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Breaking WEIGHT BIAS

Promoting Health without harming through digital training tools

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3.2. Internalised weight bias & health motivation

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TRAINING CONTENT

3.2. Internalised weight bias & health motivation

When encountering weight stigma, an individual will either react adaptively or maladaptively depending on the characteristic of the motivation they receive to adopt health-promoting behaviours. Their reaction may either be a way of conforming to behaviour they believe is expected of them without truly internalising that attitude (**controlled motivation**), or it may be a genuine reaction based on internalised beliefs (**autonomous motivation**). Compared to controlled motivation, which only results in an external behaviour change, the latter results in a permanent change of behaviour, and should be the focus when treating people who experience internalised weight bias (Tauber et al., 2018).

These concepts are based on Self Determination Theory (SDT; Deci & Ryan, 2013) and are used to explain the effects that different types of motivation have on behaviour and internal attitudes. The distinction between autonomous motivation and controlled motivation is outlined below:

<u>Autonomous and controlled motivation</u>

Autonomous motivation involves carrying out behaviour that you intrinsically believe to be good, and this comes from within the self rather than the outside world. This behaviour is considered to be self-determined. Since the behaviour is a result of personal choice, individuals are more likely to stick to this behaviour and feel a sense of autonomy. This helps the individual to feel like an autonomous agent, without outside control. This means that no external incentives are needed for the individual to persist with the behaviour, as it originated internally. **Individuals who are autonomously motivated are more likely to effectively self-regulate their behaviour**.

In contrast, controlled motivation concerns the engagement in behaviours to please external actors, or gain rewards. As opposed to feelings of autonomy, individuals with controlled motivation feel a sense of obligation and pressure to carry out a particular behaviour. This means that the removal of external objects of motivation will result in a cessation of behaviour. Thus, **individuals are controlled by outside influence and are less likely to engage in self-regulating behaviour** (Hagger et al., 2014).

How can the type of motivation affect people who have internalised weight bias?

It is suggested that individuals living in large bodies who encounter weight stigma will either experience autonomous or controlled motivation. For example, Tauber et al. (2018) write that when individuals living in large bodies are faced with moral aspects of being seen as 'overweight' (such as statements that it's immoral to eat too much), they are more likely to display controlled motivation and temporarily change their eating/exercise behaviours, without committing to long-term health changes. In contrast, when these individuals are presented with statements about competence in relation to weight (such as statements that it's a good skill to exercise), they are more likely to adopt autonomous motivation and create long-lasting lifestyle changes to support their overall health. **Autonomous motivation in relation to weight stigma is, therefore, more powerful** because it involves the individual internalising attitudes rather than temporarily changing behaviour to please others, as is the case with controlled motivation.

To illustrate the connection between the type of motivation and resulting health, a study by Pelletier & Dion (2007) found that autonomous motivation was the main causal factor in the participant's healthier relationship with food. Furthermore, their study found a negative correlation between controlled motivation and healthy relationship with food, suggesting that this type of motivation is counter-productive when tackling dysfunctional relationships with food. This supports the conclusion that **the type of motivation plays a role in changing behaviour**, and focusing on autonomous motivation will ensure that people who face weight stigma are able to truly internalise attitudes and behaviours promoting physical and mental health. It further suggests that controlled motivation is not only less effective, but it actually encourages dysfunctional behaviours and should therefore be carefully recognised and tackled in patients who experience internalised weight bias (Hayward et al., 2018).

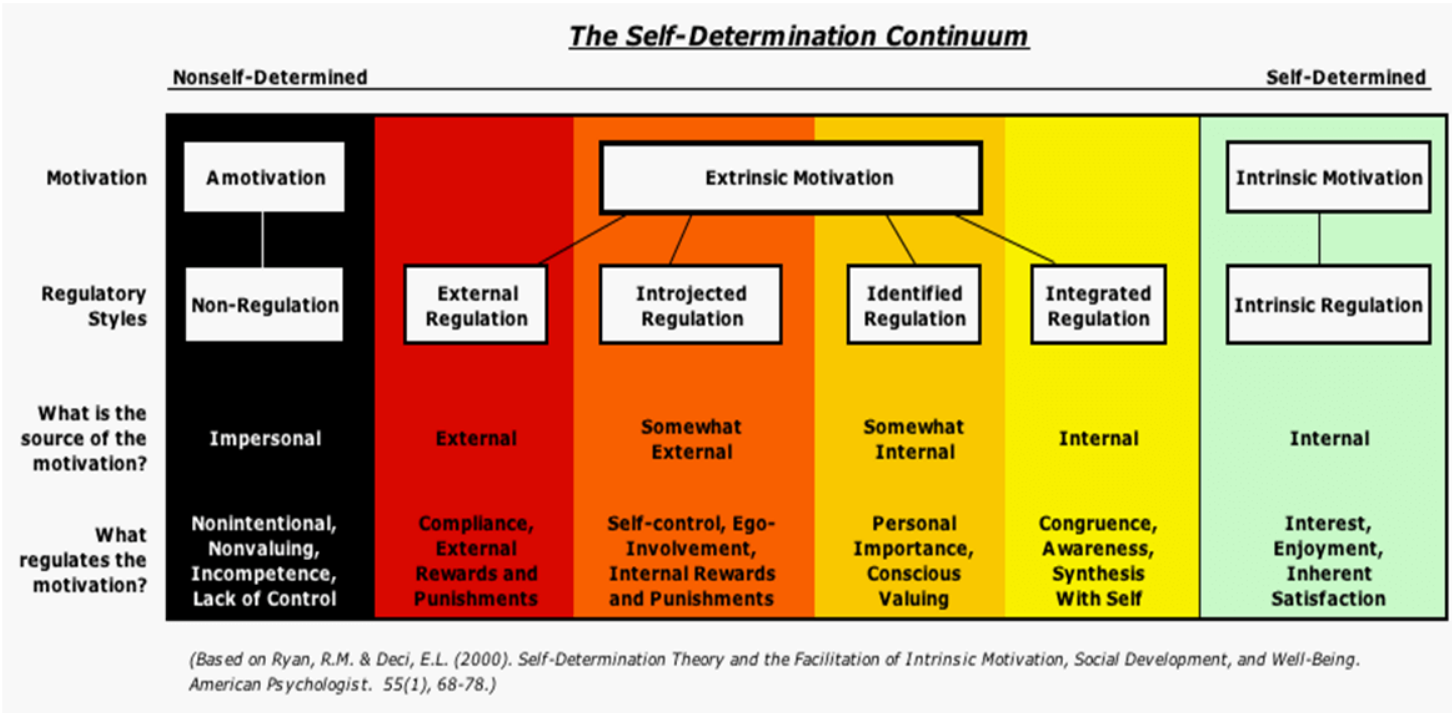
Self-Determination Theory

In order to better understand the connection between autonomous/controlled motivation and resulting behaviour, it is important to consider their roots in Self-determination Theory (SDT) developed by Deci and Ryan in 1985 (cited in Deci & Ryan, 2013).

The theory mainly concerns how the meaning given to internal and external stimuli influences whether a behaviour or attitude will be internalised or not. To clarify, if meaning is given to internal stimuli, such as one's own desire to adopt health-promoting behaviours in their life, then this would result in a genuine behaviour and attitude change (autonomous motivation). Whereas giving meaning to external stimuli, such as the opinions of other people that one must lead a '*healthy lifestyle*' would only result in a superficial behaviour change (controlled motivation). The theory, therefore, focuses on the basis of motivation and its impact on behaviour.

Self-Determination Theory states that autonomous motivation requires a combination of intrinsic motivation, and identified regulation type of extrinsic motivation (Vallerand, 2000). Identified regulation of extrinsic motivation means recognising the external object of motivation and valuing the associated behaviour. For instance, a person with overweight recognises if a health professional is providing an external stimulus for promoting health - such as engaging in joyful movement. This extrinsic motivation is not the main motivating factor, unlike intrinsic motivation. However, autonomous motivation requires the individual to also value this external behaviour. Therefore, when the individual is intrinsically motivated and identifies the source of extrinsic motivation, then autonomous motivation is achieved according to SDT.

The gradual shift from extrinsic to intrinsic motivation is outlined in the table below:



(Based on Ryan, R.M. & Deci, E.L. (2000). Self-Determination Theory and the Facilitation of Intrinsic Motivation, Social Development, and Well-Being. American Psychologist. 55(1), 68-78.)

This table presents the steps that lead to intrinsic motivation, suggesting that an individual becomes interested and satisfied when reaching the final stage of intrinsic motivation and regulation. It is important to recognise that it is a gradual process, and individuals may lie on different parts of the scale. So, health practitioners could work with patients to identify their current type of motivation and guide them towards becoming intrinsically motivated to engage in health-promoting behaviours.

Understanding where the different types of motivation come from also helps to understand their connection to adaptive and maladaptive behaviour. If an individual who has internalised weight bias, adopts autonomous intrinsic motivation, then they are more likely to have an adaptive attitude concerning the adoption of health-promoting behaviours, because the motivation originated within themselves. This also explains why controlled motivation leads to maladaptive responses, as the individual only changes their behaviour to please those external to themselves. They, therefore, do not truly adopt the attitude and this can become maladaptive once the external stimuli is removed, as seen in the extrinsic motivation side of the table.

Key messages for health practitioners

Practitioners should aim to instill autonomous motivation in individuals who experience internalised weight bias in order to help them find **intrinsic motivation** within themselves. This can facilitate the adoption of meaningful and sustainable behaviours that take care of their health in a sustainable way. This would ensure an adaptive response from the patients as they would be internally motivated, and it would help them to foster a more positive attitude towards health & overall well-being. This would, in turn, facilitate better mental health as the patients would not be changing their behaviour for the approval of others but instead for their own well-being.

At the same time, practitioners should avoid instilling controlled motivation in their patients, like the application of “tough love” that we examined in sub-module 2.2.2. Even though such approaches may result in temporary changes that seem to have a positive effect, it would overall be more harmful to the patient. This type of motivation would not create long-lasting change and it would instead serve to damage their mental wellbeing, and in turn, create further barriers to engage in health-promoting behaviours in the long-term.

EXTERNAL RESOURCES

Aguilar-Vafaie, M.E. & Abiari, M. (2007). Coping Response Inventory: Assessing coping among Iranian college students and introductory development of an adapted Iranian Coping Response Inventory (CRI). 18:106–111. https://doi.org/10.1080/13674670600996639

Boswell, R. G., & White, M. A. (2015). Gender differences in weight bias internalisation and eating pathology in overweight individuals. *Advances in Eating Disorders*, *3*(3), 259-268.

Brown, CL. Skelton, JA. Perrin, EM. Skinner, AC. (2016). Behaviors and motivations for weight loss in children and adolescents. Obesity, *24*(2), 446–452. https://doi.org/10.1002/oby.21370.

Carraça, EV. Markland, D. Silva, MN. Coutinho, SR. Vieira, Minderico, PN. Sardinha, LB. Teixeira, PJ. (2011). Dysfunctional body investment versus body dissatisfaction: Relations with well-being and controlled motivations for obesity treatment. Motivation and Emotion, 35, 423. https://doi.org/10.1007/s11031-011-9230-0

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology, 56*(2), 267–283. https://doi.org/10.1037/0022-3514.56.2.267

Carver, C.S. (1997). You want to measure coping but your protocol' too long: Consider the brief cope. International Journal of Behavioral Medicine, 4:92–100. https://doi.org/10.1207/s15327558ijbm0401_6.

Deci, E. L., & Ryan, R. M. (2013). *Intrinsic motivation and self-determination in human behavior*. Springer Science & Business Media.

Degher, D., Hughes, G. (1999). The adoption and management of a ''fat'' identity. In J. Sobal, D. Maurer (Eds.), Interpreting weight: the social management of fatness and thinness (pp. 11–27), New York. Mazurkiewicz

Duart, C. Pinto-Gouveia, J. Ferreira, C. (2014). Escaping from body image shame and harsh self-criticism: Exploration of underlying mechanisms of binge eating. Eating Behaviors, 15(4), 638-643. https://doi.org/10.1016/j.eatbeh.2014.08.025.

Durso, LE. Latner, JD. (2008). Understanding self-directed stigma: development of the Weight Bias Internalization Scale. Obesity (Silver Spring). 16:80-86.

Emmer, C., Bosnjak, M., & Mata, J. (2020). The association between weight stigma and mental health: A meta-analysis. *Obesity Reviews*, *21*(1), e12935.

Folkman, S. Moskowitz, JT. (2004). Coping: pitfalls and promise. Annual review of psychology, 55, 745-74. https://doi.org/10.1146/annurev.psych.55.090902.141456.

Gerend, M. A., Patel, S., Ott, N., Wetzel, K., Sutin, A. R., Terracciano, A., & Maner, J. K. (2021). Coping with weight discrimination: Findings from a qualitative study. *Stigma and Health*.

Guyll, M., Matthews, K. A., & Bromberger, J. T. (2001). Discrimination and unfair treatment: relationship to cardiovascular reactivity among African American and European American women. *Health Psychology*, *20*(5), 315.

Hackman, J., Maupin, J., & Brewis, A. A. (2016). Weight-related stigma is a significant psychosocial stressor in developing countries: evidence from Guatemala. *Social Science & Medicine*, *161*, 55-60.

Hagger, M. S., Hardcastle, S. J., Chater, A., Mallett, C., Pal, S., & Chatzisarantis, N. L. D. (2014). Autonomous and controlled motivational regulations for multiple health-related

behaviors: between-and within-participants analyses. *Health Psychology and Behavioral Medicine: An Open Access Journal*, *2*(1), 565-601.

Hatzenbuehler, M. L., Keyes, K. M., & Hasin, D. S. (2009). Associations between perceived weight discrimination and the prevalence of psychiatric disorders in the general population. *Obesity*, *17*(11), 2033-2039.

Hayward, L. E., Vartanian, L. R., & Pinkus, R. T. (2018). Weight stigma predicts poorer psychological well-being through internalized weight bias and maladaptive coping responses. *Obesity*, *26*(4), 755-761.

Hilbert A., Braehler E., Schmidt R., Löwe B., Häuser W., Zenger M. (2015). Self-Compassion as a Resource in the Self-Stigma Process of Overweight and Obese Individuals. *Obes Facts 8*:293–301 https://doi.org/10.1159/000438681

Himmelstein, M. S., Puhl, R. M., Quinn, D. M. (2018). Weight stigma and health: The mediating role of coping responses. *Health Psychology, 37*(2), 139–147. https://doi.org/10.1037/hea0000575

Hoverd, W. J., & Sibley, C. G. (2007). Immoral bodies: the implicit association between moral discourse and the body. *Journal for the Scientific Study of Religion*, *46*(3), 391-403.

Joanisse, L. Synnott, A. (1999). Fighting back: reactions and resistance to the stigma of obesity. In J. Sobal, Maurer D. (Eds.), Interpreting weight: the social management of fatness and thinness (pp. 49–70), New York.

Lawrence, J.W. Fauerbach, J.A. Heinberg, L.J. Doctor, M. Thombs, B.D. (2006). The reliability and validity of the Perceived Stigmatization Questionnaire (PSQ) and the Social Comfort Questionnaire (SCQ) among an adult burn survivor sample. Psychological Assessment, 18:106–111. https://doi.org/10.1037/1040-3590.18.1.106.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer publishing company.

Lee M.S., Gonzalez B.D., Small B.J., Thompson J.K. (2019). Internalized weight bias and psychological wellbeing: An exploratory investigation of a preliminary model. PLoS ONE 14(5): e0216324. https://doi.org/10.1371/journal.pone.0216324

Lewis, TT. Aiello, AE. Leurgans, S. Kelly, J. Barnes, LL. (2010) Self-reported experiences of everyday discrimination are associated with elevated C-reactive protein levels in older African-American adults. Brain, Behavior, and Immunity, 24: 438–443.

Li, W., & Rukavina, P. (2009). A review on coping mechanisms against obesity bias in physical activity/education settings. *Obesity reviews*, *10*(1), 87-95.

Mazurkiewicz, N. Lipowski, M. Krefta, J. Lipowska, M. (2021). "Better If They Laugh with Me than at Me": The Role of Humor in Coping with Obesity-Related Stigma in Women. International Journal of Environmental Research and Public Health, 18 (15), 7974. https://doi.org/10.3390/ijerph18157974

Menzel, J. E., Schaefer, L. M., Burke, N. L., Mayhew, L. L., Brannick, M. T., & Thompson, J. K. (2010). Appearance-related teasing, body dissatisfaction, and disordered eating: A meta-analysis. *Body image*, *7*(4), 261-270.

Pearl, R. L., & Puhl, R. M. (2014). Measuring internalized weight attitudes across body weight categories: validation of the modified weight bias internalization scale. *Body image*, 11(1), 89–92. https://doi.org/10.1016/j.bodyim.2013.09.005

Pearl, R. L., & Puhl, R. M. (2018). Weight bias internalization and health: a systematic review. *Obesity Reviews, 19*(8), 1141–1163. https://doi.org/10.1111/obr.12701

Pearl, R. L., Wadden, T. A., Tronieri, J. S., Chao, A. M., Alamuddin, N., Bakizada, Z. M., ... & Berkowitz, R. I. (2018). Sociocultural and familial factors associated with weight bias internalization. *Obesity facts*, *11*(2), 157-164.

Pelletier, L. G., & Dion, S. C. (2007). An examination of general and specific motivational mechanisms for the relations between body dissatisfaction and eating behaviors. *Journal of social and clinical psychology*, *26*(3), 303-333.

Puhl, R. Brownell, KD. (2003). Ways of coping with obesity stigma: review and conceptual analysis. Eating Behaviors, 4(2003), 53-78. https://doi.org/10.1016/s1471-0153(02)00096-x.

Puhl, R.M., & Himmelstein, M. S. (2018). Weight bias internalization among adolescents seeking weight loss: Implications for eating behaviors and parental communication. Frontiers in psychology, 9, 2271.

Puhl, R.M. Moss-Racusin, CA. Schwartz, MB. (2012). Internalization of Weight Bias: Implications for Binge Eating and Emotional Well-Being. Obesity, 15(1), 19-23. https://doi.org/10.1038/oby.2007.521

Puhl R.M., Moss-Racusin C.A., Schwartz M.B., Brownell K.D. (2008). Weight stigmatization and bias reduction: perspectives of overweight and obese adults. *Health Educ Res.* *23*(2):347–58. https://doi.org/10.1093/her/cym052

Puhl, RM. Wall, MM. Chen, C. Austin, S.B. Eisenber, ME. and Neumark-Sztainer, D. (2017). Experiences of Weight Teasing in Adolescence and Weight-relted Outcomes in Adulthood: A 15-year Longitudinal Study. Preventive Medicine, 100, 173-179. https://doi.org/10.1016/j.ypmed.2017.04.023

Stanisławski K. (2019). The Coping Circumplex Model: An Integrative Model of the Structure of Coping With Stress. *Frontiers in psychology,* 10, 694. https://doi.org/10.3389/fpsyg.2019.00694

Täuber, S., Gausel, N., & Flint, S. W. (2018). Weight bias internalization: the maladaptive effects of moral condemnation on intrinsic motivation. *Frontiers in psychology*, *9*, 1836.

Thompson, R. Mata, J. Jaeggi, S.M. Buschkuehl, M. Jonides, J. Gotlib, I. (2010). Maladaptive Coping, Adaptive Coping, and Depressive Symptoms: Variations across Age and Depressive State. Behaviour Research and Therapy, 48(6), 259-466. https://dx.doi.org/10.1016%2Fj.brat.2010.01.007

Teegardin C. (2012). Grim childhood obesity ads stir critics. The Atlanta Journal Constitution. In Tomiyama, A., Carr, D., Granberg, E.M. Major, B. Robinson, E. Sutin, AR. Brewis, A. (2018). How and why weight stigma drives the obesity 'epidemic' and harms health. *BMC Med* 16, 123. https://doi.org/10.1186/s12916-018-1116-5

Tomiyama, AJ. Carr, D. Granberg, EM. Major, B. Robinson, E. Sutin, AR. Brewis, A. (2018). How and why weight stigma drives the obesity 'epidemic' and harms health. BMC Medicine, 16, 123. https://doi.org/10.1186/s12916-018-1116-5

Tylka, T.L. Annunziato, R.A. Burgard, D. Daníelsdóttir, S. Shuman, E. Davis, C. Calogero, R.M. (2014). "The Weight-Inclusive versus Weight-Normative Approach to Health: Evaluating the Evidence for Prioritizing Well-Being over Weight Loss", Journal of Obesity, vol. 2014, Article ID 983495, 18 pages,. https://doi.org/10.1155/2014/983495

Vallerand, R. J. (2000). Deci and Ryan's self-determination theory: A view from the hierarchical model of intrinsic and extrinsic motivation. *Psychological inquiry*, *11*(4), 312-318.

van Amsterdam, N. (2013). Big fat inequalities, thin privilege: An intersectional perspective on 'body size.' *European Journal of Women's Studies*, *20*(2), 155–169. https://doi.org/10.1177/1350506812456461