



Repressive coping, stigmatization, psychological distress, and quality of life among behavioral weight management participants



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ABSTRACT

Repressive coping has been associated with elevated risk of disease and negative health outcomes in past studies. Although a prior study of healthy men found that repression was associated with lower body mass index (BMI), no study has examined repressive coping among obese individuals. This study examined the relationship of repressive coping with BMI and obesity-relevant psychosocial factors among 104 overweight and obese participants in a behavioral weight management program. Participants completed questionnaires assessing repressive coping, stigmatization, psychological distress, and quality of life. BMI was objectively measured. Repressors reported lower stigmatization, anxiety, and depression as well as higher emotional and weight-related quality of life. Repressors and non-repressors had equivalent BMI and reported similar impairment in physical quality of life, but stigmatization moderated the relationship between repressive coping and physical quality of life ($b = 0.31, p = 0.039$), reflecting better physical quality of life among non-repressors with lower stigmatization. Obese individuals who engage in repressive coping may tend to underreport psychological symptoms, social difficulties, and impairments in quality of life. Higher physical quality of life among non-repressors with lower stigmatization may reflect a combined influence of coping and social processes in physical quality of life among obese individuals.

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1. Introduction

Repressive coping, characterized by low self-reported trait anxiety and high self-reported defensiveness (Weinberger, Schwartz, & Davidson, 1979), is more common among individuals with chronic medical conditions than in the general population and has been associated with negative health outcomes (see Myers et al., 2008 and Myers, 2010 for reviews). Repressive coping has been associated with increased risk of cancer and hypertension (Mund & Mitte, 2012) and elevated risk of death and myocardial infarction (MI) among patients with coronary artery disease (Denollet, Martens, Nyklíček, Conraads, & de Gelder, 2008). Similarly, among post-coronary angioplasty patients without a history of MI, repressive coping style combined with higher levels of cardiac information was associated with increased risk of medical complications (Shaw et al., 1986). Taken together, these results suggest that avoidance of negative affect and information among repressors may be detrimental to long-term health (Myers, 2010). However, the relationship between repressive coping and poor physical health outcomes does not appear to be consistent across medical conditions. In

fact, repressive coping was associated with better physiological control in patients with diabetes and better objective lung function in patients with asthma, possibly because repressors may be better able than non-repressors to engage in health behaviors that require self-control (Myers et al., 2005).

Repressive coping also has been associated with poorer quality of life in medical populations. Repression was associated with lower physical quality of life among adults with colorectal cancer, but repression was not associated with mental quality of life or social relations quality of life (Hyphantis, Paika, Almyroudi, Kampletsas, & Pavlidis, 2011). Thus, repressors may tend to minimize deficits in areas of quality of life other than physical quality of life. However, in a second sample of colorectal cancer patients, repression was associated with lower ratings on multiple aspects of quality of life (physical health, mental health, social relationships, environment; Paika et al., 2010). Overall, the data suggest that repressive coping may be associated with poorer quality of life, but not in all patient populations.

Although repressive coping is highly relevant for physical health, mental health, and quality of life among patients with obesity, only one published study has examined repressive coping in relation to body weight. Surprisingly, in a sample of healthy middle-aged and older adult men with BMIs between 17 and 46, repression measured with the repression subscale of the MMPI was associated with lower

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body mass index (BMI) and smaller waist-to-hip ratio. In hierarchical multiple regression analyses, repression was a significant predictor of BMI when controlling for waist-to-hip ratio and general maladjustment (Niaura et al., 2003). These data appear consistent with the notion that higher repression may be associated with greater ability to engage in health behaviors that require self-control (Myers, 2010), however this study did not specifically focus on overweight and obese individuals, and it did not examine quality of life or psychological variables that may moderate the influence of repressive coping.

Because repressive coping may not be associated consistently with negative body weight outcomes, it is important to consider obesity-relevant psychosocial factors as moderators of the relationship between repressive coping and body weight. Psychological distress is especially relevant as a moderator because it is associated with lower quality of life in obesity (e.g. Fabricatore, Wadden, Sarwer, & Faith, 2005; Lillis, Levin, & Hayes, 2011; Mannucci et al., 1999). In addition to standard measures of depression and anxiety, stigma is a common source of psychological distress among individuals with obesity (Puhl, Moss-Racusin, Schwartz, & Brownell, 2008), and weight-related stigmatization has been associated with poorer obesity-specific quality of life (Sarwer, Fabricatore, Eisenberg, Sywulak, & Wadden, 2008) and poorer health-related quality of life (Lillis et al., 2011). Stigmatization also is important to consider in the present context because stigmatization may make it more challenging for individuals with higher levels of obesity to engage in repression (i.e., avoidance of negative affect and information).

This study was designed to examine the relationships of stigma, anxiety, depression, BMI, and quality of life to repressive coping among treatment-seeking overweight and obese adults. Repressors were expected to report minimal anxiety and depression as well as lower levels of stigmatization than non-repressors. It was further hypothesized that stigmatization, anxiety, and depression would moderate the relationship between repressive coping and quality of life such that the influence of distress on quality of life would be greater among non-repressors than among repressors. Because repression has been associated with lower BMI among healthy men in a previous study (Niaura et al., 2003), it was hypothesized that repression would not be associated with BMI among overweight and obese adults, and distress would not function as a moderator.

2. Methods

2.1. Participants

One hundred four overweight or obese men and women were recruited from a comprehensive outpatient behavioral weight management program at a large Midwestern university-based medical center. As shown in Table 1, the mean BMI of the sample was in the extreme obesity range, and participants were middle-aged on average. Participants were predominantly Caucasian and female, and most participants had completed at least some college. Participants included individuals preparing for gastric bypass surgery after completion of the comprehensive weight management program ($n = 48$) as well as individuals not seeking gastric bypass surgery. Prospective participants were recruited during the first or second educational class of the six-month outpatient weight management program. All participants provided written

consent at the time of recruitment. Participants completed self-report questionnaires at home. Data were collected as part of a larger longitudinal study, but only baseline data were utilized for this study.

2.2. Measures

Height and weight were measured during the intake assessment for the weight management program. The following self-report questionnaires were completed within the first two weeks of initiation of the weight management program to assess coping style, level of perceived stigma, psychological distress, and quality of life:

2.2.1. Coping style

Marlowe-Crowne Social Desirability Scale-Form C (M-C Form C). The M-C Form C is a 13-item short form of the Marlowe-Crowne Social Desirability Scale (M-C SDS) assessing the extent to which individuals exhibit a bias toward presenting themselves in a positive light. Each item may be marked either true or false and scores range from 0 to 13 (Crowne & Marlowe, 1960; Reynolds, 1982). Cronbach's alpha for the current sample was 0.70.

Taylor Manifest Anxiety Scale Short Form (TMAS). The TMAS is a 20-item true/false scale assessing trait anxiety with adequate internal consistency reliability (0.76; Taylor, 1953; Bendig, 1956). Scores range from 0 to 20. The TMAS is used in conjunction with the M-C SDS to identify repressors (Shaw, Cohen, Doyle, & Palesky, 1985). Cronbach's alpha for the current sample was 0.88.

2.2.2. Perceived stigma

Social Impact Scale (SIS). The SIS is a 24-item questionnaire originally developed to examine facets of stigma and assess the impact of perceived stigma among individuals with chronic illnesses. Each item is rated on a 4-point likert scale that includes a "not applicable" response option. In this study, "not applicable" responses were assigned a score of 1, consistent with a "Strongly Disagree" response. The questionnaire includes four subscales representing social rejection, financial insecurity, internalized shame, and social isolation. Each of the subscales has good internal consistency with Cronbach's alpha of 0.85 or higher. Correlations among the subscales range from 0.28 to 0.66, indicating that each subscale is measuring a different aspect of stigma (Fife & Wright, 2000). For the current study, the word "illness" was replaced with "condition" and participants were instructed to rate stigmatizing experiences in relation to body weight. In this sample, Cronbach's alpha was 0.95 for the total SIS, and total scores were utilized in all study analyses to reflect perceived stigmatization among participants.

2.2.3. Psychological distress

Hospital Anxiety and Depression Scale (HADS). The HADS is a 14-item measure of anxious and depressive symptoms in medical populations. Each item is rated on a 4-point likert scale. Scores on each subscale range from 0 to 21. Scores from 0 to 7 are considered normal, scores from 8 to 10 are considered borderline abnormal, and scores from 11 to 21 are considered abnormal. Patient ratings on anxiety and depression subscales are significantly correlated with interview ratings of anxiety and depression (Zigmond & Snaith, 1983). In this sample,

Table 1
Comparison of repressors and non-repressors on demographic variables.

Variable	Full sample, M (SD) ($n = 104$)	Repressors, M (SD) ($n = 32$)	Non-repressors, M (SD) ($n = 64$)
BMI	47.97 (12.05)	46.43 (13.12)	48.20 (11.60)
Age	45.38 (11.82)	49.53 (10.29)	44.70 (11.80)
Race (% Caucasian)	80.61	76.67	86.67
Gender (% female)	75.96	65.63	78.13
Surgery status (% presurgical)	47.06	54.84	44.44
Level of education (% some college or greater)	85.29	81.25	88.71

Note: BMI = body mass index.

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