



Weight and health-related quality of life: The moderating role of weight discrimination and internalized weight bias



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ABSTRACT

Objectives: Obesity is an increasingly prevalent public health concern, with associated medical comorbidities and impairment in health-related quality of life (HRQoL). Obese women are frequently victims of weight-related discrimination. The HRQoL impairments among obese people could be related to this discrimination and to internalized weight bias.

Design

We examined the potential moderating role of discrimination (from others) and self-directed (internalized) weight-based discrimination in the association between body mass index (BMI) and HRQoL.

Methods: Eighty-one women (mean age = 41.1 years; mean BMI = 43.40 kg/m², 97% Caucasian) completed valid and reliable measures of weight bias internalization (weight bias internalization scale), perceived discrimination by others (everyday discrimination scale) and both physical and mental HRQoL (SF-36 Health Survey). Multiple regression analysis was used to test whether internalized weight bias or discrimination moderated the association between BMI and the summary scores for physical and mental HRQoL, controlling for age.

Results: Significant associations were found between BMI and discrimination ($r = .36, p = .002$), between internalized weight bias and both mental ($r = .61, p < .001$) and physical HRQoL ($r = .45, p < .001$), and between discrimination and physical HRQoL ($r = .29, p = .014$). A statistically significant interaction was found between BMI and internalized weight bias ($b = -.21, SE = .10, p < 0.05$) in accounting for the variance in physical HRQoL.

Conclusions: The association between higher BMI and poorer physical HRQoL was found only in individuals reporting high levels of internalized weight bias. Self-discrimination among overweight individuals may be a critical factor in their physical health impairment.

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1. Introduction

Obesity is an increasingly prevalent public health concern (Flegal, Carroll, Kit, & Ogden, 2012) with many associated medical comorbidities (e.g. Bray, 2004; Lawrence & Kopelman, 2004). Increased weight is associated with significant health impairment due to greater prevalence of conditions such as diabetes, cardiovascular disease, atherosclerosis, and many other risks. High body mass has been repeatedly shown to be associated with multiple domains of poorer health-related quality of life (HRQoL), the subjective perception of mental and physical health and functional impairment (de Zwaan et al., 2009; Hassan, Joshi, Madhavan, & Amonkar, 2003; Jia & Lubetkin, 2005; Kolotkin, Crosby, Kosloski, & Williams, 2001; Kozak et al., 2011). In

one striking example, children with obesity were shown to have poorer HRQoL than children diagnosed with cancer (Schwimmer, Burwinkle, & Varni, 2003).

Obese individuals are subject to a steady stream of pervasive and harmful discrimination. The prejudice faced by obese individuals is evident across interpersonal, employment, educational, and medical settings (Puhl & Heuer, 2009; Puhl & Latner, 2007), and the intensity of weight-based discrimination is increasing over time (Andreyeva, Puhl, & Brownell, 2008; Latner & Stunkard, 2003). Some forms of weight-based discrimination may even be equally or more prevalent than other forms of discrimination such as sexism, racism, homophobia, and religious intolerance (Latner, O'Brien, Durso, Brinkman, & MacDonald, 2008; Puhl, Andreyeva, & Brownell, 2008). Weight-related discrimination is especially common among obese women, who experience prejudice more commonly than obese men (Puhl et al., 2008). Weight-based discrimination can lead to symptoms of depression, poorer body image and self-esteem, poorer educational and occupational attainment, and even suicidal ideation (Puhl & Heuer, 2009).

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The impairments in health and HRQoL among obese individuals are commonly attributed to the direct physical toll of increased adiposity itself. However, it is also possible that the discrimination of obese people may negatively affect their well-being. As a parallel example, discrimination has been shown to have a negative impact on health in minority populations such as racial and sexual orientation minorities (Krieger, 1999; Pascoe & Richman, 2009). Discrimination could also affect the health outcomes of obese individuals and exacerbate health disparities (Puhl & Heuer, 2010). For example, patients with obesity receive poorer treatment by medical professionals and health education instructors, many of whom exhibit strong weight prejudice (Puhl & Heuer, 2009). As a result of discrimination, obese individuals may be more likely to avoid medical care (Amy, Aalborg, Lyons, & Keranen, 2005) and physical activity (Faith, Leone, Ayers, Heo, & Pietrobelli, 2002), to exhibit maladaptive eating patterns (Durso, Latner, & Hayashi, 2012), and to gain weight over the long term (Sutin & Terracciano, 2013). More research is needed to directly examine the relationship between discrimination and health impairment.

The internalization of weight bias, defined as holding negative beliefs about oneself due to weight or size, may also have a powerful relationship to well-being (Durso & Latner, 2008; Durso, Latner, & Hayashi, 2012). In treatment-seeking overweight and obese adults, internalized weight bias was associated with HRQoL (Latner, Durso, & Mond, 2013). Research in ethnic minorities suggests a parallel process whereby internalized racism may be associated with health outcomes (Butler, Tull, Chambers, & Taylor, 2001). Similarly, dissatisfaction with current weight predicted physical and mental health impairment to a greater extent than body mass index (BMI; kg/m²) in U.S. adults (Muennig, Jia, Lee, & Lubetkin, 2008). Body image dissatisfaction, a construct highly correlated with internalized weight bias (Durso & Latner, 2008), mediated the association between self-reported BMI and poorer physical functioning in U.S. college students (Wilson, Latner, & Hayashi, 2013). Interestingly, in a Dominican Republic community sample that did not stigmatize obesity, BMI was not associated with self-reported health (Muennig & Bench, 2009). It is possible that findings in minority groups linking both discrimination from others and internalized bias to health outcomes may also apply to obese individuals.

It is possible that the stress associated with internalized bias or prejudice from others could have an impact on cardiovascular health and metabolic abnormalities, leading to poorer HRQoL (Meyer, 2003). It is possible that these factors could, in turn, increase weight gain and future risk of additional discrimination and internalized stigma, thus initiating and maintaining a vicious circle (Puhl & Latner, 2007). Obesity stigma has been posited to threaten health and magnify health disparities (Puhl & Heuer, 2010). In treatment-seeking overweight adults, internalized weight bias mediated the relationship between BMI and weight-related quality of life, suggesting that the health impairments associated with obesity may be accounted for, in part, by weight-related self-stigma (Lillis, Levin, & Hayes, 2011). However, it is unknown whether internalized weight bias or discrimination by others is a more potent moderator of the relationship between BMI and HRQoL, and more research in additional samples is needed.

The purpose of the present study was to examine the potential moderating role of both external weight-based discrimination, perpetuated by others, and of weight-based self-discrimination, internalized within the self, in the relationship between BMI and health-related quality of life. It was hypothesized that both external and internal discrimination would independently moderate the association between BMI and HRQoL in a non-clinical sample of women.

2. Material and methods

2.1. Participants and procedure

Participants were initially contacted by email announcements to 34 weight-related Yahoo! Groups (a listserv and message board platform;

see <http://groups.yahoo.com>.) In total, 119 adults responded to the on-line survey, with 87 providing enough information for analysis in the present study. Of these, 5 identified as male, 1 identified as transgender, and one did not provide information about their gender. Given the much larger number of women in the sample, and as the weight-related experiences and attitudes of women may be more negative than those of men (Puhl et al., 2008), we present only those data from female participants. The final sample included 81 women from 23 U.S. states and 4 non-U.S. countries (97.5% White, 2.5% Asian-American; mean BMI = 43.40; SD = 15.38, mean age = 41.1 years; SD = 10.92). BMI was calculated from self-reported height and weight due to the nature of the data collection. The majority of participants were obese (80%) or overweight (9%), with 92% self-identifying as “slightly overweight,” “overweight,” or “extremely overweight.” This study was approved by the Institutional Review Board at a U.S. university.

2.2. Measures

2.2.1. Weight bias internalization scale (WBIS)

The WBIS assesses the degree to which respondents believe that negative stereotypes and self-statements about being overweight apply to themselves (Durso & Latner, 2008). Eleven questionnaire items are rated on a 7-point scale from “strongly disagree” to “strongly agree” (e.g. “I hate myself for being overweight.”). The WBIS has shown internal consistency and convergent validity in community samples of overweight and obese adults, as well as in a clinical sample of overweight and obese adults seeking treatment for binge eating disorder (Durso & Latner, 2008; Durso, Latner, White, et al., 2012). Higher scores indicate greater internalized bias ($M = 3.31$, $SD = 1.60$). Cronbach's alpha in this sample was .76.

2.2.2. Everyday discrimination scale (EDS)

The EDS is an 11-item scale measuring perceived discrimination because of such things as race, ethnicity, gender, age, religion, physical appearance, sexual orientation, or other characteristics (Kessler, Mickelson, & Williams, 1999; Williams, Yu, Jackson, & Anderson, 1997). Participants were asked whether they had ever experienced any of 11 different scenarios due to discrimination (“Have you EVER been discriminated against in each of the following ways because of such things as your race, ethnicity, gender, age, religion, physical appearance, sexual orientation, or other characteristics?”). For example, participants were asked whether they had ever been (0 = no, 1 = yes) “You were discouraged by a teacher or advisor from seeking higher education,” “You were not hired for a job,” or “You were denied or provided inferior medical care.” Responses to each of the 11 items were then totaled for a summary score from 0 to 11 ($M = 2.08$, $SD = 1.96$).

2.2.3. SF-36 health survey

The Medical Outcomes Survey Short-form Health Survey (SF-36; Ware & Sherbourne, 1992) is a 36-item measure of health-related quality of life. Many of the questions pertain to the past four weeks, and some refer to the present time more generally. The SF-36 is composed of an 18-item physical component summary score (PCS; sample item: “Did you feel tired?”), and an 18-item mental component summary score (MCS; sample item: “Have you felt calm and peaceful?”). The summary scores have been demonstrated to be valid and reliable measures of HRQoL, with each scale normed to have a mean of 50 and standard deviation of 10 (Ware & Sherbourne, 1992). The RAND scoring method, which employs factor weightings derived by means of oblique, rather than orthogonal, factor rotation, was used on account of its superior psychometric properties and recommended use (Windsor, Rodgers, Butterworth, Anstey, & Jorm, 2006). Lower scores indicate greater functional impairment (PCS $M = 61.07$, $SD = 24.18$, Cronbach's alpha = .78; MCS $M = 56.43$, $SD = 23.75$, Cronbach's alpha = .73).

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