



Associations between Obesity and Diet-Related Compensatory Health Beliefs

***Malgorzata OBARA-GOLEBIEWSKA¹, Katarzyna EUFEMIA PRZYBYLOWICZ²**

1. *Dept. of Psychology of Development and Education, University of Warmia and Masuria, Olsztyn, Poland*
2. *Dept. of Human Nutrition, University of Warmia and Masuria, Olsztyn, Poland*

***Corresponding Author:** Email: malgorzata.obara@gmail.com

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Dear Editor-in-Chief

The internal conflict that arises in response to the desire to undertake a pleasant but unhealthy activity involves several self-regulation strategies. Compensatory health beliefs (CHB) are a popular strategy that is used to resolve the temptation dilemma in a way that enables the belief holder to avoid feelings of guilt (1). Compensatory health beliefs are defined as the conviction that unhealthy but gratifying behaviors can be compensated with a healthy behavior, for example: "I can eat this cake now if I go jogging tonight". Such beliefs relieve the holder of a guilty conscience and justify giving in to temptation. Compensatory beliefs do not always have negative implications for health. However, habitual unhealthy behaviors with a promise of delayed "redemption" usually have adverse health consequences, mostly because people fail to carry out the promise (2). In this way, unhealthy self-regulation strategies such as diet-related CHBs can contribute to problems with weight maintenance or weight regulation (3).

In view of the growing prevalence of obesity in Poland (4, 5), the objective of this study was to investigate diet-related CHBs in groups of obese and normal-weight women. The study was conducted on 432 women aged 23-63 years. Half of the surveyed subjects were overweight or obese (BMI>25), whereas the other half were characterized by normal weight (18.5<=BMI<25). The respondents were patients of a private health care

facility in Butryny, Poland. The research tool was the Compensatory Health Beliefs Scale (1). In this study, only diet-related items of the CHB scale were analyzed.

The results of this study revealed significantly higher levels of CHBs among overweight and obese women (m=3.3861) (0.74) than among normal-weight individuals (m=3.03) (0.64) at $t(430) = 5.211, P < 0.05$.

In the group of overweight and obese patients, 22.2% of participants received high scores (n=48, m=4.17) (0.43), 68.9% of subjects received average scores (n=149, m=3.29) (0.26), whereas 8.76% of women received low scores (n=19, m=2.14) (0.29).

In the group of normal-weight women, 13.4% of patients received high scores (n=29, m=4.11) (0.39), 75.5% subjects received average scores (n=163, m=3) (0.30), whereas 11.1% of women received low scores (n=24, m=2.12) (0.31).

Significantly higher scores in the group of overweight women indicate that the intensity of diet-related CHBs is one of the factors that contribute to excessive weight and obesity. In the literature, the intensity of CHBs was also found to be significantly correlated with the probability of unhealthy behaviors (1- 3). For this reason, self-regulatory strategies for eating should be included in therapeutic programs for persons experiencing problems with weight reduction or weight maintenance.

Attempts to change the subjects' CHBs concerning weight control and nutrition could be an important psychological intervention in the treatment of obesity. The distribution of high, average and low scores in both groups points to the need for broader health and nutrition education covering all patients and not only overweight subjects. To tackle the growing problem of worldwide obesity (6), the main focus of research in health psychology and health-related sciences should be on factors responsible for eating behaviors.

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