational and occupational attainment, and poorer health care (Puhl & Heuer, 2009; Puhl & Latner, 2007; Tylka et al., 2014). While weight loss is associated with health benefits for individuals who are overweight and obese (Blackburn, 1995; Mertens & Van Gaal, 2000), the evidence suggests that the health benefits associated with weight loss are likely the result of changing lifestyle habits such as increasing physical activity and improving nutrition, rather than the reduction of adiposity itself (e.g., Blackburn, 1995; Storlien et al., 1987; Blair et al., 1989). Further, there is only limited and mixed evidence on whether weight loss can reduce weight-related stigma (e.g., Fardouly & Vartanian, 2012; Latner, Ebnetter & O'Brien, 2012). Moreover, research has clearly demonstrated that substantial and sustained long-term weight loss is difficult and relatively rare (e.g., French, Jeffery, & Murray, 1999; Mann et al., 2007). Given that weight loss is challenging and may not eliminate weight stigma, self-

acceptance of body size and shape may be a more successful and realistic method of managing weight stigma (Puhl & Brownell, 2003).

Excess weight may also contribute to greater body dissatisfaction (Sarwer, Wadden, & Foster, 1998; Schwartz, Brownell, Galuska, Gillespie, & Mokdad, 2004; Annis, Cash, & Hrabosky, 2004). Body dissatisfaction is associated with increased psychological distress, increased risk for developing eating disturbances, and increased risk for weight gain (Ricciardelli, Tate, & Williams, 1997; Neumark-Sztainer, Paxton, Hannan, Haines, & Story, 2006). It is also important to note that body dissatisfaction is observed in the majority of women in developed countries (Lewis & Cachelin, 2001; Coker & Abraham, 2014) and is so pervasive that it has been termed “normative discontent” (Rodin, Silberstein, & Striegel-Moore, 1985). Further, the practice of “fat talk” — verbally expressing dislike for ones' weight and shape—is also widespread among women (Nichter & Vuckovic, 1994). Research has demonstrated that participating in fat talk may be a way for women to garner social approval (e.g. Britton, Martz, Bazzini, Curtin, & LeaShomb, 2006; Nichter, 2000), but at least one study has demonstrated that individuals who do not participate in fat talk are viewed more favorably than those who engage in it (Tompkins, Martz, Rocheleau, & Bazzini, 2009). Despite this finding, little is known about the stigma that results from body dissatisfaction itself.

Given the harmful effects and ubiquitous nature of body dissatisfaction, weight acceptance is an important part of eating disorder prevention and treatment programs (Cooper & Fairburn, 2001; Cooper & Fairburn,

\* Corresponding author.

E-mail addresses: [jmmuraka@hawaii.edu](mailto:jmmuraka@hawaii.edu) (J.M. Murakami), [jlatner@hawaii.edu](mailto:jlatner@hawaii.edu) (J.D. Latner).

2002; Cooper, Fairburn, & Hawker, 2003; Fairburn, 2008). Fostering weight acceptance is also a component of weight-inclusive approaches for managing obesity and chronic dieting such as Health at Every Size (Bacon, Stern, Van Loan, & Keim, 2005) as well as in cognitive behavioral body-image therapy for body-image disturbance (Rosen, Salzbeg, & Srebnik, 1989). Health at Every Size contrasts the ineffectiveness and risks of dieting with self-acceptance, fosters recognition of body diversity, and teaches strategies to improve social, emotional, spiritual, and physical health and psychological well-being (Bacon et al., 2005; Bacon, 2008; Robinson, 2005). Cognitive Behavioral Body-Image Therapy uses a variety of strategies to modify beliefs and attitudes about weight and shape (Rosen et al., 1989) and has been found to be effective in improving body image in overweight and obese persons in the absence of weight loss (Rosen, Orosan, & Reiter, 1996). In the context of obesity management, weight-inclusive approaches like Health at Every Size and Cognitive Behavioral Body-Image Therapy represent a major paradigmatic shift away from weight loss to weight acceptance and health promotion. In their synthesis contrasting approaches to weight management, Tylka et al. (2014) advocated for weight-inclusive approaches like Health at Every Size, citing documented superior findings of psychological, physical, and behavioral benefits over traditional weight-normative approaches. Similarly, research indicates that Cognitive Behavior Body-Image Therapy can result in significant psychological and physical benefits (Provencher et al., 2009; Rosen, Reiter, & Orosan, 1995). There is also evidence that body acceptance can be successfully incorporated as a component of weight-loss treatment (Ramirez & Rosen, 2001).

Despite these promising findings, body acceptance—especially as a stand-alone treatment—is controversial. In some contexts, body acceptance may be perceived as a forfeiture of control and embracing of a non-ideal weight and lifestyle. Further, despite evidence to the contrary (e.g., Bacon et al., 2005; Steinhardt, Bezner, & Adams, 1999; Provencher et al., 2009; Miller, Wallace, Eggert, & Lindeman, 1993), some critics have charged that body acceptance may cause individuals to abandon health-promoting behaviors, resulting in weight gain and poor physical health (Bacon & Aphramor, 2011). Controllability theory posits that weight stigma results from blaming overweight and obese people for failing to control their weight (Crandall, 1994). Therefore, body acceptance could potentially compound stigma by adding the perceived failure to even attempt to control body weight to the public's blame of overweight or obese individuals. Considering the negative consequences of weight stigma and the importance of preventing increased stigma, research is needed to examine societal attitudes about those who practice self-acceptance.

Given the widespread and detrimental nature of body dissatisfaction, the benefits of body acceptance, and the controversy that surrounds body acceptance, the purpose of the present study was to examine attitudes toward normal-weight and obese individuals who either accept or do not accept their weight. Given the relative paucity of literature on the influence of body acceptance on stigma, we proposed the following speculative hypotheses: Based on Tompkins et al. (2009) finding that fat talk could negatively impact an individual's likeability, we hypothesized that non-acceptance would be more stigmatized than acceptance on dimensions of anti-fat stigma, self-esteem, and perceived psychopathology. We also hypothesized specifically that non-accepting obese individuals would be more stigmatized than their accepting obese counterparts. However, in light of controllability theory and the possibility that weight-acceptance might compound obesity stigma, we also aimed to explore the competing hypothesis that weight-accepting obese individuals would be more highly stigmatized than other individuals.

## 2. Methods

### 2.1. Participants and recruitment

The study sample consisted of 394 university participants (70.0% female; mean age = 20.80 years,  $SD = 5.20$ ) recruited from 4 university

campuses across the state of Hawaii. The ethnic background of this sample was 20.3% Caucasian, 40.4% Asian, 35.3% mixed ethnicity, 2% Hispanic, 1.3% Pacific Islander, 0.3% African or African American, 0.3% Native American or Alaska Native, and 0.3% other ethnicity. Their mean body mass index (BMI,  $\text{kg}/\text{m}^2$ ), based on self-reported height and weight, was 23.61 ( $SD = 4.81$ ); 7.61% underweight ( $\text{BMI} < 18.5$ ), 60.15% normal weight ( $18.5 \leq \text{BMI} < 24.99$ ), 21.80% overweight ( $25 \leq \text{BMI} < 30$ ), 9.39% obese ( $\text{BMI} \geq 30$ ); 2.5% failed to provide adequate information (i.e. height and/or weight) to determine their BMI.

### 2.2. Procedures

Data were collected online at [SurveyMonkey.com](http://SurveyMonkey.com). At recruitment, participants were informed that the study was examining attitudes about different groups of people. Participants were randomized to read vignettes describing an accepting or non-accepting target who was either obese or normal-weight, in a 2 (accepting vs. non-accepting)  $\times$  2 (obese vs. normal weight) between-subjects design. As women are stigmatized on the basis of weight more often than men (Puhl & Brownell, 2001; Puhl & Heuer, 2009), the target was female. The target was described as 21 years old, matching the mean age of respondents typically recruited from the University system campuses, and the most common name among 21-year old U.S. females at the time of data collection was chosen as the target's name (Ashley). The vignettes referred differentially to the target's body acceptance (i.e. "Ashley believes her body shape and body weight is attractive and her body is satisfactory at her current weight" vs. "Ashley believes her body shape and body weight is unattractive and her body is unacceptable because of her current weight"). The target's weight and height reflected BMI levels of 35.2 and 20.6 in the obese and normal weight range, respectively (i.e. "Ashley is now 5' 4" (1.62 m) tall, weighs 205 lb (93 kg)" vs. "Ashley is now 5' 4" (1.62 m) tall, weighs 120 (54.43 kg)"). All vignettes were made uniform such that details unrelated to weight status or body satisfaction and text length (105–114 words), were matched across conditions; vignette texts can be obtained from the first author.

After reading the vignette, participants completed several measures. All measures asked participants for their opinions about the specific target described in the vignette (target-specific) while retaining as much of their original language as possible.

### 2.3. Measures

#### 2.3.1. Target-directed stigma

The short-form of the Fat Phobia Scale (FPS; Robinson, Bacon, & O'Reilly, 1993; Bacon, Scheltema, & Robinson, 2001) was used as a measure of stigma against the target. This scale has demonstrated strong psychometric properties (Yuker, Allison, & Faith, 1995), with evidence of its excellent reliability and construct validity (Robinson et al., 1993; Bacon et al., 2001). The FPS is a 14-item measure scored on a five-point semantic differential scale. Each item contains two adjectives (e.g., 1 = industrious to 5 = lazy) that are weighted on opposing sides of the scale. Participants were asked to choose the word that more closely described the target. Higher mean scores indicate greater levels of stigma. In the present sample, Cronbach's alpha was 0.84.

The Crandall Anti-fat Attitudes scale (AFA; Crandall, 1994) was used to further assess negative attitudes related to people of the target's weight. This scale has demonstrated adequate psychometric properties with evidence of its reliability and construct validity (Crandall, 1994) as well as its cross-cultural value (Crandall & Martinez, 1996). The original 13-item scale assesses negative attitudes related to fat (e.g., "I really don't like fat people much.") across three domains: Dislike, Willpower, and Fear of Fat. Responses range from 0 = very strongly disagree to 9 = very strongly agree such that higher scores indicate greater stigma. This measure was modified to be target-specific (e.g., "I really don't like people who are Ashley's weight much.") while retaining as much of the

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