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Exploring the Possible Reduction of Obesity Stigmatization in Healthcare and Women's Healthcare Avoidance

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ABSTRACT

Background: The established obesity bias in medical care and perception of health by women in general is studied. Variables measured in this thesis study were body mass index, self-esteem, attribution for weight, satisfaction with medical care and delay/ avoidance of medical care. Previous research established obesity bias by Aramburu-Drury. This is a replication of her thesis from 1996.

Methods: A 29-question study utilizing a convenience sampling of adult women returned 143 questionnaires. Several of the questionnaires were incompletely answered. SPSS, a statistics software, and correlations to previous research utilizing vassarstats.net for the Fisher R to Z Transformation were performed.

Results: There is a relationship between body mass index and delay /avoidance of healthcare ($r=.19$, $p= .74$, $n= 133$). Low self-esteem was demonstrated in all participants, however, there is no relationship in obese women to delay/avoid healthcare ($r= -.062$, $p= .722$, $n=35$). There is a decrease in the correlation coefficients of the variables attribution of weight and delay/ avoidance of healthcare ($r= -.192$, $p= .052$, $n= 103$). There is a statistically significant ($p=.0135$) reduced correlation between satisfaction of medical care and delay/ avoidance of healthcare ($r=-.153$, $p=.381$, $n=35$). There is a significant difference ($p= .0022$) in the correlation coefficients of this study $r= .137$, $p=.104$, $n=141$, and the previous study, showing a positive relationship in the personal attribution for weight and satisfaction with medical care.

Conclusion: This study suggests that while self-esteem for the general adult women population has decreased, it is not dependent upon the variables attribution for weight, body mass index or satisfaction with medical care. There is significance between attribution of weight and delay, as well as satisfaction with medical care and delay.

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

LIST OF TABLES AND FIGURE

CHAPTER ONE

Introduction

Problem Statement

The stigmatization of excess weight in women experienced by previous

generations has been well documented and studied in various healthcare specialties (Puhl,

Schwartz, & Brownell, 2005). Has the significant increase in women's excess weight in

the United States, along with the influences of plus-size models increased women's self-

esteem and self-acceptance? In 1996, Christine Aramburu-Drury researched and

documented the stigma of obesity in healthcare through her thesis titled, "Exploring the

Association Between Body Weight and Health Care Avoidance", published through

University of Nevada, Las Vegas. Her discussion of beauty standards of thin models and

the reduced utilization of healthcare preventative exams (pelvic exams especially)

depicted what we know now as 'weight stigmatization' and perceived risk of humiliation.

Do the overweight or obese patients feel that healthcare professionals, especially primary

care, have biases of weight towards them today? There may be a significant reduction of

bias and discrimination of overweight persons by providers, because the majority of the

population is overweight or obese. However, obesogenic related comorbidities and

patients' health still need to be addressed by providers without approaching bias or

feelings of stigmatization.

Do a majority of women feel prejudice, avoid examinations, and experience

shame or blame by their healthcare provider(s) (Aramburu-Drury & Louis, 2002)? Have

healthcare providers improved their relationships with their patients? Has the 'fat

acceptance movement' and increase in obesity rates globally allowed women to feel

reduced effects of stigma and increased levels of self-esteem and overall health? In other words, is fat now normalized? Major department stores such as Wal-Mart, Target, Old-Navy, Saks Fifth Avenue, Macy's, and Nordstrom carry plus size clothing, making plus size women's clothing more readily available compared to 1996, when Dr. Aramburu-Drury (Aramburu Alegria) published her original master's thesis. Has the fat acceptance movement affected a woman's psychology and feelings of stigmatization towards obesity, allowing more women to feel comfortable about themselves?

The challenges of weight loss in primary care are motivating patients to see the dangers of obesity, the lack of in-depth relationship between clinician and patient, and macro and micro levels of prevention in illness through cardiovascular fitness (Martins & Burbank, 2011). One of the biggest challenges in dealing with obesity and its current epidemic status is the normalization of obesity that takes place in contemporary culture. This normalization and the lack of perceived health threat are, frequently, difficult to address for the primary care provider. Patients can have difficulty accepting the diagnosis of obesity and may have an unconcerned outlook towards it, in part, because of the prevalence of obesity (NHANES, 2013).

Definition, Prevalence and Health Impact of Obesity

Patients and especially women may not perceive the stigma of obesity to the degree they did twenty years ago for many reasons, including the greater percentage of the population that is overweight or obese. Obesity related comorbidities are further enhanced with management of medications keeping people living longer. Obesity can be understood as, "stemming from an energy imbalance derived from complex interplay of behavioral genetic, environmental and social factors" (Cheng, 2012, p. 1976). Body

Mass Index (BMI) is a calculation used globally to estimate weight (kg) versus height

$(m^2) = kg/m^2$ and the normalized ratios of populations (World Health Organization,

2007). Adult obesity is defined as a person over the age of 20 with a body mass index

greater than or equal to 30 (Kushner & Ryan, 2014). According to the National Health

and Nutrition Examination Survey (NHANES) the BMI's listed equal the following

rating: BMI <19.9= Underweight; BMI of 20-24.9= Normal Weight; Overweight BMI=

25.0-29.9, Obesity 1 BMI= 30-34.9, Obesity 2=35-39.9 and Morbidly or Obese 3 ≥ BMI

40.

The BMI categories of overweight and obesity were not clearly defined in the

original study. Multiple references would have different rages of BMI for overweight

and obesity as Aramburu-Drury noted in 1996 (p.2). In the span of 1988-1993 the

definitions of overweight and obesity were lumped together into anyone over a BMI of

27 was overweight and obesity was more adipose tissue (NHANES, 1996). A

comparison of statistics indicate that in 1994, 41.4% Americans were of healthy weight,

in 2012, that rate was 29.5% (NHANES, 2013). The obesity rate in the adult population

in 1994 was 22.8%, almost half of the current statistics. In 2011-2012 NHANES scores

of obesity rate in the population was 35.1%. While current data, 2013-2014, shows a

percentage of 37.7% of United States adults are obese (NHANES, 2013). The goals of

Healthy People 2020 are to decrease obesity to 30.5 percent, but obesity is only

increasing (NHANES, 2013).

Socioeconomic status in countries with high gross domestic products shows an

inversion of inequity with education and body size. Wells, Marphatia, Cole and McCoy

(2012), concluded that the reduction of energy expenditure with influx of under-nutrition

and energy-dense foods contribute to poor health and obesity in urban populations; specifically, women. Carr and Freedmann (2005) found that the interpersonal and social consequences of obesity in women is harder for those that are young (<25 years), caucasian and of higher socio-economic status. Per the Centers for Disease Control (CDC) and Prevention (2013), those of low socioeconomic status, generally, have reduced levels of physical activity and fresh-food deserts (lack of fresh food options) with increased fast-food restaurant availability.

Obesity has been linked with an increased incidence of diabetes, hypertension, dyslipidemia, heart disease, stroke, degenerative joint disease, arthritis, chronic pain, sleep apnea, non-alcoholic fatty liver disease, cirrhosis, and obesity related cancers (Nguyen & El-Serag, 2010). All of these destructive diseases can be prevented in the primary care approach with a focus on physical activity and fitness-based interventions over weight loss (Barry et al., 2014). Barry (2014) and his authors found in their meta-analysis that cardiovascular fitness, even in healthy normal weight populations, reduces all-cause mortality and especially obesity related comorbidities. More interestingly, they found that the cardiovascular unfit individuals had twice the risk of death regardless of BMI (Barry et al., 2014).

Healthy People 2020

Healthy People 2020 have a very long list of topics, objectives, and goals compared to Healthy People 2000. These topics were developed in 2010 with the help of the NHANES under the CDC information and data collection (ODPHP, 2016). Under the topic of nutrition and weight status the Healthy People 2020 goal is to "Promote health and reduce chronic disease risk through the consumption of healthful diets and

achievement and maintenance of healthy body weights" (Overview Tab, para 1).
The objectives relevant to this thesis listed in Nutrition and Weight Status (NWS) are:

> NWS-5: Increase the proportion of primary care who regularly record the
> body mass index of their patients.

> NWS-6: Increase the proportion of physician office visits that include
> counseling or education related to nutrition or weight.

> NWS-8: Increase the proportion of adults who are a healthy weight. In
> 2008 30.8 percent were a healthy weight with a target or 33.9 percent by
> 2020.

> NWS-9: Reduce the proportion of adults who are obese. In 2008, 33.9
> percent were obese with a target of 30.5 percent by 2020.

The goals of Healthy People 2020 cannot be acquired without measurements. However, women state that they do not want their physicians to talk about weight with them and they feel providers do not take the time to get their needs met (Merrill & Grassley, 2008). The goals of Healthy People 2020 cannot be met if women delay or avoid healthcare. The authors Ferrante, Seaman…Puhl, (2016), found that the most frequent stigmatization situations occurred when doctors equated weight with bad health. If the patients' health is not appropriately addressed in primary care before it is of concern, hypertension, diabetes and all the other obesogenic comorbidities will eventually occur. The issue for many providers is that they should ask the chief complaints and address them, then

respectfully ask the patient if they are willing to talk about their weight and health

(Ferrante et al., 2016).

Rationale

The costs associated with obesity related health disparity and related chronic

disease management was 147 billion dollars annually in 2008, now up to 210 billion

dollars annually as of 2014 in the United States (Heffler et al., 2005; Finkelstein, et al.,

2009; Nguyen & El-Serag, 2010). The leading causes of death in Nevada are heart

disease, cerebrovascular disease, and diabetes (America's Health Rankings, 2014).

Reducing healthcare costs in Nevada can be achieved through the implementation of

education about fresh and healthy foods and increasing physical activity to assist in

reduction of obesity. Another discussion of addressing preventative care before chronic

disease management is fixing the comorbidities of obesity by increasing activity and

reducing patients' weights.

The overall well-being of patients in the United States and their obesity related

disorders are most cost effective if addressed before it becomes a health problem, in

primary care. Women need to visit primary care in early adulthood, with yearly

examination and preventative screening, along with discussion of health to reduce

chronic health problems. The CDC (2016a) has the following rates and costs of the three

most common obesity comorbidities is as follows:

Diabetes: Total medical costs and lost work and wages of those diagnosed,

245 million.

Hypertension: Total medical costs of medications, health care services and missed days of work, 48.6 billion.

Cardiovascular Disease: Persons dying of heart disease every year in the United States, 610,000.

The financial costs alone are not the only problem. Another problem is the reduced level of freedoms with these comorbidities and reduced life expectancy. Globally women are 50 percent more likely to be obese than men because cheap foods are often lacking in micronutrients but high- in refined carbohydrates (Wells, Marphatia, Cole, & MCCoy, 2012). Patients with multiple comorbidities are tied to their medications, screening, preventative care, and an inability to travel without available medical resources and supplies (Wells, Marphatia, Cole, & MCCoy, 2012). Most of the world's population live in countries where overweight and obesity kills more people than underweight (WHO, 2016).

Significance for Nurse Practitioners

Women want to feel good about themselves. They want to feel that their providers care about them. When it comes to weight, women want their providers to not feel rushed and, therefore, would not use previously experienced heavy-handed communication with limited levels of psychological support (Ferrante et al., 2016). The previous information shows the importance of an unbiased and approachable view of women and their size. The presence of obesity stigmatization negatively impacts the relationship between providers and their patients (Mold & Forbes, 2011). Culturally competent care provided by nurse practitioners is an individual level trait, that can lead to truly patient-centered care (Nazione, 2015). Inactivity is not the only cause of obesity. The environmental, social, and economic stressors placed on women today also cause obesity.

Many nurse practitioners have provided patient centered care as nurses for many years. This experience enhances the critical thinking skills necessary to refer patients for specialized or emergent care when necessary. Because of our bedside experience, patients have a higher satisfaction with nurse practitioner care and pay less with fewer tests and expensive diagnostic procedures ordered compared to physician care (Cassidy, 2013). With such positive experience ratings, do providers still show as much bias to women who are obese today compared to 1996?

Purpose

There are increased obesity rates and a possible reduction in medical bias/ stigmatization though cultural competence and the fat acceptance movement (Puhl & Brownell, 2003; Puhl, Moss-Racusin, Scwartz, & Brownell, 2008). The purpose of this study is to see if the stigma of obesity acts as a barrier to health care utilization. Utilization of women's perceptions using a proven instrument and healthcare avoidance from twenty years ago allows for a statistical comparison of bias today. There are other reasons why women avoid healthcare and this instrument is inclusive in those reasons allowing for a complete view of healthcare delay/avoidance for women. This is a follow-up study on research conducted by Aramburu-Drury, unpublished thesis in 1996.

CHAPTER TWO

Literature Review

Introduction

The literature review was conducted regarding current articles of knowledge into the obesity epidemic; weight stigmatization and bias in medical and social perspectives, perception of stigmatization and bias, as well as self-esteem, the fat acceptance movement, and patient experiences. The first part of this review is obesity and self-esteem as well as the fat acceptance movement. The second part of this literature review is obesity as a sociological stigma. The third part of this literature review is healthcare stigma and patients' perceptions of obesity stigma and bias. The fourth part of this review covers what is known about the relationship between obesity and healthcare avoidance today. The fifth part covers the many other reasons women avoid healthcare. Finally, because this a follow-up study on the research and tool used by Aramburu-Drury, that study's results are also discussed.

Obesity and Self-Esteem

The unrelenting exposure to extremely thin women in fashion, beauty pageants, travel and many other sources have been concerning women and their self-esteem since photo prints came out in the 1930's (Klaczynski, Goold, & Mudry, 2004). With the increase in overweight and obesity, people that internalize a value of thinness and perceive that they have no control over their weight will devalue themselves (Klaczynski,

Goold, & Mudry, 2004). The rising concern and frequent messages about the obesity epidemic has formed a group of women, and some men, into what has been termed as the fat acceptance movement. This movement is not just fat acceptance as it has so frequently been termed, but is about self-acceptance and self-esteem (Donaghue & Clemitshaw, 2012). The authors speak of healthism: body size is understood as a modifiable personal characteristic through the balance of food and physical activity (Donaghue & Clemitshaw, 2012). Women who are a part of this movement speak of diets that don't work and that 'big boobs and a big butt' is in (Donaghue & Clemitshaw, 2012, p 416). Obesity may be penalized in the western world but thinness is no longer "generally constructed as an imposed obligation on women" and the goal is to flip negative public attitudes towards any body type or identity (Donaghue & Clemitshaw, 2012, p. 416; Murray, 2005).

Positive self-esteem of overweight and obese women can be attributed to the increase in plus size models, clothing and over all visual availability of beautiful obese women. The increase in plus size department stores, sections of malls and displays allows for more frequent appearances of women in a 'larger size'. People have more frequent interaction with obese people because more than 2/3 of the current us population is overweight or obese. With all these changes in the social and public environment regarding obesity women of any weight can feel more at home with the size they are.

Obesity as a Sociological Stigma

The movement into adulthood for most women is a social and economic transition increasing their vulnerability to obesity. Those within the lowest socioeconomic status have decreased access to public parks, fresh food retailers, and access to clean drinking

water while there are more fast food restaurants (CDC, 2013). Those in the lower socio-economic statuses in the United States have reduced leisure and exercise time because of family needs (Loring & Robertson, 2014). The researchers Loring and Robertson (2014) found that mothers of low socio-economic status are less likely to have time off and therefore less likely to breast feed their children, thereby making it less likely to lose weight gained during pregnancy.

Obesity is greatest at lower socio-economic levels; however, obesity has moved into even the highest socio-economic statuses and can be visualized everyday on television with people such as Tom Hanks, Christina Aguilera, Jessica Simpson, Amy Schumer and many more. These celebrities have allowed depiction of obese people in a more positive light as suggested in previous research (Puhl & Latner, 2007; Puhl, Moss-Racusin, Scwartz, & Brownell, 2008)

Scientific research into the medical, economic, and social costs of obesity may have increased the negative view of the obese person as an individual. This is because those that stigmatize others will only see obese individuals by their unproven stigmatizing characteristics (Lewis et al., 2011). The authors found in some studies that obesity stigma can actually motivate individuals to lose weight. However, people that have a BMI of 30-34.9 (Obesity 1) do not mention life experiences suggestive of stigma at all. Many women who are obese state that they are unwilling to exercise because of perceived social stigma and that they will be 'laughed at' even though these adults that have not had this experience (Brewis, Hruschka, & Wutich, 2011). One blogger, Mills (2011), brings up her professional and personal experience with obesity and the effects of being the 'fat kid' preventing women from exercise and getting on a scale in adulthood.

As women increase in BMI and obesity, the perceived stigma increases and their own fat bias decreases. These obese women feel they are being judged by their weight even though their social partners are not making judgements (Brewis et al., 2011). A large majority of women state they would rather have other stigmatized conditions or other undesirable outcomes than be obese (Brewis et al., 2011). Educated white women also perceive more judgement from family members and their medical providers, even when not founded. Obese people, especially obese 2 & 3 (BMI-35-40+), believe they are the targets of discrimination and this affects their psychological well-being (Carr & Friedman, 2005).

In summary, some stigma and biases remain in the public view regarding obesity. The news coverage regarding the obesity epidemic may not be helping women of any weight with their self-esteem. This is contradictory to the proposition of the Fat Acceptance Movement goals. However, the fat acceptance movement and general increase in weight of the overall population may be reducing stigma perceived by women regarding the healthcare profession. Thus, women may not be avoiding healthcare as they did in 1996. The question remains; if, with increased BMI do women currently perceive stigma from their healthcare providers and avoid preventative care?

Healthcare Stigma and Bias towards the Obese

Life experience by patients and providers shape their cultural views, biases and stigmas. Humans make quick judgements and 'once over' our observations of others in everyday interactions and observations. However, healthcare professionals, such as nurses, providers, and physicians, are given many 'hours of training in dealing with difficult patients' (Phelan et al., 2015, p 986). These many hours of cultural competency

and difficult patient training, is actually increasing provider bias because they see overweight individuals as being in control of their weight and unlikely to make behavior changes (Phelan et al., 2015; Nazione, 2015). Thankfully, a national survey found that the patients perceived quality of the patient-provider relationship has not been shown to change with patients' weight statuses (Gudzune, Huizinga, & Cooper, 2011). The authors concluded providers have a decreased bias in obesity because of a general increase in patient size and positive learning experiences of patients that are obese (Gudzune et al., 2011).

Implicit or unconscious bias is one that has been statistically shown as decreasing in medical school students from 2010 to 2014 as the publics implicit bias has increased (Phelan et al., 2015). This shows that positive contacts between providers and patients with obesity will increase both provider and patient satisfaction in the relationship (Phelan et al., 2015). These positive interactions bolster patients' trust in providers' treatments of them and their clinical judgement for future interactions (Mold & Forbes, 2011).

Previous generations of healthcare providers laid the strong foundation of obesity stigmatization that remains is evident in healthcare today. These providers held a negative bias towards obese patients and even blamed them for their own comorbidities with obesity. Those physicians could not look beyond a patients' weight for further differentials possibly misdiagnosing patients. Shaming of patients with weight problems is never acceptable. Previous review done by Aramburu-Drury (1996), found that physicians and nurses held low perceptions of obese patients and that with physicians such perceptions induced negative responses. Thankfully, the author also found that

nurses could hide their negative bias from their patient more effectively.

Obesity and Healthcare Avoidance Today

Many studies have shown that once an obese person perceives a negative experience with primary care regarding weight, it is very difficult for that patient psychologically to put herself in the power-relation situation of provider and patient again (Mold & Forbes, 2011). Women from the silent generation (1928-1945) have a renewing self-esteem and do not rate their health with obesity as negatively as those from the Baby Boomers generation (1946-1964) and Generation Xrs (1965-1979) (Altman, Hook., & Hillemeiser, 2016). More interestingly is that Millennial adult women do not report their health and obesity as low as do those of the Generation Xrs (Altman et al., 2016).

There is a greater number of medications available today to reduce long-term health consequences of obesity comorbidities allowing younger generations an increased life expectancy with obesity (Altman et al., 2016). The Millennial generation was not a part of the obesity health scares of the 1990s. This, along with a significant increase of the average percent of the population who are overweight, could allow Millennials a more confident view of their weight and an increased self-esteem. The experiment performed by Roddy, Stewart and Barnes-Holmes (2011) found that when people only know someone's weight and see their photo, that implicit and explicit bias is only present when they know more about their lifestyles. In reference to this study, weight itself may no longer be an issue of bias for a majority of the population.

There are many ways providers can and need to accommodate obese patients. These accommodations include: larger chairs, larger blood pressure cuffs, a scale that is private, and culturally competent providers who does not show bias, even if they have

any (NIDDK, 2011; Merrill & Grassley, 2008). Without these accommodations healthcare avoidance will only increase. A few reasons why obese patients avoid healthcare are: negative past experiences with providers, challenges of patient examinations because of size, over usage of the term obese instead of weight or BMI, disrespectful comments of office staff, and psychological barriers such as phobias and depression, and reading material available that values thinness (NIDDK, 2011). How to offer the best care for the majority of the patient population is a necessary tool for providers and patients regarding weight and self-esteem.

Healthcare providers are exposed to many hours of cultural competence, as previously stated, and are increasingly aware that it may be possible to be fat and fit. In reference to fat and fit, the authors Frederick, Saguy and Gruys (2016), found that fat acceptance viewpoints can reduce the consequences of obesity stigmatization that increases empathy in healthcare. With the training that healthcare providers receive to provide holistic care to all of their patients, and with the fat acceptance movement increasing understanding of obese perceptions, members of the healthcare team may be moving forward in a very positive direction. Healthcare may not have reduced obesity in numbers; however, exposure to healthy weight and an increase in activity pressures (walking etc.) through the media may be giving women the self-esteem to prevent disease and promote their own healthy size.

Other Reasons for Healthcare Avoidance

The Affordable Care Act of 2010 has given people more coverage and insurance, yet there is a shortage of primary care providers, forcing patients to utilize emergency departments instead of primary care offices (Janke et al., 2015). Patients continue to

have difficulty getting time off work and have reduced transportation options to receive preventative care, pushing them to the more-accessible emergency department (Janke et al., 2015). Wellness exams, such as pap smears, breast exams, monitoring of blood pressure, diagnostic labs, and dental care are unavailable and uncovered in the emergency department by insurance companies (Janke et al., 2015). While obesity stigma may be a reason for healthcare avoidance, another reason is simply that providers are unavailable to take on new patients (Frieden, Dietz & Collins, 2010).

Summarization of Previous Research by Aramburu-Drury (1996)

Aramburu-Drury apply a qualitative and quantitative study to examine women and healthcare avoidance in a southwestern city. Aramburu-Drury utilized an instrument originally developed by Jaclyn Packer Ph.D. (1990) in her dissertation entitled, *Barriers to Healthcare Utilization: The Effect of the Medical Stigma of "Obesity" on Women*. Dr. Packer granted her permission to use this tool.

Packer (1990) interviewed fourteen obese women for her study (Aramburu-Drury, 1996). Aramburu-Drury questioned stigma through a self-administered correlational survey of two-hundred sixteen women from several churches in the area. The research by convenience sample included normal weight, over-weight, and obese women to further validate the research started by Packer. Specifically, the questionnaire asked about the delay and avoidance of healthcare in relation to a patient's self-esteem, BMI, designation for weight and over-all satisfaction with preventative and medical care. The research found that weight and non-weight related reasons for avoiding healthcare included: women's self-esteem, lack of confidence in the healthcare provider, healthcare insurance coverage, and perception of health. Many of the participants did not like

having to undress in the provider's office and had gained weight since their previous visit.

Aramburu-Drury utilized multiple regression analysis between the dependent variable delay/ avoidance of health care and the independent variable of body mass, self-esteem, attribution for weight, and satisfaction with medical care was conducted (Aramburu-Drury, 1996). The respondent's variables not related to weight and healthcare were perceived health status, age, and education for contribution to delay/ avoidance of health care (Aramburu-Drury, 1996). Validity was established through the scales of this instrumentation on previous studies. Imogene King's Interacting Systems Framework was utilized by Aramburu-Drury and provided a foundation for her study.

The results of Aramburu-Drury's research showed that the medical and societal stigma of obesity in the 1980s and 1990s prevented women from seeking preventative care in the healthcare setting and this increased their risk of disease. This medical stigma also made providers shortsighted on a patient's weight and led to misdiagnosing, excluding from appropriate treatment, and being 'rough' during examination, especially gynecological and abdominal exams. Harsh words and admonitions to take self-responsibility for obesity were commonly used by providers during the research conducted. These experiences were hard on women outside of the normal body weight scale and the impacts have left a lasting impression in the healthcare field in regard to obesity and patient treatment.

Summarization of Current Research

Some of the previous literature supports the theory that obesity stigmatization in medical and social areas may be decreasing. Some literature does not support decreasing

stigmatization. The increased incidence of obesity and cultural competence teaching by healthcare staff may have reduced patients fears of healthcare because of weight and fat acceptance. There is an overall desire to meet the needs of obese populations, including not using the term 'obese' (Ferrante, et al., 2016). Medical supplies for providers and obese-friendly waiting rooms are becoming the norm. Socially, women still experience bias towards their weight, especially from family and friends. However, some of this bias is perceived because of their own self-esteem and is not real (Brewis, Hruschka Wutich, 2011) . Healthy people 2020 is already showing failure regarding obesity reduction and healthy weight increase. It is up to future primary care providers to have an unbiased approach to their over-weight and obese populations and help them to find reassurance in the health care field. Follow-up on Aramburu-Drury's research and examination of healthcare avoidance and obesity bias are needed to evaluate if we have made any progress in cultural and obesity competence as a healthcare profession.

CHAPTER THREE

Conceptual Framework and Research

Margaret Newman's grand theory of Health as Expanding Consciousness (HEC) provide the theoretical framework for this research study. Consciousness is a manifestation of an evolving pattern of person-environment interaction, a process of becoming more of oneself, of finding greater meaning in life, and of reaching new dimensions of connectedness with other people including the provider-patient relationship. The increase in conventional awareness of stigmatization of and bias towards obese individuals has led to an expansion of healthcare providers' objectivity in addressing patients' overall health, not just their size. Newman's theory includes the health of all persons regardless of the presence or absence of disease. This construct is utilized in the understanding that obesity does not equal disease (Newman, M., 1997). Health is a process of developing awareness of self and the environment. Newman called the unitary process of health and illness the "pattern of the whole."

Nurses are responsible for facilitating the revelation of meaningful patterns in patients' lives that lead to a personal evolution or higher level of consciousness (Petiprin, 2015). Unitary-transformative paradigm embraces health through focusing on clients' wholeness, relationships, caring, patterns, and recognition (Bateman & Merryfeather, 2014). Margaret Newman's theory of health as an expanding consciousness (HEC) is applied to address the complexity of obesity and stigma in the United States through the patient, family, community, and healthcare providers. Findings thus far suggest that patients with obesity have tried many times to lose weight through diets, self-help books, and commercial programs. These challenges show the social, environmental, and

behavioral determinants of obesity (Kusher & Ryan, 2014).

People are constantly changing. The relation of time and space surrounding provider-patient relationships and the sociological and physical environment is constantly in a state of flux. Newman's theory utilizes six concepts that can be applied to this study:

1. The pathology of health includes physical and mental illness; this pertains to obesity as a diagnosis.

2. Pathological conditions are influenced through patients' environment and social/behavioral interactions creating self-image.

3. The physical weight gains and influences of changes within a patient does not change the true person and the perception of health.

4. Getting rid of excess weight, as with obesity, will not change whom the patients are. Their experiences shape who they are.

5. If becoming obese is the only way a person can manifest true self then that is the pattern of social and health-care influences for that patient. Health, not just weight, is an expansion of the consciousness.

Concepts that are in particular relevance to this study include perception of health, social interaction and stigma, self-image, and communication and interaction with members of the healthcare team. HEC follows the process of a girl growing through womanhood with the understanding that her awareness of the world around her (consciousness) and interactions within members of family, society, and healthcare formulates either oppression or elevation of self-image and body-image. Providers can use this theory to help patients understand health and diagnosis through dialogue that

focuses on the patient's life situation and diagnoses. Providers who consciously free

themselves of any personal preoccupations or expectations and allow the patient to reflect

on their own transformation of consciousness, including understanding of health, follow

this theory (Parker & Smith, 2015).

Figure 1. Utilization of Newman's Theory of Health as Expanding Consciousness.

Hypothesized relationship of woman as patient, member of society, and understanding of

health with provider.

Assumptions

1. Obesity rates have increased dramatically in the last twenty years (CDC, 2016b; Heffler, 2005; Finkelstein, 2009; Nguyen, 2010; NHANES, 2013; NIIKD, 2010; ODPHP, 2016; Wells, et al., 2012; and WHO, 2013).

2. There is a reduction in the stigmatization of obese women compared to 1996 (Mold & Forbes, 2011; Nazione, 2015; Phelan et al., 2015; and Puhl, Moss-Racusin, Scwartz, & Brownell, K. D. 2008)

3. There is a continued stigma in society regarding obesity (Brewis, Hruschka, & Wutich, 2011; Ferrante, Seaman…Puhl, 2016; and Altman, Hook., & Hillemeiser, 2016)

Hypothesis in Comparison of Aramburu-Drury Study Results

1. There is a significantly lower correlation coefficient between body mass index and the delay/ avoidance of health care than the previous researchers' correlations due to a greater self-acceptance by obese persons.

2. There is a significantly lower correlation coefficient of the previously established inverse relationship between self-esteem and obese women in delay/ avoidance of healthcare in previous researchers' correlations due to a greater self-acceptance by obese persons.

3. There is a significantly lower correlation coefficient of personal attribution of weight and the delay/ avoidance of healthcare in previous researchers' correlations.

4. Among obese women there is an inverse relationship comparative to the previous researchers' correlation between satisfaction of medical care received and delay/ avoidance.

5. There is an inverse relationship comparative to the previous researchers' correlation of personal attribution for weight and satisfaction with medical care.

6. The independent variables of: body mass index, self-esteem, attribution for weight, and satisfaction for healthcare can be used to predict the dependent variable delay/ avoidance of healthcare.

Methodology

Research Design

The design is to explore the relationships between the variables in the survey utilized by Aramburu-Drury and the current independent variables of body mass index, self-esteem, attribution for weight, and satisfaction of medical care versus the dependent variable of delay/ avoidance in healthcare (Aramburu-Drury, 1996). Then to describe the intensity and direction of these variables from past and present is through calculating correlation coefficients (Polit & Beck, 2014).

Proposal for Sample Selection

I followed the same criteria of Aramburu-Drury for sample selections. Women, 18 years of age or older, who are not pregnant during the time of survey are invited to participate. I had hoped to expand on Aramburu-Drury's original study into the rural Nevada and Spanish speaking populations. However, no Spanish translation s of the questionnaire were returned. To expand on Aramburu-Drury previous study profile, this

survey did include unemployed and employed Spanish speaking minorities of Washoe County who attend church with Spanish as the primary language, as well as any religious congregations of the English language. The goal of achieving the same number of participants as Aramburu-Drury, two-hundred sixteen, to give the most accurate analogy was not achieved. Included in participation were women from a rural area in Fallon, NV, as well as utilization of churches and a day-care/ pre-school in the Northern Nevada area.

Human Subjects Rights

This researcher assumed all responsibility for insuring informed consent will be obtained from the participants. There was implied consent to participate through reading and returning the questionnaire and cover page stating the instruments used in the study for this thesis as approved though the Institutional Review Board (see Appendix A & B).

Procedure

The questionnaire was distributed to the participant either before or after church services or upon picking-up and dropping-off children at day-care. The questionnaire is an amalgamation of previously used questionnaires', originally developed by Jacklyn Parker in 1990 and Saltzer's weight locus of control study in 1978. The questionnaire was utilized by Aramburu-Drury allowing for direct correlation of current patient views of healthcare by women. No changes were made to the questionnaire with the exceptions: that Physician Assistants was added to the primary care list, and income levels were increased. In 1996 Physician Assistants were not utilized in primary care as they are in 2016.

Instrumentation

The instrument utilized by Aramburu-Drury in her thesis of 1996, titled, *Women*

and Healthcare: A Thesis Study, retyped with minor changes of the original study. The exception is made with the Spanish translation utilizing the Spanish translation application through Microsoft Word Translator Hub and verified by Spanish speaking healthcare workers from a local Emergency Department. Utilization of the amalgamation of previous studies provided a proven questionnaire for analysis and comparison utilizing correlation coefficients from 1996 to the current year of 2016. The comparison of correlation will be utilized through a quantitative spreadsheet and the software SPSS. The sample population was demographically profiled to Northern Nevada women and a statistical analysis of correlation coefficients was conducted.

The Instrument

Woman and Healthcare: A Thesis Study of Obesity Stigma Reduction and Healthcare. Replication of Study by Christine Aramburu-Drury Summer/Fall 1996 UNLV Master of Science Nursing Student UNLV. Minor changes were made, approved by the thesis committee, to the tool from Aramburu-Drury's original thesis study in 1996. (See Appendix C)

The Variables

The operational definition of this research design is a descriptive correlational study. Comparisons were made statistically through responses if there is a positive relationship between body mass index and delay or avoidance of healthcare using Pearson's Correlation Coefficient. One of the variables was Body Mass Index, BMI, and is calculated using the globally accepted conversion of weight (kg) versus height (m^2) = kg/m^2 and the normalized ratios of populations is standardized. Self-esteem calculations were generated from ten items utilizing a Likert scale in question number 13. A score of

one to five for each item was given and a sum of all ten items gives the respondents score. The variable of satisfaction with medical care, had twelve items on a Likert scale of one to five, with question number 14 thus giving a corresponding score. The attribution for weight variable utilized five items in question number 17. This variable was formatted using a Likert scale of one to five with a sum of all items to give the respondents a total score.

CHAPTER FOUR

Findings

The questionnaires were obtained from 143 women within three churches and one daycare-preschool in two counties, Lyon and Washoe, Nevada. An in person convenience sample of adult women of any size were recruited as subjects for this study. The Spanish translation of the questionnaire was provided, however no Spanish questionnaires were returned. Participant demographics were included in questionnaires. The variables measured were body mass index, self-esteem, attribution for weight, satisfaction with medical care, and delay/ avoidance of healthcare.

Demographics

The majority of participants were Caucasian (77.2%, $n= 98$) and catholic faith (40.2%, $n=45$). These results were similar to results achieved by Aramburu-Drury (p.36). Limitations in participation by lack of completed questionnaires or skipping questions is understood. Most of the participant population had some college (30.7%, $n=39$) or were college graduates (32.3%, $n=41$). The second highest form of education by participants were post graduate (16.4%, $n=21$). The majority of participants were working class, outside of the home (70.3%, $n=90$) and ages 30-39 (27.7%, $n=39$) and 60-69 (19.1%, $n=27$). Most participants included demographics in their responses increasing total percentages, example 2 participants left age blank. The results can be viewed in Tables 1-6.

Table 1

Race of Participants

		Frequency	Percent	Cumulative Percent
	Hispanic	15	10.5	11.8
	Asian/ Pacific Islander	8	5.6	18.1
	African American/ Black	1	.7	18.9
	Caucasian	98	68.5	96.1
	Native American	4	2.8	99.2
	Other	1	.7	100.0
	Total	127	88.8	
Missing	Blank	16	11.2	
Total		143	100.0	

Table 2

Religion of Participants

		Frequency	Percent	Cumulative Percent
	Seventh Day Adventist	1	.7	.9
	Christian	23	16.1	21.4
	Catholic	45	31.5	61.6
	No/ None/ n/a	23	16.1	82.1
	Atheist	4	2.8	85.7
	Agnostic	5	3.5	90.2
	Methodist	1	.7	91.1
	Episcopal	1	.7	92.0
	Protestant	1	.7	92.9
	Jehovah's Witness	1	.7	93.8
	Mormon	6	4.2	99.1
	Wiccan	1	.7	100.0
	Total	112	78.3	
Missing	Blank	31	21.7	
Total		143	100.0	

Table 3

Education of Participants

		Frequency	Percent	Cumulative Percent
	Some high school	1	.7	.8
	High School Graduate	15	10.5	12.6
	Vocational/ Business School	9	6.3	19.7
	Some College	39	27.3	50.4
	College Graduate	41	28.7	82.7
	Post Graduate Degree	21	14.7	99.2
	Other Formal Education	1	.7	100.0
	Total	127	88.8	
Missing	Blank	16	11.2	
Total		143	100.0	

Table 4

Occupation of Participants

		Frequency	Percent	Cumulative Percent
	Professional	43	30.1	33.6
	Clerical	31	21.7	57.8
	Manual	16	11.2	70.3
	Homemaker	9	6.3	77.3
	Retired	23	16.1	95.3
	Student	3	2.1	97.7
	Other	3	2.1	100.0
	Total	128	89.5	
Missing	Blank	15	10.5	
Total		143	100.0	

Table 5

Income of Participants

		Frequency	Percent	Cumulative Percent
	0-19,999	8	5.6	6.1
	20,000-39,999	21	14.7	22.1
	40,000-59,000	23	16.1	39.7
	60,000-79,999	23	16.1	57.3
	80,000-99,999	14	9.8	67.9
	100,000-120,000	17	11.9	80.9
	121,000-150,000	15	10.5	92.4
	151,000-200,000	6	4.2	96.9
	201,000+	4	2.8	100.0
	Total	131	91.6	
Missing	Blank	12	8.4	
Total		143	100.0	

Table 6

Age Brackets of Participants

		Frequency	Percent	Cumulative Percent
	18-29	19	13.3	13.5
	30-39	39	27.3	41.1
	40-49	16	11.2	52.5
	50-59	25	17.5	70.2
	60-69	27	18.9	89.4
	70-79	13	9.1	98.6
	80-89	2	1.4	100.0
	Total	141	98.6	
Missing	Blank	2	1.4	
Total		143	100.0	

Instrument

The statistical significance of the instrument with a measure of internal reliability was calculated by Aramburu-Drury. The writer utilized Cronbach's alpha to calculate for the Self-Esteem Scale, Satisfaction with Medical Care Scale, and Delay Avoidance of Healthcare Scale (Aramburu-Drury, p.43-44, table 7). She had found the alpha coefficients for self-esteem scale and the satisfaction with medical care scale were greater than 0.80. The Delay/ Avoidance of healthcare scale was designed by Packer and found by Aramburu-Drury to have an alpha score of 0.75 (p.43, Table 7). The scale was divided into two separate time periods, for 'ever' and '12 months'. The majority of completed questionnaires in the 2016 study only filled out the 'ever' side. This caused a necessity to group all completed responses into 'ever', and leaving out the 12-month response category.

Overview of Participants General Health Status

Many women in the convenience sample view themselves to be in excellent, very good or good health (89.6%, *n=*128) as was noted by Aramburu-Drury. Interestingly, all study participants filled out the perception of health question (Table 7). The perception of preventative care is beneficial by those who strongly or agree (74%, *n=*100) of participant populations (Table 8). Of participants only 7.7% percent (*n=*11) had not seen a healthcare provider in the last 12 months (Table 9).

Participants Medical Coverage and Provider Utilization

All participants (100%, *n=*143) marked medical coverage for visits. This may be deduced from the requirement of medical coverage and the Affordable Care Act signed into law March 23, 2010.

All participants (*n=143*) marked what type of provider utilized for health concerns. Of the 143 participants in the study, only 9 (6.3%) did not have a provider of whom they would call or visit for needed medical advice. All participants that marked a provider marked more than one (93.7%, *n=134*), difficult to ascertain which providers the participants see the most frequently. The number of visits to healthcare providers in the last 12 months of the study varied from 0-60 and listed (Table 9).

Table 7

Participant Perception of Health

	Frequency	Percent	Cumulative Percent
Excellent	14	9.8	9.8
Very Good	64	44.8	54.5
Good	50	35.0	89.5
Fair	10	7.0	96.5
Poor	5	3.5	100.0
Total	143	100.0	

Table 8

Preventative Care is Beneficial

		Frequency	Percent	Cumulative Percent
	Strongly Agree	87	60.8	64.4
	Agree	13	9.1	74.1
	Ambivalence	10	7.0	81.5
	Disagree	7	4.9	86.7
	Strongly Disagree	18	12.6	100.0
	Total	135	94.4	
Missing	Blank	8	5.6	
Total		143	100.0	

Table 9

Participant Visit to Healthcare Providers in Last 12 Months

	Frequency	Percent	Cumulative Percent
.00	11	7.7	7.7
1.00	26	18.2	25.9
2.00	39	27.3	53.1
3.00	17	11.9	65.0
4.00	16	11.2	76.2
5.00	4	2.8	79.0
6.00	8	5.6	84.6
7.00	1	.7	85.3
8.00	3	2.1	87.4
10.00	4	2.8	90.2
12.00	5	3.5	93.7
14.00	1	.7	94.4
20.00	4	2.8	97.2
25.00	1	.7	97.9
40.00	1	.7	98.6
48.00	1	.7	99.3
60.00	1	.7	100.0
Total	143	100.0	

STUDY VARIABLES

Body Mass Index

Body Mass Index (BMI) is a calculation used globally to estimate weight (kg)

versus height (m^2) = kg/m^2 and the normalized ratios of populations (World Health

Organization, 2007). According to the National Health and Nutrition Examination

Survey (NHANES), the BMIs listed equal the following rating: BMI <19.9=

Underweight; BMI of 20-24.9= Normal Weight; Overweight BMI= 25.0-29.9, Obesity 1

BMI= 30-34.9, Obesity 2=35-39.9 and Morbidly or Obese 3 ≥ BMI 40. The study

participants of this sample population were 56.1% overweight or obese (*n*=74). Of the

participants 27.3% (*n*=38) this does compare with the obesity prevalence for Nevada at

25-30% (CDC, 2016b).

Table 10

Body Mass Index Category

		Frequency	Percent	Cumulative Percent
	Underweight <19.9	3	2.1	2.3
	Normal Weight 20-24.9	55	38.5	43.9
	Over weight 25.0-29.9	38	26.6	72.7
	Obesity 1 30.0-34.9	22	15.4	89.4
	Obesity 2 34.9-39.9	7	4.9	94.7
	Obesity 3 40+	7	4.9	100.0
	Total	132	92.3	
Missing	System	11	7.7	
Total		143	100.0	

Delay/ Avoidance in Healthcare

There were nineteen reasons for Delaying/ Avoiding Healthcare listed. Participants were asked to recall reasons and mark the appropriate column. However, many may not have understood the difference between last 12 months and ever column. The majority of completed questionnaires in this study only filled out one side, with a necessity to group all completed responses into 'ever', and leaving out the 12-month response category.

The only participant who did not finish the questionnaire after question seven did not complete the delay section. All other participants hand wrote items such as, "I never delay seeing my doctor", "I see my NP when-ever I need to", or "N/A". It could be compare that unless marked, those participants do not delay seeing their providers for items listed (Question 8, Table 11).

The most frequent reasons for delaying healthcare in this study were "time" and "cost" and (Table 12, 13 & 14). Very similar results to Aramburu-Drury study in 1996 (p. 55, Table 16). The most frequent reason, at 14.1% of all participants (n=20/ 142), for weight related delay of healthcare was "gained weight" (Table 15).

Table 11

Number of Items Causing Delay/ Avoidance in Seeking Healthcare Ever

		Frequency	Percent	Cumulative Percent
	0	50	35.0	35.2
	1	29	20.3	55.6
	2	29	20.3	76.1
	3	12	8.4	84.5
	4	8	5.6	90.1
	5	5	3.5	93.7
	6	4	2.8	96.5
	7	2	1.4	97.9
	8	1	.7	98.6
	9	1	.7	99.3
	14	1	.7	100.0
	Total	142	99.3	
Missing	Blank	1	.7	
Total		143	100.0	

Table 12

Statistics of Non-Weight Related Delay/ Avoidance

	N	
	Marked	Not Marked
Time	54	89
Cost	41	102
Lack Confidence	34	109
Rushed Office	15	128
Appointment	36	107
Travel	11	132
Transportation	3	140
Fear of Problem	21	122
Child Care	14	129
Waiting Time	7	136
Pain	3	140
Testing	14	129
Smoker	4	139
Other	5	138

Table 13

Time. Non-Weight Related Delay

		Frequency	Percent	Cumulative Percent
	1.00	54	37.8	100.0
Missing	System	89	62.2	
Total		143	100.0	

Table 14

Cost. Non-Weight Related Delay

		Frequency	Percent	Cumulative Percent
		41	28.7	100.0
Missing	System	102	71.3	
Total		143	100.0	

Table 15

Weight Related Reasons Delay/ Avoid Healthcare

	Gained Weight	Weighed at Office	Told 2 Lose Weight	Undress	Rid Problem with Weight Loss
N	20	8	15	0	15
Missing	123	135	128	143	128
Mean	.9500	1.0000	1.0000		1.0000
Median	1.0000	1.0000	1.0000		1.0000
Mode	1.00	1.00	1.00		1.00
Sum	19.00	8.00	15.00		15.00

Self-Esteem, Satisfaction with Medical Care, and Attribution for Weight

Participants appeared to have a generally moderate self-esteem with an average of 32.67 of a possible 50 points (Table 16). This result compares to the 1996 Aramburu-Drury study resulting average of 40 out of possible 50 points (p. 58, Table 18). The results in satisfaction of medical care of participants was approximately 35 points on average with a possible maximum points of 60. Aramburu-Drury (1996) participants averaged 33 out of 60. The mean attribution for weight scale was 18.3 out of a possible 25. This is a slight reduction from Aramburu-Drury (1996) results of 19.8 out of 25.

Table 16

Descriptive Statistics

	Total Self-Esteem	Total Satisfaction with Medical Care	Total Attribution for Weight
N	142	141	141
Missing	1	2	2
Mean	32.6690	34.9291	18.3191
Median	33.0000	34.0000	19.0000
Mode	34.00	34.00	21.00
Std. Deviation	4.06808	5.04359	3.24988

Research Questions in Comparison of Aramburu-Drury Study Results

1. There is a reduced relationship between body mass index and delay/ avoidance of healthcare. In comparison to the study results by Aramburu-Drury, $r= 0.15$, $p= 0.03$, $n=210$, Pearson's R is higher, though the current results are not statistically significant from zero, $r= 0.19$, $p= 0.74$, $n=133$ (Table 17, 18). It was considered that medical stigma was reduced though training and societal acceptance of obesity. A test of two different correlation coefficients was not significant, $p=0.71$. The difference between the previous and current correlation coefficients for all comparisons utilizing the Fisher R to Z transformation supplied by the website, vassarstats.net. This website is utilized to test the difference between all correlation coefficients between current and previous statistics for comparative analysis to the previous research by Aramburu-Drury.

Table 17

Correlations

		Total Delay/ Avoidance	Body Mass Index of Participants	Total Self- Esteem	Total Attribution for Weight	Total Medical Satisfaction
Total Delay/ Avoidance	Pearson Correlation	1	.185	-.174	-.192	-.206[*]
	Sig. (2-tailed)		.067	.080	.052	.037
	N	103	99	103	103	103
Body Mass Index of Participants	Pearson Correlation	.185	1	.035	-.070	.012
	Sig. (2-tailed)	.067		.687	.427	.888
	N	99	133	133	133	133
Total Self- Esteem	Pearson Correlation	-.174	.035	1	.208[*]	.168[*]
	Sig. (2-tailed)	.080	.687		.013	.046
	N	103	133	142	141	141
Total Attribution for Weight	Pearson Correlation	-.192	-.070	.208[*]	1	.137
	Sig. (2-tailed)	.052	.427	.013		.104
	N	103	133	141	141	141
Total Medical Satisfaction	Pearson Correlation	-.206[*]	.012	.168[*]	.137	1
	Sig. (2-tailed)	.037	.888	.046	.104	
	N	103	133	141	141	141

*. Correlation is significant at the 0.05 level (2-tailed).

Table 18

Correlations between BMI and Delay/ Avoidance of Healthcare

		Total Delay	Body Mass Index of Participants
Total Delay Marked	Pearson Correlation	1	.185
	Sig. (2-tailed)		.067
	N	133	133

2. There is no statistical significance in the difference between correlation

    coefficients of the previously established inverse relationship between self-esteem

    and obese women in delay/ avoidance of healthcare. Current statistical

    comparison variables self-esteem of obese women and delay/ avoidance of

    healthcare is not significant, *r*= -.062, *p*= .722, *n*=35 (Table 19, 20, 21).

    Aramburu-Drury's study (1996) did demonstrate a significant correlation with her

    testing of correlation coefficients resulting *r*=.36, *p*= .002, *n*=73. A test of the

    difference between the two different correlation coefficients resulted in the

    significant *p* value of 0.0394. This is evidence to support the hypothesis of a

    lower correlation coefficient in the current study. Obese women report avoiding

    healthcare less in this study.

Table 19

Correlations-Obese Only Delay Healthcare

		Total Delay	Body Mass Index of Participants
Total Delay	Pearson Correlation	1	-.262
	Sig. (2-tailed)		.128
	N	35	35

Table 20

Correlations- Obese Only Self-Esteem

		BMI > 29.9 (Obese)	Total Self-Esteem
BMI > 29.9 (Obese)	Pearson Correlation	1	-.038
	Sig. (2-tailed)		.802
	N	47	46

Table 21

Correlations of Obese, Esteem and Delay

		BMI > 29.9 (Obese)	Total Self-Esteem	Total Delay/ Avoidance
BMI > 29.9 (Obese)	Pearson Correlation	1	-.038	-.262
	Sig. (2-tailed)		.802	.128
	N	47	46	35
Total Self-Esteem	Pearson Correlation	-.038	1	-.062
	Sig. (2-tailed)	.802		.722
	N	46	46	35

3. There is a statistical significance in the difference between correlation coefficients between personal attribution of weight and the delay/ avoidance of healthcare compared to the previous researcher's correlations (Table 22). The results for Aramburu-Drury's study (1996) indicated that women with both high and low levels of attribution for weight report avoiding healthcare, *r=.24, p=.004, n=137* (p. 64). A test of the difference between the two different correlation coefficients with the current data, *r= -.192, p= .052, n= 103,* was significant with *p* value of 0.0009 (*p< .05*). This does support the hypothesis of a lower correlation coefficient between the two variables. There is a decrease in the correlation between attribution of weight and delay/ avoidance of healthcare.

Table 22

Correlations of Attribution of Weight & Delay/ Avoidance of Healthcare

		Total Delay	Total Attribution for Weight
Total Delay	Pearson Correlation	1	-.192
	Sig. (2-tailed)		.052
	N	103	103

4. Among obese women there is statistical significance of the difference between the correlations in the two studies between satisfaction of medical care and delay/ avoidance by obese women. The current statistical analysis shows no statistical significance in the relationship between Satisfaction of Medical Care and Delay/ Avoidance of Healthcare in obese women (Table 23). Comparison of Aramburu-Drury's ($r= .25$, $p=.03$, $n=73$) results to a test of the difference between the two different correlation coefficients was significant with the current study of $r=-.153$, $p=.381$, $n=35$. The resulting p value of 0.0135 is significant and does support the hypothesis of a difference in the correlation coefficients of the two variables. There is a reduction in the correlation between satisfaction of medical care and delay/ avoidance of healthcare compared to the previous researcher's correlation. Obese women delay/ avoid less because of medical care received.

Table 23

Correlations of Delay, Satisfaction of Medical Care & Obese

		Total Delay/ Avoidance	Total Satisfaction of Medical Care	BMI > 29.9 (Obese)
Total Delay/ Avoidance	Pearson Correlation	1	-.153	-.262
	Sig. (2-tailed)		.381	128
	N	35	35	35
Total Satisfaction of Medical Care	Pearson Correlation	-.153	1	-.223
	Sig. (2-tailed)	.381		.141
	N	35	45	45

5. There is a significant difference in the correlation coefficients of this study and the previous study for personal attribution for weight and satisfaction with medical care. Aramburu-Drury (1996) results were, $r= -.23$, $p= .001$, $n= 209$ (p. 78 & Table 28). A test of the difference between the two different correlation coefficients, current study results of $r=.137$, $p=.104$, $n= 141$, resulted in the p value of .0022 is significant and supports the hypothesis of a difference in the relationship between the two variables. This is showing a positive relationship between personal attribution for weight and unimportance in the satisfaction with medical care. Woman are not satisfied with medical care and is not relevant to attribution for weight

Table 24

Correlations of Satisfaction with Medical Care and Attribution for weight

		Total Satisfaction with Medical Care	Total Attribution for Weight
Total Satisfaction with Medical Care	Pearson Correlation	1	.137
	Sig. (2-tailed)		.104
	N	141	141

6. The independent variables of: body mass index, self-esteem, attribution for
   weight, and satisfaction for healthcare cannot be used to predict the dependent
   variable delay/ avoidance of healthcare. There is not significant correlation
   between body mass index, self-esteem, attribution for weight and satisfaction with
   medical care and the dependent variable delay/ avoidance of healthcare. When
   there is no significant relationship of any of the variables they cannot be used for
   predictive purposes. Therefore, multiple regression analysis of results is
   unnecessary. This study shows that while self-esteem for the general adult
   women population has decreased it is not dependent upon the variables attribution
   for weight, body mass-index and satisfaction with healthcare.

CHAPTER FIVE

Discussion

Summary

This thesis study was a replication of the thesis study by Aramburu-Drury. The

purpose was to see if there was a reduction in the perceived obesity bias of healthcare

professionals by women, in congruence with possible greater self-esteem. This was

accomplished through examination of the association between body mass index and the

delay/ avoidance of healthcare by adult women. The three additional variables included

in the study were self-esteem, satisfaction with medical care, and attribution for weight.

The increasing over weight and obese female population is established (Nguyen & El-

Serag, 2010). The increase in risk to health has also been discussed and a focus on the

over-weight and obese was utilized (Nguyen & El-Serag, 2010).

Delay/ Avoidance of Medical Care

There lacked statistically significant changes in the delay/ avoidance of healthcare

from the Aramburu-Drury study done twenty years ago. Out of 19 possible items 14

were non-weight related and 5 were weight related. The summary of statistics is that

non-weight related reasons for avoiding healthcare outnumber the weight related reasons.

The majority of participants marked time and cost as the reasons for delaying medical

care, at 37.8% and 27.8% respectfully showing that weight is not the only factor for

avoiding healthcare. Women have time and cost restraints to delay or avoid healthcare

greater than weight attribution. This is compared to the most frequent weight related

reason to delay/ avoid healthcare at 14.1% pertaining to "I had gained weight since my

last visit". It is still a significant finding and strong reason for a woman to delay or avoid healthcare.

Self Esteem/ Attribution for Weight

This study did not find statistical significance between participants' Body Mass Index (BMI) and a self-esteem score nor attribution for weight. The statistical significance was founded in the dramatic decrease in self-esteem of the participants in this study analysis results of 32.67/50 possible points, versus Aramburu-Drury results average of 40/50 possible points. This is opposite to the presumptive increase in self-esteem with the fat acceptance movement and increase in overweight and obese would then correlate an increase in generalized acceptance of body image (Paquette & Raine, 2004). This was an incorrect presumption and a more in depth understanding of the reduced self-esteem of woman in general, not only the over-weight or obese, is not well understood by this student at this time.

There is also a statistically significant (p=0.046, table 17) correlation to satisfaction with medical care and self-esteem. The notion that those women with increased self-esteem also seek and are satisfied with medical care could be explored. The previous researcher (Aramburu –Drury, 1996) hypothesized that those that attend church have a strong sense of well-being and may increase self-esteem (p. 89). This study's results included a large amount from drop off recipients of the day-care center had significant influence on the analysis and results. My hypothesis of results is that working mothers who utilize day-care, may have a lower self-esteem and less sense of strength and belonging than those that do not need to resort to day-care.

The majority (70.7%) of participants have some college education (Table 3) and

51.8% are in professional or clerical forms of employment (Table 4). With these high numbers for employment and education, it would not be presumptive to assume increased self-esteem. Another possible hypothesis of low self-esteem scores is humility. Bragging is a negative trait and women may not have wanted, even though the questionnaire was anonymous, to appear proud. Brewis, Hruschka, and Wutich (2011), concluded that in obese populations, bias may not be real, and that the bias is perceived because of their own self-esteem. This may be a correlation of the low self-esteem with an increased attribution for weight. Women may feel responsible for themselves and their weight.

Satisfaction with Medical Care

The low overall satisfaction with medical care by all participants, regardless of Body Mass Index, is disturbing. Even with the implementation of the Affordable Care Act of 2010, fewer participants now are satisfied with their medical care compared to twenty years ago (Janke et al., 2015). There is a statistically significant positive correlation between Satisfaction of Medical Care and Delay/ Avoidance of health care by all participants, $p= .037$, $n=103$ (Table 17). This is not surprising that women would delay/ or avoid healthcare if they are not satisfied with health care received. Aramburu-Drury (1996) perceived that the benefits of medical care should outweigh the risks. I speculate that there is a perceived inconvenience to medical care because of time and cost that was not anticipated in prior studies.

Newman's Theory of Healthcare as Expanding Consciousness

Health in the presence of disease can be overlooked and patients can be seen only as the disease is part of my understanding of Healthcare as Expanding Consciousness

(HEC). The participants in this study showed that through statistical analysis, the education and employment of a woman does not correlate to satisfaction of medical care and self-esteem. As women, we are more than what we do for a living or the education we have achieved. Our self-esteem scores compare to the responsibility we feel towards our own weight (attribution for weight) and correlate into the expansion of healthcare consciously. The participants in this study did not demonstrate a correlation between BMI >29.9 (obese) and over-all delay/ avoidance of healthcare (Table 21). Any delays in health care were not weight related. Utilizing Newman's Theory of HEC, it can be hypothesized that women do not see weight as a reason to seek or delay healthcare. The no statistical significance (2-tailed) in this study, $p=.128$, $n=35$, to correlated total delay/ avoidance and obesity. The diagnosis of obesity does increase the risk of chronic health conditions, however, it does not guarantee chronic disease (Barry et al., 2014).

Limitations

Convenience sampling is a statistically significant limitation of long questionnaires such as this. The type of person who actually answers such questionnaires are those that presumptively find the desire to assist people by nature. The coincidence of high amounts of college education (70%) with participation in this questionnaire is something to think about with most questionnaires. Does some form of college education increase the compliance of surveys? That is a possibility for future research.

The lack of time available to complete a survey is a big limitation. Woman may not have had the time to fill out the survey when asked. This is a possible correlation to the reason why time was a constraint of women to seek healthcare in the delay/ avoidance section. Women are busy.

Another limitation is my lack of fluency in the Spanish language. Spanish translators were utilized to translate the questionnaire into Spanish. Perhaps not enough trust was not conveyed to potential only Spanish speaking participants. The greatest limitation into statistical significance and effect size is the number of participants.

Recommendations

The increase in attribution for weight and delay of healthcare is something that should be explored by further studies. The following are possible reasons why there is an increase in attribution for weight and healthcare delay/ avoidance in the general population:

1. Public education of weight related comorbidities.

2. The increase in overweight and obese women in the general population

3. The utilization of internet search engines for medical symptoms.

Socially, women still experience bias towards their weight, especially from family and friends. This bias may be over thought or misconstrued by women and is not actually a fact (Brewis, Hruschka & Wutich, 2011).

Secondly, recommendation for future studies are to look at time constraint for men and women and reason to delay/ avoid medical care on a greater scale. Increasing the number of participants, by not utilizing convenience sampling, as well as, including men and women in the questionnaire is another option. Women may not be the only ones who allow time, cost, and attribution of weight to cause a delay or avoidance in healthcare.

APPENDIX A

Research Integrity Office
218 Ross Hall / 331,
Reno, Nevada 89557
775.327.2368 / 775.327.2369 fax
www.unr.edu/research-integrity

University of Nevada, Reno

DATE: November 17, 2016
TO: Christine Aramburu-Alegria
FROM: University of Nevada, Reno Institutional Review Board (IRB)

PROJECT TITLE: [986794-1] Woman and Healthcare: A 2016
Thesis Study REFERENCE #: BioMedical
SUBMISSION TYPE: New Project
ACTION: DETERMINATION OF
EXEMPT STATUS DECISION DATE: November 17,
2016
REVIEW CATEGORY: Exemption Category # 2

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The Research Integrity Office, or the IRB reviewed this project and has determined it is
EXEMPT FROM IRB REVIEW according to federal regulations. Please note, the federal
government has identified certain categories of research involving human subjects that qualify
for exemption from federal regulations.

Only the Research Integrity Office and the IRB have been given authority by the
University to make a determination that a study is exempt from federal regulations. The
above-referenced protocol was
reviewed and the research deemed eligible to proceed in accordance with the requirements of
the Code of Federal Regulations on the Protection of Human Subjects (45 CFR 46.101
paragraph [b]).

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Reviewed Documents

- Application Form - Application-MRiches.docx (UPDATED: 11/10/2016)
- Consent Form - ConsentinSpanish-Thesis-Study-MRiches.docx (UPDATED: 11/9/2016)
- Consent Form - Consent-Thesis-Study-MRiches.docx (UPDATED: 11/9/2016)
- Letter - BlueKangarooSiteApproval (UPDATED: 11/10/2016)
- Letter - WordOfLifeMinistries-SiteApproval (UPDATED: 11/10/2016)
- Letter - Grace-Church-SiteApproval.pdf (UPDATED: 11/10/2016)
- Letter - SaintPatrick'sSiteApproval (UPDATED: 11/10/2016)
- Questionnaire/Survey - Aramburu-questionnaire-Spanish.docx (UPDATED: 11/9/2016)
- Questionnaire/Survey - Aramburu-Thesis-Questionnaire.docx (UPDATED: 11/9/2016)
- University of Nevada, Reno - Part I, Cover Sheet - University of Nevada, Reno - Part I,

Cover Sheet (UPDATED: 11/10/2016)

If you have any questions, please contact Valerie Smith at 775.327.2370 or at valeries@unr.edu.

NOTE for VA Researchers: You are not approved to begin this research until you receive an approval letter from the VASNHCS Associate Chief of Staff for Research stating that your research has been approved by the Research and Development Committee.

Sincerely,

Richard Bjur, PhD
Co-Chair, UNR IRB
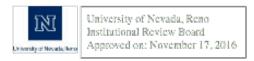University of Nevada Reno

Janet Usinger, PhD
Co-Chair, UNR IRB
University of Nevada Reno

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Nevada, Reno IRB's record

APPENDIX B

University of Nevada, Reno
Institutional Review Board
Approved on: November 17, 2016

This Nurse and Student Needs Your Assistance!
Please give me your opinion in regards to women and
Healthcare!

My name is Michelle Riches. I am a Registered Nurse in a busy Emergency Department in Reno, NV. I am also a Graduate Student working on my thesis in order to receive my Master's Degree in Nursing, specializing in Family Practice. I am conducting a research study to learn about women and how they feel about their health and their utilization of primary health care, as well as, their perceptions about the healthcare profession. Women participants must be 18 age or over, and cannot be pregnant.

I hope you will assist me in completing this 30 question survey titled **Woman and Healthcare: A 2016 Thesis Study**. This questionnaire takes approximately 5-10 minutes of your time to complete. This study is considered to be minimal risk of harm. This means the risks of your participation in the research are similar in type or intensity to what you encounter during your daily activities. You may experience boredom, restlessness, and or frustration with the number of questions (30). Please do not put your name, address, phone number, or any form of identification on the questionnaire. Your participation in this study is completely voluntary. You may stop at any time. Declining to participate or stopping your participation will not have any negative effects on your membership to your church or daycare.

This letter is yours to keep. You may ask questions of the researcher at any time by calling or writing.

Primary Investigator overseeing this study is: Dr. Christine Aramburu-Alegria
University of Nevada, Reno (0134), 1664 N. Virginia Street, Reno, NV 89557
(775) 682-7147/ aramburu@unr.edu

This research study is conducted as part of my master's thesis:
Michelle Riches R.N.-BSN. mriches@nevada.unr.edu

APPENDIX C- INSTRUMENT

Please answer the questions below by checking or circling the appropriate response, or filling in the information requested. All information on this questionnaire will remain confidential.

1. Would you say your health in general is: circle correct answer.

   a. Excellent

   b. Very Good

   c. Good

   d. Fair

   e. Poor

2. Do you have a particular heath care provider whom you could call or visit if you needed medical advice or check-up? Please Circle.

   a. Yes

   b. No

   c. If yes, which of the following providers do you call or visit? Circle all that are appropriate.

      i. Family Practice Physician

      ii. Internist

      iii. Gynecologist

      iv. Nurse Practitioner

      v. Physician Assistant

      vi. Nurse Midwife

   vii. Chiropractor

   viii. Nutritionist

   ix. Acupuncturist

   x. Homeopathic Provider

   xi. Other (Please Specify)

     1. _____

  d. Approximately how long have you had your primary care provider?

   i. _____

  e. What is the gender of your provider? Please Circle.

   i. Male

   ii. Female

  f. What is your providers approximate age? _____

  g. What is your providers weight? Please circle your best guess.

   i. "Under" weight

   ii. "Normal" weight

   iii. "Over" weight

3. During the past twelve months, about how many times did you see any providers about your health? (Count each visit separately, even if it was for the same problems/ symptoms.)

  a. _____ Times (Indicate Number)

4. About how long has it been since you last saw a healthcare provider about your health?

  a. _____ Years _____ Months

5. For this last visit with a provider, approximately how much time passed between the time you thought you ought to see a provider until you actually saw him or her? _____ Years _____ Months

6. During the past five years, approximately how many different health care providers have you seen about your health?

    a. _____ Times (Indicate Number)

7. Do you have health insurance for yourself that covers? Please circle.

    a. Medical check-ups   yes   no

    b. Medical visits, not check-ups   yes   no

    c. Hospital Stays   yes   no

    d. Health services by other   yes   no

        people than medical doctors?

8. People frequently experience health problems or symptoms for which they might like to use a healthcare provider, but do not for some reason. Listed below are some common reasons that people delay or avoid seeing a health care provider, even if they have a problem with their health. Please indicate below

    1. Whether any of these reasons has <u>ever kept or delayed</u> you in seeing a health care provider.

    2. Whether any has kept or delayed you in seeing a health care provider during the <u>past twelve months</u>.

  <u>Ever</u>   <u>Past Twelve Months</u>

a. 1. _____   2. _____   I lacked confidence in available providers
b. 1. _____   2. _____   I don't have time

c. 1. _____ 2. _____ I would be rushed in and out of the office.

d. 1. _____ 2. _____ I felt it would cost too much

e. 1. _____ 2. _____ I had gained weight since my last visit.

f. 1. _____ 2. _____ I couldn't get an appointment.

g. 1. _____ 2. _____ I would have to travel to far.

h. 1. _____ 2. _____ I didn't have a way to get there.

I. 1. _____ 2. _____ I didn't want to get weighed on the providers scale

j. 1. _____ 2. _____ I was afraid of finding out what was wrong.

k. 1. _____ 2. _____ I didn't have anyone to care for children or other

family members.

l. 1. _____ 2. _____ I felt I could get rid of the problem myself, by losing

weight.

m. 1. _____ 2. _____ I would have to wait to long in the waiting room.

n. 1. _____ 2. _____ I was afraid of experiencing pain.

o. 1. _____ 2. _____ I would be given unnecessary medical tests.

p. 1. _____ 2. _____ I would be told to stop smoking.

q. 1. _____ 2. _____ I would be told to lose weight.

r. 1. _____ 2. _____ Other reasons not listed: _____

8. During the past twelve months, about how many days did illness or injury keep you

from performing your normal activities (for example, work, school, homemaking)?

_____ Days (indicate number)

9. During the past twelve months, about how many days did illness or injury keep you in

bed all or most of the day?

_____ Days (indicate number)

10. During the past twelve months, about how many days did illness or injury keep you in

bed all or most of the day? _____ Days (indicate number)

11. During the past twelve months, about how many days were you a patent in an

_____

overnight hospital?   Days (indicate number)

12. We are interested in how likely people are to make an appointment with a healthcare provider when they experience certain symptoms. Listed below are health problems which people might experience. Imagine that you have been experiencing each of the following symptoms for one week. Please indicate how likely it is that you would call a health care provider for an appointment:

	Very Unlikely- Likely				
a. Pain in the legs while walking	1	2	3	4	5
b. Diarrhea	1	2	3	4	5
c. Blood in Urine	1	2	3	4	5
d. Fatigue	1	2	3	4	5
e. Loss of sight in one eye	1	2	3	4	5
f. Back ache	1	2	3	4	5
g. Chest pain	1	2	3	4	5
h. Sore throat	1	2	3	4	5
i. Headache	1	2	3	4	5
j. Fainting	1	2	3	4	5
k. Cough	1	2	3	4	5
l. Loss of feeling in an arm	1	2	3	4	5
m. Leg Cramps	1	2	3	4	5
n. Trouble Sleeping	1	2	3	4	5
o. Heat Rash	1	2	3	4	5

13. For the following items, please indicate below how well each statement describes you: Doesn't describe me- Describes me

a. On the whole, I am satisfied with myself.	1	2	3	4	5

b. At times I think I am no good at all.   1   2   3   4   5

c. I feel that I have a number of good qualities   1   2   3   4   5

d. I am able to do things as well as most other   1   2   3   4   5

    people.

e. I feel that I am a person of worth   1   2   3   4   5

f. I certainly feel useless at times.   1   2   3   4   5

g. I feel that I am a person of worth, at least   1   2   3   4   5

    on an equal basis with others.

h. I wish I could have more respect for myself   1   2   3   4   5

i. All in all, I am inclined to feel that I am a   1   2   3   4   5

    failure.

j. I take a positive attitude toward myself   1   2   3   4   5

14. People may say good things and bad things about healthcare providers and medical care. From your experiences, please indicate below how much you agree or disagree with the following statements:

Strongly Disagree- Strongly Agree

a. Doctors spend as much time as necessary with   1   2   3   4   5

    each patient.

b. Doctors should be a little friendlier than they are.   1   2   3   4   5

c. Most doc tors do not care how medical   1   2   3   4   5

    procedures affect you.

d. Patients receive nothing but the best care from   1   2   3   4   5

    their doctors.

e. Many doctors don't care whether or not they   1   2   3   4   5

    hurt you.

f. Doctors don't care how long the patients have   1   2   3   4   5

    to wait.

g. Most doctors take an interest in their patients   1   2   3   4   5

h. In an emergency you can always get a doctor   1   2   3   4   5

i. Doctors clearly explain what is wrong before   1   2   3   4   5

giving you treatment.

    j. Doctors teach patients how to prevent sickness   1   2   3   4   5

       and accidents.

    k. Most doctors let you talk about your problems   1   2   3   4   5

    l. Doctors are careful to perform thorough exams   1   2   3   4   5

15. Please indicate how much you agree or disagree with the statement:

    Preventative healthcare (for example: Pap smears, Blood Pressure) is beneficial.

                       Strongly Disagree-Strongly Agree

                          1   2   3   4   5

16. In comparison to the weight that most people in the United States consider the "norm" for your height, do you consider your current weight to be:

    a. _____ Below the "norm"

    b. _____Just about the "norm"

    c. ——A little above the "norm"

    d. _____ somewhat above the "norm"

    e. _____ very much above the "norm".

17. People have different ideas and experiences about their weight. Please indicate how much you agree or disagree with the following statements:

                     Strongly Disagree- Strongly Agree

    a. I feel personally responsible for whether or not   1   2   3   4   5

       I am above the "norm" on weight.

    b. I feel personally responsible for getting down to   1   2   3   4   5

       a weight that is considered to be at "norm".

    c. I feel that I am able to lose enough weight   1   2   3   4   5

       to be considered to be at norm and keep it off permanently.

    d. Being at the "norm" on weight is largely a matter   1   2   3   4   5

       of luck.

    e. If I eat properly, and get enough exercise and   1   2   3   4   5

       rest, I can control my weight in the way I desire.

18. What is your age bracket?

  a. _____ 18-29

  b. _____ 30-39

  c. _____ 40-49

  d. _____ 50-59

  e. _____ 60-69

  f. _____ 70-79

  g. _____ 80-89

  h. _____ 90 and above

19. What is your total household income?

  a. _____ $0-19,999

  b. _____ $20,000- 39,999

  c. _____ $40,000- 59,999

  d. _____ $60,000-79,000

  e. _____ $80,000- 99,999

  f. _____ $100,000-120,000

  g. _____ $121,000-$150,000

  h. _____ $151,000- 200,000

  i. _____ $201,000 and above

20. What is your race/ ethnic background? Circle all that apply:

  a. Hispanic

  b. Asian/ Pacific Islander

  c. Black

  d. White/ Caucasian

  e. Native American

  d. Other _____

21. What is your religion? _____

22. What is your occupation? (If you are presently employed, or if you are a student of homemaker, please indicate this) _____

23. What is the highest level of formal education you have obtained?

      a. _____ Elementary School

      b. _____ Some high school

      c. _____ High school graduate

      d. _____ Vocational/ Business school

      e. _____ Some college

      f. _____ College graduate

      g. _____ Post graduate degree

      h. _____ Other formal education (specify) _____

24. How tall are you? _____ Feet _____ Inches

25. How much do you weigh? _____ Pounds

26. If you have been heavier than your current weight (except when pregnant), how much

      did you weigh at your heaviest? _____ Pounds

  a. Approximately how long of a period of time were you at that weight? _____

  b. How long ago did you last weigh this amount? _____

27. Are you now on a reducing diet?

      _____ Yes _____ No

  a. If yes, how long have you been at it? _____

  b. How much weight have you lost during this time period? _____Pounds

28. Over the past year, approximately how many days (out of 365) would you say that

you were attempting to reduce your food intake in order to lose weight? If none write 0.

_____ Days

29. Do you currently smoke cigarettes?

_____ Yes _____ No

    a. If yes, approximately how many cigarettes a day? _____

    b. If no, did you smoke cigarettes in the past? _____Yes _____No

       i. How long ago did you stop smoking? _____

THANK YOU FOR YOUR TIME AND COOPERATION

THIS STUDY IS CONFIDENTIAL AND FOR INFORMATION PURPOSES ONLY

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