Weight Stigma as a Barrier to Routine Cervical and Breast Cancer Screening

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Introduction

- While BMI has been shown to be negatively associated with preventative health screenings, little research has investigated whether weight stigma (the social devaluation of people with obesity as expressed through prejudice and discrimination) is associated with the incidence of cervical and breast cancer screenings.
- Experienced weight stigma can be interpersonal in nature, manifesting as inappropriate comments, social exclusion, or bullying, or structural in nature, manifesting as inappropriately sized medical equipment (blood pressure cuffs), stereotypical portrayals of people with obesity in media, or lack of insurance coverage for obesity treatment.
- Internalized weight stigma occurs when external devaluation leads to stigma being self-directed and personalized to one's body weight.
- The purpose of this study is to identify whether experienced and internalized weight stigma are associated with the receipt of routine cervical and breast cancer screenings.

Methods

- A diverse sample of 1,033 women aged 25-64 and 471 women aged 40-64 were recruited from a US online panel to evaluate cervical and breast cancer screening frequency, respectively.
- Experienced weight stigma was assessed with the Stigmatizing Situations Survey-Brief (SSI-B) and internalized weight stigma was assessed with the Modified Weight Bias Internalization Scale (WBIS-M).
- Using multiple regression, history of screening for cervical and breast cancer (ever vs. never) and time since last screening (within the past year, two years, three years, five years, 10 years, or 10 years ago or more) were predicted from experienced weight stigma and internalized weight stigma, while controlling for BMI and demographic characteristics.

Results

Table 1. Demographics (N=1,033)

Variable: M (SD) or N (%)	
Age	40.2 (10.9)
BMI	29.9 (9.2)
Black or African American	398 (39%)
Latina or Hispanic	302 (29%)
Sexual Minority	329 (32%)
Normal Weight (18.5-24.9)	317 (31%)
Overweight (25-29.9)	242 (23%)
Obese Class 1 (30-34.9)	193 (19%)
Obese Class 2/3 (≥ 35)	237 (23%)

Figure 1.

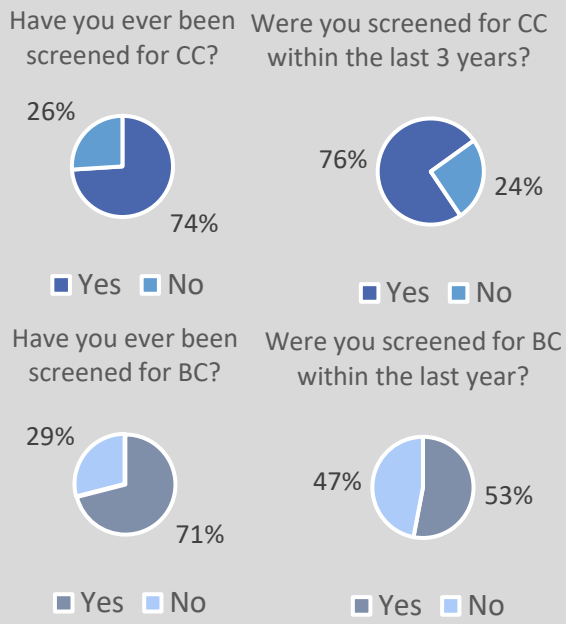

Table 2. Primary Results

	Ever Been Screened for CC? (Yes or No)	Time Since Last CC Screening?	Ever Been Screened for BC? (Yes or No)	Time Since Last BC Screening?
Experienced Weight Stigma (SSI-B)	NS	+*	NS	+*
Internalized Weight Stigma (WBIS-M)	-**	NS	NS	NS

* Higher experienced weight stigma = longer time since last CC and BC screening
** Higher internalized weight stigma = lower likelihood of ever been screened for CC

Discussion

- Although experienced weight stigma was not associated with uptake of either cervical or breast cancer screening, higher internalized weight stigma was associated with significantly lower odds of cervical cancer screening, OR=0.87, 95% CI: 0.77, 0.96.
  - The more exposed nature of a pap smear, inadequately sized tables and gowns, and the earlier start for pap smears may precipitate more of the stress and avoidance mechanisms of internalized weight stigma.
- A significant positive relationship was observed between experienced weight stigma and both time since last cervical cancer screening, B=.29, p<.001, and time since last breast cancer screening, B=.34, p=.005, indicating that higher frequency of experienced weight stigma was associated with a longer time since the last cervical and breast cancer screening.
  - These findings reflect that stigmatizing experiences instigate avoidant behaviors, while the effects of internalized weight stigma may be more complex depending on the one's resilience and the intersectionality of multiple stigmatized identities.

Conclusion

- Findings suggest that weight stigma may serve as an important barrier to women receiving timely screening for breast and cervical cancer.
- Strategies to break this barrier include weight stigma education for all healthcare professionals, as well as more expansive patient-centered communication that tunes into an individual's healthcare experiences and health behaviors through an open and safe space of communication.
- The primary limitation for this study is that all screening data was self-reported and thus may not be fully accurate.