



Mechanisms underlying weight status and healthcare avoidance in women: A study of weight stigma, body-related shame and guilt, and healthcare stress

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ABSTRACT

Studies show that women with high BMI are less likely than thinner women to seek healthcare. We aimed to determine the mechanisms linking women's weight status to their healthcare avoidance. Women ($N = 313$) were surveyed from a U.S. health-panel database. We tested a theory-driven model containing multiple stigma and body-related constructs linking BMI to healthcare avoidance. The model had a good fit to the data. Higher BMI was related to greater experienced and internalized weight stigma, which were linked to greater body-related shame. Internalized weight stigma was also related to greater body-related guilt, which was associated with higher body-related shame. Body-related shame was associated with healthcare stress which ultimately contributed to healthcare avoidance. We discuss recommendations for a Weight Inclusive Approach to healthcare and the importance of enhancing education for health professionals in weight bias in order to increase appropriate use of preventive healthcare in higher weight women.

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1. Introduction

Multiple professional societies and health agencies, both in the U.S. and internationally, have proposed new guidelines for the treatment of individuals based on body mass index (BMI) (Ryan, 2016). These guidelines presume a person with “obesity” is beset with a disease requiring intervention, as driven by The Obesity Society's (TOS) “Obesity as a Disease Writing Group” (Allison et al., 2008). Accordingly, in the U.S., per the current Obesity 2 Guidelines (Jensen et al., 2014), healthcare professionals are expected to: (a) calculate BMI at annual visits (or more often); (b) advise patients on high BMI risks; (c) counsel patients with BMIs over 30 (and BMIs over 25, if they have comorbidities) to lose weight, noting larger losses will lead to more benefits; (d) prescribe calorie restriction and, if feasible, nutrition counseling to aid with this; (e) suggest long-term comprehensive high intensity lifestyle programs to implement physical activity and lower calorie eating; and

(f) advise bariatric surgery in individuals with BMIs over 40 (and over 35, if comorbidities are present and behavioral approaches were unsuccessful) (Apovian, 2014). These expectations—and the assumptions on which they are based—constitute what Tylka et al. (2014) have referred to as the *Weight Normative Approach*. Although the Weight Normative Approach currently dominates Western healthcare practice, this paradigm has been criticized for having the potential to harm patients (e.g., Calogero, Tylka, & Mensinger, 2016; O'Hara & Gregg, 2012; Tylka et al., 2014). In contrast, the *Weight Inclusive Approach* challenges the belief that a particular BMI reflects certain health practices or health status, suggests that health and wellness can be fostered independent of weight, celebrates the natural diversity of bodies, and seeks to eradicate weight stigmatization within healthcare, thereby facilitating access to healthcare for all individuals (Tylka et al., 2014).

While a discussion of problems and controversies surrounding the new U.S. Obesity 2 Guidelines extends beyond the scope of this paper, we note two important considerations. First, physicians report lacking the comfort, knowledge, time, and skill set to effectively counsel patients on issues surrounding weight (Ashman, Sturgiss, & Haesler, 2016). Second, there is a burgeoning body of research documenting pervasive weight stigmatization among healthcare providers (e.g., Forhan & Salas, 2013; Puhl, Latner, King, & Luedicke, 2014). In fact, one study showed over two-thirds

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(69%) of higher weight people reported feeling stigmatized by their physicians, second only to family members (at 72%) in sources of experienced stigma (Puhl & Brownell, 2006). This finding was later replicated in a Taiwanese sample (Wu & Liu, 2015). Although there has been some attention towards stigma reduction programs in healthcare (e.g., Poustchi, Saks, Piasecki, Hahn, & Ferrante, 2013), a recent review showed only small beneficial effects of the programs studied, and, little long-term evidence has been substantiated (Alberga et al., 2016). It is very concerning that multiple studies have noted a delay in seeking healthcare, for women in particular, in order to avoid being fat shamed or being given unsolicited advice to lose weight (e.g., Cossrow, Jeffery, & McGuire, 2001; Drury & Louis, 2002; Lee & Pausé, 2016). Thus, there seems to be a disconnect between the push in the healthcare field to more consistently provide weight loss treatment (Apovian, 2014; Jansen, Desbrow, & Ball, 2015; Ko et al., 2008), and the avoidance of healthcare, especially among higher weight women, because of felt biases and stigma surrounding their weight (Amy, Aalborg, Lyons, & Keranen, 2006; Merrill & Grassley, 2008; Pausé, 2014).

Stigma is defined as “the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination, in a context in which power is exercised” (Hatzenbuehler, Phelan, & Link, 2013, p. 813). Theoretical frameworks have been proposed in public health that conceptualize stigma as a *fundamental cause* of ongoing health inequities (Hatzenbuehler et al., 2013). Weight or fat stigma is the “moral discrediting” (Brewis, 2014) experienced by a person living in a higher weight body as a result of the negative decrees and social judgements casted by others. This moral discrediting includes beliefs that fatter people are sloppy, dishonest, and non-compliant (Puhl & Peterson, 2014). Notably, despite the increasing attention towards weight in the past two decades, doctors’ negative reactions towards higher weight patients are not new (Najman, Klein, & Munro, 1982), and this negativity does not appear to be waning (Phelan et al., 2014; Tomiyama et al., 2015). Multiple forms of weight stigma exist and terms to describe stigmatization vary from prejudice to bias to discrimination. Although each of these terms have unique nuances, we are using the term “stigma” broadly in this context to cover these multiple but related concepts (Stuber, Meyer, & Link, 2008). In this study, we are also distinguishing two forms of weight stigma, “experienced” and “internalized.”

The experience of weight stigmatization has a compelling history of studies showing its negative implications on health outcomes (e.g., Hunger & Major, 2015; Sutin et al., 2016; Udo, Purcell, & Grilo, 2016; Vadeloo & Mattei, 2017), including mortality (Sutin, Stephan, & Terracciano, 2015), and stigmatization in general negatively impacts population health through structural oppression (Link & Phelan, 2006) (see Pascoe & Smart Richman, 2009, for a review). However, recent research demonstrates that internalized weight stigma may actually be even more insidious than experienced weight stigma (Latner, Barile, Durso, & O’Brien, 2014; Pearl & Puhl, 2016). While experienced weight stigma describes specific instances where individuals are treated negatively because of their fatness, internalized weight stigma on the other hand, occurs when stigma is self-directed, personalized, and afflicted towards oneself (Durso & Latner, 2008).

Internalized weight stigma has been consistently associated with markers of negative psychological well-being, such as disordered eating, body dissatisfaction, lower levels of physical activity, emotional dysregulation, and low self-esteem (e.g., Hilbert, Braehler, Haeuser & Zenger, 2014; Pearl, Puhl, & Dovidio, 2015; Puhl, Moss-Racusin, & Schwartz, 2007; Webb & Hardin, 2016). Moreover, the internalization of weight stigma has also been implicated as a moderator of the relationship between BMI and health-related quality of life (Latner et al., 2014). This study demonstrated that there was an association between higher weight status and poorer health-related quality of life, but *only* in individuals

with high levels of internalized weight stigma. Similarly, high levels of internalized weight stigma was also found to be a barrier to improving physical activity and eating outcomes in healthy living interventions (Mensinger & Meadows, 2017; Mensinger, Calogero, & Tylka, 2016).

Experienced weight stigma can be explicit (i.e., deliberate, such as beliefs that fat patients are lazy and weak-willed) or implicit (i.e., non-deliberate, such as an environment that does not accommodate fatter bodies), and research suggests that even implicit biases among physicians contribute to health disparities for marginalized people (Chapman, Kaatz, & Carnes, 2013). Ultimately, weight stigma (both implicit and explicit) can manifest as healthcare professionals’ negative attitudes and behaviors towards higher weight patients (Phelan et al., 2014; Sabin, Marini, & Nosek, 2012; Tomiyama et al., 2015; see Malterud & Ulriksen, 2011 for a review). These negative attitudes and behaviors not only contribute to higher weight patients’ experiences of weight stigma at their healthcare provider’s office, but they likely negatively impact their future healthcare utilization, either with that provider or other providers.

To date, existing research has only focused on the association between patient BMI and healthcare utilization (e.g., Adams, Smith, Wilbur, & Grady, 1993; Reidpath, Crawford, Tilgner, & Gibbons, 2002) and has not yet explored processes that may connect these variables, such as experienced weight stigma from their healthcare provider and the internalization of weight stigma. Indeed, the mechanisms underlying this association are unclear, and the nature and direction of this relationship tends to depend on the type of services considered. Whereas BMI has shown a positive relationship with outpatient medical services and Emergency Room (ER) use (Fontaine, Faith, Allison, & Cheskin, 1998; Reidpath et al., 2002), BMI is negatively related with preventive care, such as gynecological and/or breast cancer screenings (Adams et al., 1993; Amy et al., 2006; Fontaine et al., 1998; Reidpath et al., 2002; Wee, McCarthy, Davis, & Phillips, 2000), as well as colorectal cancer screening (Rosen & Schneider, 2004).

Because healthcare is one of the primary sources of stigma faced by people with high BMI (Puhl & Brownell, 2006; Wu & Liu, 2015), one group of researchers tested the hypothesis that “doctor shopping” might partially explain the increased ER service utilization rates in patients with high BMI (Gudzune et al., 2013). In their sample of over 20,000 healthcare beneficiaries, analyses of claims data indicated that patients labeled as “overweight” and “obese” had increased odds of doctor shopping (defined as having five or more different primary care providers within a period of 24 months) compared to lower weight patients. Doctor shoppers, regardless of weight, tended to utilize more services, as determined by ER visits (Gudzune et al., 2013).

In the present study, we aimed to show the variables linking BMI and healthcare avoidance. We constructed a model grounded in Stereotype Threat Theory (Steele & Aronson, 1995) and Social Identity Threat (Major & O’Brien, 2005). Stereotype Threat Theory elucidates how stigmatized groups tend to underperform under certain situational cues, and Social Identity Threat describes how stigma elicits both volitional and non-volitional stress responses (e.g., increased blood pressure, nonverbal anxiety) to social situations that are potentially threatening. Women are particularly vulnerable to social identity threat according to previous research examining stress within workplace settings and burnout (e.g., Hall, Schmader, & Croft, 2015). The implicit and explicit weight biases in healthcare professionals are indeed potentially threatening to patients (Merrill & Grassley, 2008; Pausé, 2014). Once stigma-induced identity threat is anticipated, some people cope using disengagement (i.e., avoidance) strategies (Merrill & Grassley, 2008; Miller & Kaiser, 2001), and hence avoid the healthcare encounter altogether.

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