



Original article

Coping with Weight-related Discrepancies: Initial Development of the WEIGHTCOPE


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A B S T R A C T

Purpose: The present research sought to provide the initial development, validation and reliability for a measure (WEIGHTCOPE) to assess the variation in how women, who are currently trying to lose or maintain weight, cope with common, perceived weight-related discrepancies.

Methods: To this end, two studies were conducted to 1) develop an initial list of coping responses to common weight-related triggers, 2) create an initial measurement model through exploratory factor analysis (study 1; n = 470), and 3) provide initial validation for the measure through confirmatory factor analysis (study 2; n = 310).

Findings: Results support the initial validity and reliability of a 38-item, 10-factor structure: Physical Activity, Healthy Eating, Suppressed Eating, Supplement Use, Self-Regulation, Positive Reframing, Social Support, Disengagement, Camouflage, and Comfort Food. The present findings reiterate individual variation in coping choice in response to a perceived weight-related discrepancy, and its prospective assessment with the WEIGHTCOPE.

Conclusions: The WEIGHTCOPE can be an integral tool for public health and clinical practice, where triggers are common, and interventions are employed to enhance the use of more positive forms of weight control behaviors and/or avoid negative consequences of weight- and fat-related discrepancies. Future research can use the WEIGHTCOPE to help guide theoretical and pragmatic approaches to various triggering events and potential moderators of coping.

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Triggering events have been cited as important sparks for weight loss and control behaviors in women, especially those related to diagnosis of risk and health concerns (i.e., medical trigger), improving appearance, and emotional or ongoing discontent (Gorin, Phelan, Hill, & Wing, 2004; LaRose, Leahey, Hill, & Wing, 2013; Wing & Phelan, 2005). Triggering events for weight loss have been cited in successful losers and maintainers of at least 10% of initial body weight for greater than 1 year (Wing & Phelan, 2005). Similar findings have been found in smoking cessation literature, with medically related triggering events (e.g., myocardial infarction) substantially increasing one's odds of quitting (Wray, Herzog, Willis, & Wallace, 1998).

Weight-related Discrepancies

Screening for overweight and obesity has been promoted to combat the high prevalence and associated health problems (Moyer, 2012). Such screenings are a common component of primary care, public health, and fitness settings, hopefully providing both awareness and motivation for change in weight control behaviors. According to the feedback processing model of self-regulation, a desire to change is initiated with a perceived discrepancy about oneself in relation to a standard or goal (Carver & Scheier, 2001). For example, one may find at her annual physician's visit that she has gained 10 pounds. The perceived discrepancy can then act as "trigger" for subsequent efforts to reduce the discrepancy and/or any affective response.

Triggers, or sparks for change, can also come from other common sources. One may stumble across an old picture reminding her of how much she used to weigh, try on a pair of old pants that are now too tight, or have difficulty taking the stairs. Such discrepancies can stem from innate, personal, cultural, and/or psychosocial pressures to control weight and fat

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levels (Brownell, 1991; Faries & Bartholomew, 2012; Rodin, 1993; Symons, 1995), alongside the heavy promotion from the health and medical communities. Health care settings (Merrill & Grassley, 2008), common weight and body composition testing (Faries, Boroff, Stults-Kolehmainen, & Bartholomew, 2011), and simple awareness of one's body weight and/or fat from daily situational factors (Rahimi, 2010) have been shown to produce discrepancies and negative affective responses in women. To complicate matters, previous research has established that a substantial number of women, spanning all ages and weight classifications, are dissatisfied with their body weight and/or bodies (Frederick, Peplau, & Lever, 2006; Millstein et al., 2008; Neighbors, Sobal, Liff, & Amiraian, 2008). In addition, practitioners' ability to diagnose overweight and provide weight counseling can be inadequate, and not conducive to encouraging healthy weight control practices in their patients. For example, 60% of internal medicine residents across two residency programs did not know the minimum body mass index (BMI) for diagnosing obesity, with 69% not recognizing waist circumference as a reasonable measure of obesity (Block, DeSalvo, & Fisher, 2003). In primary care, physicians have been found to express major barriers to providing weight counseling, such as poor confidence, knowledge, and skills, which translated to only 5% of patients receiving weight loss, exercise, and dietary advice from their physician (Huang et al., 2004). Similarly, Cox et al. (2011), found that primary care physicians rarely expressed empathy or used patient-centered techniques in their weight loss discussions with their overweight and obese patients. Even with the concern of excessive gestational weight gain and long-term obesity, providers have been found to provide inadequate and incorrect advice to patients, such as being advised to gain too much weight, providing limited advice on exercise, or giving no recommendation for weight gain and physical activity at all (Stengel, Kraschnewski, Hwang, Kjerulff, & Chuang, 2012).

Positive and Negative Behavioral Choices

The stress and negative affect that comes from such discrepancies can be dealt with in a number of ways. Clearly, practitioners hope that discrepancies created in practice or experiences in the patients' personal lives will trigger positive motivation for healthy eating, physical activity, and self-monitoring, which are generally recommended for a healthy lifestyle (Bastian et al., 2010; Blair, 1993; Donnelly et al., 2009; Elfhag & Rossner, 2005). However, individuals might also be inclined to respond through more negative or unhealthy behaviors, such as excessive dietary restraint, skipping meals, supplement/diet pill use, vomiting, use of laxatives and fad diet products, or smoking (Kruger, Galuska, Serdula, & Jones, 2004; Neumark-Sztainer, Story, & French, 1996; Neumark-Sztainer, Paxton, Hannan, Haines, & Story, 2006; Saper, Eisenberg, & Phillips, 2004; Serdula et al., 1994; Tyler, Allan, & Alcozer, 1997; White, McKee, & O'Malley, 2007).

Coping with Weight-related Discrepancies

Unfortunately, little research exists on common, weight-related triggers, or variation in emotional and behavioral responses. These individual differences can be better conceptualized by the transactional model of stress and coping (Folkman & Lazarus, 1985; Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). Problem-focused coping refers to behaviors that are perceived to change the relationship between the person and

the present environment by reducing the cause of the stressor or problem, such as the aforementioned positive and negative weight control behaviors. Emotion-focused coping refers to behaviors that are perceived to regulate the emotional distress that stems from the discrepancy. Specific to weight-related distress, individuals may choose to cope with decreased motivation, psychological and behavioral avoidance, or hindered emotional regulation (Heatherton & Baumeister, 1991; Neumark-Sztainer et al., 2006; Schwartz & Brownell, 2004; Teixeira et al., 2006).

As body dissatisfaction increases in women, so may avoidance behaviors from social situations, public changing rooms, bathing suits, Physical Activity, and physical intimacy (McLaren & Kuh, 2004). Similarly, perceptions of weight stigmatization, an obstacle in public health (Puhl & Heuer, 2010), seem to be related positively to disengagement and avoidant coping (Myers & Rosen, 1999; Savoy, Almeida, & Boxer, 2012). Interestingly, "obese" women have reported several weight-related reasons for avoiding health care, such as gaining weight, being told to lose weight, or having to get weighed (Drury & Louis, 2002). Obese women with a history of gestational diabetes, who would presumably be triggered for weight control, are less likely to be attempting weight loss compared with obese women without such a history (Katon, Maynard, & Reiber, 2012). Disengagement may be an appropriate strategy for those who do not need to lose weight, or who have a tendency to cope with more unhealthy forms of weight control behavior. From a general coping view, however, those who enact proper, more active coping and self-regulatory responses to demands of life and difficulties in weight control behavior (e.g., exercise, dietary control, seeking instrumental social support, problem solving, and directly confronting problems) are subsequently more successful in weight control (Drapkin, Wing & Shiffman, 1995; Elfhag & Rossner, 2005; Kayman, Bruvold, & Stern, 1990; Klem, Wing, McGuire, Seagle, & Hill, 1997). On the other hand, maladaptive coping strategies are a proposed root cause of obesity, poor health, and further weight gain (Hemmingsson, 2014).

The Need for a New Measure

As shown, behavioral and psychological responses are not created equal, and triggering events could motivate women across all weight and body size classifications to choose from an array of efforts to deal or cope with the discrepancy and/or affective state. Theoretically, successful self-regulation of weight control behavior might be influenced by how one copes with these common experiences. However, a valid measure would be needed to assess this variation in coping responses, which could then inform weight-related testing, prescription, and counseling. Unfortunately, no current measure meets these needs.

Although providing insight, current coping measures are geared either toward general coping responses (e.g., Carver, 1997; Carver, Scheier, & Weintraub, 1989; Folkman & Lazarus, 1985) or general body image (e.g., Cash, Santos, & Williams, 2005). These measures are not worded to capture all specific behaviors proposed as responses to common perceived weight- or fat-related discrepancies. Other related measures are too specific in scope, such as coping only with weight stigmatization in obese individuals (Myers & Rosen, 1999). Thus, the WEIGHTC OPE measure sought to address these needs by conducting two studies to 1) develop an initial list of coping responses to common weight-related triggers in women, 2) create an initial measurement model through exploratory factor analysis

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