Original article

Multifactorial bodily representation and its effects on help seeking

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Abstract: The present paper discusses the second part of a four part series that will investigate the hypothesis that people may have biased cognitive and affective representations of the body's parts (body schema) and that this may have implications for illness behaviour, disclosure, and help seeking. To test this hypothesis, we administered a paper and pencil questionnaire to randomly selected individuals that comprised the baseline group. The results of this baseline test group from Pescara, Italy provided us with a series of statistics that mostly confirmed our hypothesis; namely that body perception of the various body parts can be parsimoniously organized on the basis of just four of the five factors suggested by the previous literature including Stigma, Vulnerability, Importance, Sexuality and Privacy, and that each body part is rated differently according to those factors. We found that the strongest resistance in help seeking occurred for the following body parts: the Anus and Genitals, which also received the highest scores on the stigma factors scale. These results were independent of age and medical history, only gender showed a moderate affect.

Key words: Body representation; Stigma; Help seeking; Intervention; Sexual parts.

INTRODUCTION

We began like Klonoff and Landrine (1992) with the assumption that representations of the body's parts reflect a sociocultural historical context of roles, norms, and values that may lend each part symbolic social, psychological, moral, and political meanings. To begin our study we identified various categories that could account for how body parts are viewed. We found support in the literature for isolating the following five dimensions that were investigated:[1]

Vulnerability. Body parts differ in their vulnerability to physical and psychosocial stressors, with some parts (e.g., heart) viewed as more vulnerable. We know through common knowledge that certain body parts can be more easily harmed. We hypothesized that people are likely to seek help quickly for parts seen as vulnerable.

Stigma. Some bodily parts are probably represented as more dirty, disgusting, and shameful than others. This comes from the beliefs that these parts are not "normal" somehow or "disfigured" and not fully socially acceptable. One hypothesis that has been put forth for stigmatization is that it exists for social control purposes.[2] We hypothesized that people are reluctant to seek help for highly stigmatized parts and that *Stigma* would be the most powerful of the dimensions because it captures a plethora of sociomoral attitudes about cleanliness, goodness vs. that which is "dirty and sinful".

Importance. Body parts probably differ in how important and useful they are viewed to be, and people might seek help quickly for dysfunction in parts viewed as important. The importance attributed to a body part may be related to its importance to maintaining life or it's usefulness.

Privacy. Privacy is probably an important dimension of the representation of body parts, and people may be more likely to seek help for a dysfunction that is visible to the public than for a hidden and private part because the first example is more accessible to scrutiny and evaluation.

Sexuality. Some body parts are likely to be viewed as more sexual than others.

Our study aimed to create a ranking system for a number of identified body parts in relation to the five factors identified above. Factor and MANOVA analyses revealed that body parts are viewed as differing in the Stigma attached to them and in the extent to which they are seen as Important, Vulnerable, Sexual, and Private, with these five dimensions found to be independent of age and health history. We also investigated which of these five factors were more strongly correlated with help seeking behaviour and which were negatively correlated with help seeking behaviour.

METHODS

Participants

One-hundred participants were randomly selected to participate in the study and asked to fill out our paper and pencil questionnaire. Four participants were excluded because they had disclosed that they had long standing psychological issues. Of the remaining ninety-six subjects, there were 36 men and 60 women that ranged in age from 18 to 69 years (mean = 37.22, standard deviation = 14.1). The questionnaires were administered at the University of Pescara (central Italy) and the rest in other previously identified public places such as gyms and parks. We checked whether participants had been to a medical specialist or had surgery (even only as an outpatient) in the last five years. In our sample, 23.3% of the participants had been to a medical specialist and 6.5% had some sort of surgery on at least one of the ten body parts investigated. The visits with the specialists were significantly more focused on Eyes (54.2%) and less focused on Hands (4.2%) compared to the other body parts, *Chi-Square* (9) = 86.682, $p < .001$. While surgery interventions were significantly more focused on Eyes (22.9%) and Mouth (14.7%) compared to the other body parts, Chi-Square (9) = 78.062, $p < .001$.

Procedure

All test subjects were current residents of Pescara, Italy. Subjects were asked to take part in a study to investigate cognitive perceptions of body parts. The individuals selected completed a questionnaire which was an evolution and an extension of the one already used by Klonoff and Landrine (1992)[1] to investigate the relationship between cognitive representations of body parts and health seeking behavior. In the questionnaire, subjects were asked to describe ten different body parts by rating each on 13 items: Important, Dirty, Private, Good, Sensitive to Stress, Embarrassing, Sexual, Useful, Disgusting, Easily Hurt, Erogenous, Ugly and Weak. Each of these descriptions was followed by a scale ranging from 1 (not at all) to 7 (extremely). Participants were asked to assess on each of these scales how each item description was associated with each of the ten different body parts. The body parts investigated were: Eyes, Mouth, Back, Hands, Lungs, Heart, Stomach, Anus, Genitals and Feet. Each participant rated all ten of these parts with the order of presentation randomized. For each body part, participants were finally asked to answer two questions on the same 7 points scale: "How quickly I would seek help if I had a problem in this part" and "How easily I would talk with my friends and family members

about this problem". Filling out the questionnaire required about 8 minutes.

RESULTS

Factor structure of the bodily representation

We aimed to test whether, consistently with the psychosocial theoretical model of the body representation described above, the participants body perception was organized on the basis of the five factors investigated: *Stigma, Vulnerability, Importance, Privacy and Sexuality*. Then we wanted to assess the weight of these factors on the body representation and finally their impact on our main variable: the propensity, in case of a problem, to talk about the body part in question and to seek medical help.

Firstly, we conducted a *principal-components analysis* with a Varimax rotation and with the number of factors retained contingent upon an eigen-value equal or greater than one. Four of the five theorized factors emerged and accounted for 66.65% of the variance. These rotated, sorted factors are illustrated in Table 1, where, very conservatively, loadings of less than .50 were omitted. The following factors emerged: *Stigma, Importance, Vulnerability* and *Sexuality*. The *Privacy* factor appeared to be incorporated into the factor *Stigma*, perhaps thus assuming the connotation of something which is inappropriate to treat publicly. *Stigma* accounted for 20.8% of the variance, *Importance* for 20.5 %, *Vulnerability* for 12.79% and *Sexuality* for 12.53%.

As in previous research, we checked if this factor structure could differ depending on age, gender or past health history (visit with a specialist or surgery) of the participants. Therefore we repeated the principal components analysis for each of these groups separately (we split the sample into two groups on the basis of the median age which was 32 years of age). The results didn't show a significant difference: for all the groups, the factor structure was essentially the same and closely matched the previous findings. Once reassured about the consistency and the stability of the four factors structure of the representation of the body parts, we proceeded in order to check the main distinctions of these representational factors among the ten parts tested with a particular focus on the Anus and Genital region. To this end, we created four perception scales using the most representative (loaded) items for the four factors. As illustrated in Table 1, *Stigma* was represented by five items (Dirty, Private, Disgusting, Embarrassing and Ugly) forming a reliable scale (a*lpha = .83*) averaged into a *Stigma Index*; *Importance* was represented by four items (Important, Useful and Good) constituting a reliable scale (a*lpha = .72*) averaged into an *Importance index*; *Sexuality* was represented by two items (Sexual and Erogenous) representing a reliable scale (a*lpha = .89*) averaged into a *Sexuality index*, and *Vulnerability* was represented by three items (Sensitive to Stress, Easily Hurt and Weak) composing a reliable scale (a*lpha = .65*) averaged into a *Vulnerability index*.

Difference among perceptions of body parts

In order to assess and rank the ten investigated body parts, and in particular the Anus and Genitals, through the lens of the reliable representation structure discussed above, we conducted a Multiple Analysis of Variance with a Duncan's post-hoc test on the *Stigma, Importance, Sexuality and Vulnerability indexes* across all ten body parts as independent variable. Body parts had a significant effect on all four indexes (respectively, F (9, 95) = 70.46, F (9, 95) = 6.97, F (9, 95) = 69.915, F (9, 95) = 8.285, for all $p < .001$). For *Stigma perception*, the Duncan Post-Hoc test showed three main body parts clusters significantly distinguished: the less stigmatized body parts were Back (2.28), Eyes (2.39), Heart (2.45) and Lungs (2.56); the moderately stigmatized parts were Hands (2.98), Mouth (3.07), Stomach (3.30) and Feet (3.38); the most stigmatized parts were Genitals (4.19) and Anus (5.11). From the *Importance index* there emerged only two significantly different body parts clusters: important parts were Feet (5.22), Anus (5.41), Back (5.43), Mouth (5,46) and Hands (5.47) while very important parts were Eyes (5.81), Lungs (5.84) and Heart (6.09), with the rest in the middle. The *Sexuality index* demonstrated a richer five cluster distinction: extremely low sexualized parts included the Lungs (2.37) and Stomach (2.55); low sexualized parts were the Heart (3.21); moderately rated items were the Back (3.74), Feet (4.06), Eyes (4.09) and Hands (4.46); highly sexualized parts were the Anus (4.89) and Mouth (5.13); and extremely highly sexualized parts were the Genitals (6.24). Finally, the *Vulnerability index* distinguished between only two clusters: moderately vulnerable parts were Hands (4.03), Feet (4.03), Mouth (4.04) and Lungs (4.23); highly vulnerable parts were Eyes (4.63), Stomach (4.87) and Heart (4.97), with the rest in the middle.

We wondered whether participants' age and gender could affect these perceptions. To check this we ran a 2 (younger vs older) by 2 (male vs female) by 10 (body parts) MANOVA on the four representation indexes. We found a main effect of age on *Importance* and *Vulnerability indexes* (respectively, F *(1, 95)* = 19.312 and F *(1, 95)* = 20.124, for both $p < .001$). Specifically, older participants perceived the body parts more important and more vulnerable compared to the younger test subjects. Furthermore, we checked whether the four body perceptions could also be affected by the past health history of the participants. A 2 (medical specialist visit vs none) by 2 (surgery vs none) by 10 (body parts) MANOVA showed a principal effect of both medical visit and surgery only on the *Stigma index*, F *(1, 95)* = 3.814, $p < .05$ and F *(1, 95)* = 4.423, $p < .05$, respectively. Specifically, participants that went to see a specialist perceived the interested body part as being less stigmatized, while participants who had undergone surgery perceived the body part as being more stigmatized.

Propensity to talk about a medical issue and to seek help

In order to make a further step toward our main goal of testing the effect of the four perceptions of body parts on the willingness to talk about medical issues and on the promptness to seek medical help, we measured the correlation between the two items assessing these dispositions and, since we found the correlation encouragingly high (r = .585, p < . 001), we averaged them into a *Help Seeking index*. Then, as we did above for the other indexes, we tested the effect of body parts on help seeking running an ANOVA. We found a significant effect, F *(9, 95)* = 24.472, $p < .001$. The Duncan post-hoc test showed that body parts could be clustered into two groups with respect to the propensity to seek help: the ones with lower propensity to seek help included the Anus (5.17) and Genitals (5.3), the ones with a higher propensity included all the other investigated body parts (with an average of 6.27).

These results highlight the critical and crucial point of our psychosocial investigation: the strongest resistance in seeking help was for the Anus and Genitals, this was irrespective of the existence of a current health problem. We wondered whether this resistance could be affected by the participants' age, gender and/or health history. Therefore we ran a 2 (younger vs older) by 2 (male vs female) by 2

(medical visit vs none) by 2 (surgery vs none) by 10 (body parts) ANOVA on *Help seeking index*. The consistency of the resistance to seek help among different populations is supported by the fact that in spite of our broad analysis, we found only one variable having a moderate but significant effect on help seeking: the participants gender, $F(1, 95) = 5.374$, $p < .05$. Women tended to seek help slightly more than men.

Bodily Representation and Help Seeking

Finally, to assess the power of the four factors of the bodies perception on the propensity to seek help we ran a linear regression analysis with *Stigma, Importance, Sexuality and Vulnerability indexes* as independent variables and *Help Seeking index* as dependent variable. The regression model resulted significant, $F(3, 95) = 84.054$, $p < .001$, and the *R square* indicated that the four factors accounted for 26.1 % of the help seeking tendency. Looking closer at the impact of each single factor, we found that *Importance* had the strongest positive effect on help seeking (*beta* = .307, $t = 9.959$, $p < .001$) immediately followed by the negative effect of *Stigma* (*beta* = - .285, $t = -9.047$, $p < .001$). A more modest positive effect was exerted by *Vulnerability* (*beta* = .123, $t = 4.079$, $p < .001$) while *Sexuality* yielded a slight inhibition to help seeking (*beta* = -.077, $t = -2.568$, $p < .05$). These results lend support to the efficacy of an approach consisting in helping people to talk about medical issues and ask for help through the implementation of a double sided intervention both aimed to increase the perception about the importance of the ill body part and, to mitigate the perception of stigma associated with it.

DISCUSSION

The results of this study demonstrated that seeking help for medical needs varied across body parts and that test subjects were less likely to seek help for body parts perceived as not very important and for highly stigmatized parts. Taken as a whole, the investigation lends support for the hypothesis that people may have complex and distorted ideas and attitudes regarding the body's parts and that these may play a role in help-seeking. We found differences in the extent to which a body part is viewed as vulnerable, stigmatized, sexual and important as well as other dimensions we did not address or assess. Further research is needed to explore other possible dimensions. The consistency of the resistance to seek help among different populations is supported by the fact that in spite of our broad analysis, we found only one variable having a moderate but significant effect on help seeking: the participants gender. Women tended to seek help slightly more than men. Also we found that older participants perceived body parts as being more important and more vulnerable compared to younger test subjects. These findings need to be further investigated in additional studies. Given the gender differences we found, and that our sample consisted mostly of women, replication with male subjects will help shed light on our results. If further studies find that in fact there is a general gender effect, this would have implications for health promotion and education. A further limitation to our study was that our sample was limited with respect to, ethnicity, and specific body parts investigated, replications with larger and more diverse subjects and body parts are necessary to assess the generalizability of our findings.

TABLE 1. – Four dimensions of Body Representation and their weights.

	Stigma (I)	Importance (II)	Vulnerability (III)	Sexuality (IV)
Important		.881		
Dirty	.754			
Private	.649			
Good		.554		
Sensitive to Stress				.642
Embarassing	.796			
Sexual			.886	
Useful		.907		
Disgusting	.808			
Easily Hurt				.732
Erogeneus			.878	
Ugly	.772			
Weak				.768
Eingenvalue	3.12	3.01	1.92	1.88
% of variance	20.80%	20.50%	12.79%	12.53%

The present explorative research has carved the path for our future investigations aimed to find out, following an action-research approach, what are the most effective "communication and educational protocols" that most impact the two main factors, *importance and stigma* that emerged as being closely associated to the propensity to seek medical help. Any effective cognitive-affective intervention will have to impact these body representations in a double way: empowering the former factor and mitigating the latter factor with respect to the targeted body part. Specifically in our future research, we will focus on the Anus and Genitals as our present investigation further demonstrated that just these two body parts suffer from the highest stigma perception which is mitigated only by a moderated importance perception. Further, this biasing phenomena poses the strongest resistance for seeking medical help. In our future investigations, we will capitalize on the present results also as a source of baseline population tendencies in perceptions, evaluations and help seeking. In fact, we will proceed comparing these tendencies in different specific samples which will be exposed to the "communications interventions" that have been demonstrated in the psychosocial literature as the most effective in changing perceptions, attitudes, and behaviour.

REFERENCES

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SOCIAL PROGRAM

Tour to Schloss Herrenchiemsee with dinner; Saturday 13th September afternoon: Start with bus at 12:00 at Literaturhaus - Fee: Euro 100,-- (including transport, guide, coffee break, dinner). Please make reservation: Secretary Mir Heidari, E-mail: MirHeidari@chkmb.de - Key-word: Herrenchiemsee

Conference Gala Dinner at Spatenhaus (Residenzstrasse 12, 1. Floor) with view to the Opera house, Sunday Sept. 14th
Fee: Euro 90,--. Please make reservation: Secretary Mir-Heidari - E-mail: MirHeidari@chkmb.de - Key-word: Dinner Spatenhaus.

Recommended pre and post tours: 2-3 day tour to Berchtesgaden and Salzburg (www.berchtesgaden.de, www.salzburg.info - 1 day tour to Schloss Neuschwanstein (www.neuschwanstein.com) - tours and events in Munich and surroundings (www.muenchen.de).

Pre-Conference Workshops:

Thursday 4th and Friday 5th of September - Pre-Conference Satellite Workshop in Terneuzen, Netherlands (CPD-points: 12)
"Multisurgeon live Master Class in Vaginal Native Tissue Surgery". *This Master Class will be limited to only 30 attendees on a first come first served basis*. Faculty: Andri Nieuwoudt, Carl Zimmerman, Sunil Doshi. Contact Andri Nieuwoudt: E-mail: nieuwoudt@gmail.comFee: will be anounced

Thursday, 11th September 2014 - Pre-Conference Live-Surgeries (CPD-points available)
Chirurgische Klinik München-Bogenhausen, Denninger Str. 44 - TFS-surgery for POP and incontinence - Elevate anterior/apical in vaginal prolapse - Advance sling for male stress urinary incontinence - Artificial sphincter in male stress urinary incontinence - Lectures with interactive discussions will take place between the surgeries.
Faculty: B. Liedl, P. Petros, A. Gunnemann, C. Zimmerman, R. Reid, L. Lander, M. Haverfield, Y. Sekiguchi, H. Inoue
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CONFERENCE PROGRAM

Friday, 12th September 2014 - Literaturhaus, Salvatorplatz 1

08:00 Registration. Introduction and welcome by B. Liedl, President

08:35 *Actual status of the FDA warning against mesh and consequences* (Chairmen: R. Reid, K. Göschen): - FDA warning against meshes at the pelvic floor: actual sight (M. Neumann) - Meshes from the view of pathology and law experiences as expert witness in the USA (B. Klosterhalfen) - From the polymer to the optimal textile implant a challenge for the engineer (A. Müllen, B. Obolenski)

10:00 *Principles of pelvic floor surgery* (Chairman: C. Zimmerman, B. Abendstein): - An Update on the Anatomy of Level One and Level Three Vaginal Supports (L. Lander) - An Update on the Anatomy of level Two Supports (R. Reid) - Development of midurethral sling and TFS-surgery: experimental phase and clinical development (P. Petros) - The basic Principles of Vaginal Native Tissue Repair; Synthetic material Repair; Third generation Biograft Repair (L. Lander) - Basis and technique of site specific repair in prolapse surgery (C. Zimmerman) - Thoughts on Regenerative Vaginal surgery (A. Nieuwoudt)

13:15 *Actual longterm experiences in the use of meshes at the pelvic floor* (Chairmen: C. Fünfgeld, A.Gunnemann): - Results of the multi-center PARETO-mesh-study (A. Fahrtmann) - Impact of mesh supported anterior colpoplasty on life quality and sexual function (B. Fünfgeld) – Two year followup results in the use of Elevate anterior/apical and Elevate posterior/apical (B. Liedl, Propel-study-group) - Longterm results of uterin preservation in cases of uterine prolapse with single incision vaginal mesh, a retrospective case series (K. Fink, N.M. Braun) - TFS surgery for 3rd & 4th degree POP- 5 year data (H. Inoue)

14:50 *Mesh-surgery: technical variations* (Chairmen: M. Neumann, C. Fahrtmann): - The SERAPRO, an innovativ re-usable suturing device for trans-vaginal Sacrospinous fixation: Feasibility and Safety study (T. Friedman, M. Neuman, H. Krissi) - Reduction of the mesh implants surface area with pelvi organ prolapse surgical repair (N. Sumerova, D. Pushkar, M. Neuman, K. Haim) - First results with mini vaginal mesh implant for pelvic floor prolapse repair: a prospective multi-center study (N. Marcus-Braun, A. Tsivian, M. Halaska, M. Neuman) - The rational of mesh usage in the pelvic floor repair: What do we expect? (A. Sivasioglu) - Surgical approach to 4. Degress total prolapse of the pelvic organs (K. Goeschen) - TFS surgery for POP under LA (Y. Sekiguchi)

Saturday, 13th September 2014 - Literaturhaus, Salvatorplatz

08:30 *Reconstruction of Vagina, Treatment of lymphedema* (Chairmen: P. Petros, R. Baumeister): - Reconstruction of vagina in transsexualism, after surgery or radiotherapy (B. Liedl) - Tethered vagina syndrome: pathophysiology, diagnostics and surgical repair (K. Goeschen) - Microsurgical reconstruction in iatrogenic lymphedemas-state of the art (R. Baumeister)

09:45 *Miscellaneous* (Chairmen: A. Gunnemann, A. Nieuwoudt): - Nocturia: causes and therapeutical approaches (C. Merz) - Nocturia caused by apical descent (A. Gunnemann) - Female urethral diverticulum: development of a new operative procedure (O. Markovsky, B. Liedl) - Botox in OAB and neurogenic bladder (I. Schorsch)

Sunday, 14th Sept 2014 - Literaturhaus, Salvatorplatz

09:00 *Complex pelvic floor dysfunctions - therapeutic strategies* (Chairmen: S. Sutherland, F. Wagenlehner): - From experimental research to future drug therapy (D. Gratzke) - Neuromodulation: review (S. Sutherland) - From function of sarcomeres to pelvic floor dysfunction - Experiences in 500 cases with posterior fornix syndrome (A. Müller-Funogea) - The diagnostic algorithm, statistical analysis in 160 patients (B. Liedl, A. Yassouridis)

10:40 *Cure of non-neurogenic urge incontinence* (Chairmen: T. Bschleipfer, W. Jaeger): - Pathophysiology of OAB (T. Bschleipfer) - Cure of urge incontinence by TFS surgery (P. Petros) - Surgical treatment of urge incontinence by VASA/CESA (W. Jaeger) - Impact of apical fixation in mesh-supported anterior colpoplasty on urge incontinence (C. Fünfgeld) - Effect of Elevate anterior and posterior on OABsymptoms (B. Liedl, S. Sutherland)

11:40 *Round table discussion on cases* (S. Sutherland, C. Gratzke, B. Liedl, W. Jaeger, C. Fünfgeld, P. Petros)

13:15 *Surgery in stress urinary incontinence* (Chairmen: A. Sivaslioglu, P. Petros): - Pathophysiology of stress urinary incontinence (O. Markovsky) - Surgical treatment of urinary stress incontinence with an adjustable, retropubic tension-free vaginal tape (TVA, AMI) in women with risk factors (A. Niesel, E. Faust) - Simultaneous treatment of stress urinary incontinence accompanied by cystocele with the cystocele mesh: a comparative prospective study (N. Marcus-Braun, P. van Theobald) - TOT versus SIMS (A. Sivaslioglu) - Longterm results of mini-sling procedure for stress urinary incontinence in patients with mixed urinary incontinence (D. Levi, N. Marcus-Braun) - TSF surgery for USI and ISD under LA- 3 year data (Y. Sekiguchi)

14:20 *State of the art lecture:* The artificial sphincter in female and male stress urinary incontinence (R. Dahlem, M. Fisch)

14:55 *Pelvic pain* (Chairmen: F. Wagenlehner, A. Niesel): - Pelvic pain in men and women: overview (F. Wagenlehner) - Pelvic pain caused by apical prolapse: cure by Elevate anterior/apical and Elevate posterior/apical (O. Markovsky) - Pelvic pain caused by apical prolapse: cure by TFS surgery (P. Petros) - Pelvic pain following transvaginal mesh surgery: a cause for mesh removal (N. Marcus-Braun, P. van Theobald) - Pelvic pain caused by endometriosis (M. Kramer)

Monday, 14th September 2014 - Anatomische Anstalt, LMU München, Pettenkofer Strasse 11

08:30 Cadaver dissections in female and male cadavers: - Mesh surgery and female artificial sphincter (B. Liedl) – Acticon (F. Pacravan) - Male sling and different sites of cuff placement (R. Dahlem) - TFS surgery (R. Reid, B. Liedl)

11:00 Demonstration of anatomical preparations

13:30 Surgery in male stress urinary incontinence and urethral stricture (Chairman: B. Liedl): - Surgery in male urethral stricture, actual overview (R. Dahlem) - Development of the male sling Advance: actual status (C. Gozzi)

14:50 Anorectal dysfunction and pelvic floor (Chairmen: D. Gold, M. Kramer): - Fecal incontinence and abnormal emptying of bowels caused by pelvic floor defects (B. Abendstein) - TFS: Crossing the divide (D. Gold) - The artificial sphincter Acticon in fecal incontinence (F. Pacravan) - Neurological causes of anorectal dysfunction (E. Leder) - Laparoscopic approach to hyperelongated sigma and descensus (M. Kramer)