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The Penalization of Obesity: Investigating the Relationship Between Patients' Sizes and Clinical Weight Discrimination Among College Students.

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Abstract

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The onset of the obesity epidemic in the past couple decades has sparked national interest in the overweight and obese population, particularly how and why more individuals have been increasing in body size. Contemporary literature on those who are living in larger physiques have primarily concentrated on the impact of excess fat on people's physiological and psychological wellbeing because of the adverse health conditions that can be induced from obesity. However, there is a gap in research examining another negative outcome of those who are overweight or obese: weight discrimination from others. An introductory assessment of the current studies investigating the phenomenon revealed that people in bigger bodies face weight-related prejudices in a myriad of settings, such as in healthcare. The present study aims to explore the association between patients' sizes and degrees of weight discrimination executed by medical providers with the hypothesis that overweight and obese individuals will experience more weight discrimination compared to their average or underweight counterparts. An online survey capturing the responses of 105 Emory University students was administered and subsequently used to perform bivariate analyses of the dependent variables including general weight discrimination, clinical weight discrimination, fear of medical providers, and penalization of obesity. The study employed a different approach to classifying weight categories by asking participants to self-report their perceived size (self-weight) and the size that they believe their medical providers would sort them into (medical weight). Two-way cross tabulations of the results portrayed that obese participants were consistently the most likely to encounter weight-stigmatizing occurrences followed by the overweight participants for all the dependent variables. Additionally, gender-stratified analyses were performed on the aforementioned measures to find that there was a statistically significant relationship between clinical weight discrimination and the body weights of women, especially obese women. Findings from the survey suggest that overweight and obese patients disproportionately face weight discrimination from medical providers, and that weight discrimination may be more prevalent in the presence of sexism.

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1. Introduction

The need for a discussion surrounding the social implications of body weight has become apparent with the ongoing global obesity epidemic. According to the World Health Organization (WHO 2024), global obesity rates have escalated substantially, from 25% of the entire population being overweight in 1990 to 43% in 2022 (WHO 2024). Likewise, the obesity rate for adults have doubled to 16%, or about 890 million people, since 1990 while the rate for adolescents (ages 5-19) have quadrupled to 20%, or about 390 million children (WHO 2024). The surge in obesity throughout the world is alarming, but it is not an issue that is unfamiliar to the U.S. Reported by the Center for Disease Control and Prevention (CDC 2024b), the national obesity rate has been on the rise since 2013, when no U.S. state had an adult obesity rate above 35%, or 1 in 3 persons (CDC 2024b). As of 2023, 23 states have been found with an adult obesity prevalence rate at or above 35%, and every state has at least 20%, or 1 in 5 people, in the rate of obesity (CDC 2024b). It is undeniable that the overweight and obese population is growing throughout the world, and the epidemic has started to shed more light on a group that has been less common before.

Spikes in global and national obesity rates have mostly been interpreted in the medical and epidemiological sphere because of the effect obesity has on human health. CDC states that the condition is comorbid with other illnesses such as heart disease, stroke, type 2 diabetes, and some cancers (CDC 2024b). Because of the severity of the diseases that may come about as a result of being overweight or obese, specialists within these fields have predominantly focused on the medical aspects of obesity in order to address the epidemic. However, body weight is not a dimension that only exists within the field of health sciences; it also plays a crucial role in how people are perceived by others. Body weight as an

identifying feature of an individual has been utilized in not just academic and professional settings but also in everyday scenarios. Typically referred to when describing one's appearance, it is a facet of the physical being that contributes to one's image and perceptions of self. To some, it may just be that: another characteristic that is derived from one's outer presentation and that is recognizable to the individual and to others. But to examine weight in this fashion reduces the considerable influence it has on social behavior, particularly how people are treated based on their size.

There are several weight categories, or body types, that people can be sorted into which each carry unique social attributes. Those who are observed as average weight are not just considered to be at the optimal range of health but also believed to be conforming to the normative view of sizes. This is in contrast to other body types that may signal a decline in health and a deviance from what is considered acceptable, leading to more unfavorable attributes. Stemming from widespread media embracement of a specific body type, particularly thinness, and other conventional standards of beauty, weight has become a sensitive topic for many who believe they do not fit the ideal shape for their gender and age group (Crampton and Hodge 2012). People who are not compliant with society's understanding of the average body type – such as those who are overweight or obese – may often find themselves excluded from the media and their communities leading to isolation in a variety of settings such as the workplace, academia, and the focus of this article: healthcare (Puhl et al. 2008; Phillip 2024; Greenleaf and Weiller 2005). According to WHO, the uptick in overweight and obese persons has been correlated with an increase in weight stigmatization for these individuals, indicating that research in this subject is becoming ever more important (WHO 2023).

Weight discrimination as one of the focal points of research has increased in prevalence with the ongoing obesity epidemic, though the literature has been limited to specific disciplines. It is often discussed in conjunction with subjects such as eating disorders and body image, both of which are predominantly located within the fields of psychology and psychiatry (Thomeczek et al. 2024; Cohrdes et al. 2021). Thorough investigation into the link of weight discrimination and disordered eating has revealed that those who experienced weight-marginalizing encounters were more likely to be at a higher risk for eating disorders and body image dissatisfaction (Cohrdes et al. 2021). Adjacent research has also explored the pervasiveness of body shaming and weight bias in public settings, such as in places of work, on popular social media applications, and the news (Crampton and Hodge 2012; Kaminski et al. 2024; Frederick et al. 2016). Despite the emergence of weight discrimination in the discourse analyzing the mental and emotional state of the victims, there is a significant lack of research on how it has been observed through a sociological lens, especially since weight-based prejudice hinges on the norms and expectations of the society an individual resides in. Interpersonal relationships, occupations, academic institutions, and online spaces impact not just the stigmatization overweight and obese people face but also how discriminatory practices are normalized; and one setting in which weight-based prejudice can cause extreme consequences is in healthcare. Studies have captured the weight bias experienced by patients from their medical providers revealing that an increase in weight discrimination in these private zones result in less effective treatments for patients of larger sizes and deep mistrust of professionals, but they rarely explore the social processes that lead to the weight stigma observed between a patient and their provider (Hill et al. 2024; Crompvoets et al. 2024).

Addressing this gap in research can supplement the dialogue concerning the proper way of caring for those who exist in larger bodies.

To provide further evidence to the scholarship on weight discrimination in healthcare and from medical providers, this study evaluates the link between weight categories and degrees of size-based prejudice through the research question: how do patients' body weights impact the level of weight discrimination caused by medical providers and institutions? In order to answer the posed inquiry, this study assesses young adults' experiences with their providers using a survey of college students. Young adults have been explicitly chosen as the target demographic for this study because of the absence of literature regarding their weight-marginalizing encounters with medical professionals and establishments. Social media and the internet have reinforced certain beliefs and mindsets about which bodies are preferrable and which are undesirable, and the younger generation, especially adolescents, is more susceptible to these messages as a good portion of online content is catered towards them (Tayyem et al. 2016; Dogan et al. 2018; Ata et al. 2007). Because of the unique territory that young adults are situated in, that being people who have consumed a lot of virtual content in their formative years and are able to advocate for themselves when receiving medical help, it is important to examine how weight discrimination felt by the cohort may operate differently from children and from older adults. After retrieving the data from the survey, the results will be analyzed for notable patterns in distinguished weight groups then discussed within the context of other similar pieces.

2. Literature Review

2.1 Weight Discrimination in the Public Sphere

Upon first glance, there may be an inclination to say that weight stigmatization and weight discrimination carry the same meaning, but there is a key difference that helps better portray the isolation of people based on size. Weight stigmatization, often predating discrimination, refers to the process in which a set of biases are created and applied against those who do not express the ideal body type (Puhl et al. 2008). It depicts prevailing beliefs about people at "non-optimal" weights, but does not always translate to actionable behaviors; rather, the stigmatization of a group provides a template for the ways in which society should feel about certain weight categories (Puhl et al. 2008). On the other hand, weight discrimination encompasses all the observable and realized interactions where individuals face uneven outcomes based on their size (Puhl et al. 2008). It references the denigrating attitudes established with stigmatization to come to a conclusion about how a person should be treated, therefore resulting in the systemic continuation of prejudices (Puhl et al. 2008).

Healthcare is not the only sector where weight discrimination can be observed; in the United States alone, weight discrimination is the fourth most common type of marginalization after race, gender, and age (Puhl et al. 2008). One arena in which it can be witnessed is the individuals' place of occupation. Through a comprehensive analysis of multiple studies exploring the prevalence of weight discrimination in the workplace, Roehling (1999) discovered that weight-based bias was present at every stage of the employment process, such as with recruitment, promotion, disciplinary measures, and release from the position (Roehling 1999). Employers would factor in their potential or existing workers' size when determining whether or not the individual is a good fit for the institution with overweight and obese women experiencing the most amount of prejudice (Roehling

1999). Since the publication of this study, there has not been a plethora of literature following-up on weight discrimination in employment, though there have still been some that have produced striking results; one study based in Canada has backed Roehling's (1999) findings by showing that obesity decreases the chances of employment for women by 25% (Sari and Osman 2018). Additionally, another study revealed that female applicants with a larger waist circumference were less likely to get employed than female applicants with an average or small waist circumference, suggesting that the appearance of excess fat affects conceptions of overweight and obese individuals (Kinge 2017).

Schools and educational centers have also been areas where weight discrimination has been observed, not just from those presiding over students but within peer networks (Greenleaf and Weiller 2005; Strauss 2003). Conducting a study on physical education teachers who are a part of the American Alliance for Health, Physical Education, Recreation and Dance, Greenleaf and Weiller (2005) discovered that these instructors were less likely to have high expectations of their overweight or obese students, and that the high adiposity of these students were due to personal attributions such as lack of self-control, bad diets, and a sedentary lifestyle (Greenleaf and Weiller 2005). 90% of the teachers agreed that personal characteristics were to blame for the overweight and obese status of their students compared to situational factors such as cultural pressures, health conditions, and socioeconomic status, and that overweight and obese students can and should lose weight with a fair amount of discipline and professional guidance (Greenleaf and Weiller 2005). In another study assessing weight discrimination amongst children, researchers found that overweight and obese children were less likely to have friends and more likely to be disconnected from their peers compared to their average weight counterparts (Strauss and Pollack 2003). Moreover, a

study from 2014 disclosed that weight-based bias of overweight and obese children still exists amongst the youth by showing that children prefer to befriend those who are average weight more than those who are obese, especially obese female children (Kihm 2014).

The media is another space in which weight-related discourse can flourish, though the rhetoric seen with overweight and obese people persists. This is especially captured by singer and songwriter Lizzo, a plus-size woman who has confidently showcased her body online and in her art, Researchers investigating the artist's Instagram found that while there were no explicit mentions of her physical health, there was a generous amount of degrading comments about her size (Albert et al. 2024). Such comments include claims that Lizzo was promoting obesity and that her body, despite not exposing her private regions, is disgusting and inappropriate (Albert et al. 2024). A few replies have also alluded to overweight and obese people, not just Lizzo, to being the antithesis of health, which demonstrates how negative attitudes about the population has infiltrated into virtual arenas (Albert et al. 2024).

2.2 Weight Discrimination in Healthcare

Though instances of weight discrimination in the public may be well-recorded because of the increased number of witnesses present, observing it in private scenarios such as in a medical clinic can be more challenging because it may not be reported often. Moreover, there is a tendency for weight-related research to focus on the association between size and differential health outcomes rather than a focus on the unfavorable attitudes held by providers which may ultimately affect the patients' level of care. Nevertheless, research regarding providers' perspectives of overweight and obese patients and the patients' experiences of the prejudice still exists, though not plentiful. In one study regarding opinions

on various medical conditions that was conducted on the members of the Michigan Academy of Family Doctors, researchers found that approximately 33.5% of the participants had a negative view of obesity and that 23.7% had a negative view of noncompliance (Klein et al. 1982). But it is difficult to say that these results are wholly reliable; the questions in the survey did not distinguish between feelings of "discomfort, reluctance, or dislike" for each medical condition or social characteristic, which is significant as each of these terms symbolizes a unique emotion (Klein et al. 1982; 882). Providers' discomfort or reluctance towards overweight and obese patients may exist for reasons other than aversion, such as how they have not been well-trained to treat these individuals or how they rarely encounter these people in their practice, and it is faulty to assume that feelings of uncertainty are on par with feelings of hostility. Given that the study was published in 1982, when the rate of obesity was far lower than what it is now, it is possible that providers had relatively little experience caring for patients who were obese because the condition was not as extensively documented (Flegal et al. 2010).

Although there were some limitations with this research, it paved the way for more exhaustive literature examining weight discrimination. Another study conducted on U.S. and Canadian nurses a decade later discovered that the nurses associated adverse traits to obese patients, such as how they lack discipline, and that those who are obese should be given a calorie-restricted diet while in the hospital (Golub 1992). In addition, more than half of the participants noted that treating obese patients was exhausting and over a third responded not wanting to treat an obese patient if given the option (Golub 1992). These results were in line with study released in 2024 surveying the degree of anti-fat attitudes in more than 3000 U.S. resident physicians which found that a large chunk of respondents concurred with weight-

stigmatizing statements (Phillip et al. 2024). About a quarter of respondents agreed that they "don't really like fat people much," more than a third agreed that "fat people tend to be fat pretty much through their own fault," a third agreed that they "dislike treating obese patients," and approximately half agreed that "some people are fat because they have no willpower" (Phillip et al. 2024; 514). Unfortunately, there is a persistent trend with some medical providers holding low views of overweight and obese patients despite an abundance of literature about the prevalence of obesity, however, this does not directly translate to these providers acting upon their dislike of overweight or obese patients in practice.

While providers are expected to remain neutral when handling their patients, studies have shown that there are many cases in which this neutrality is broken when the patient is overweight or obese. One study analyzing the rate at which weight-stigmatizing encounters occur in healthcare found that obese patients were more likely to report instances of weight discrimination than not (Crompvoets et al. 2024). About 41% of those in class I obesity (BMI of 30-35), 59% of those in the class II obesity (BMI of 35-40), and 80% of those in class III (BMI greater than 40) stated that they had at least one weight-marginalizing experience (Crompvoets et al. 2024). When asked about specific instances of weight discrimination, the most common response from participants was that medical providers blamed other physical conditions that the obese patient has on their weight with 62.5% of those in the highest class of obesity affirming (Crompvoets et al. 2024). Furthermore, 18.5% of those in class I obesity, 33.2% of those in class II obesity, and 52.5% of those in class III obesity specified that their healthcare provider advised them to go on a diet even though they did not want to talk about their weight (Crompvoets et al. 2024). These results are especially telling as they are present in other literatures investigating the degree of weight discrimination in the medical sphere.

According to a study that interviewed overweight and obese patients on their experiences with healthcare, many of the participants mentioned that they were frustrated with the care they received because of the lack of support and resources provided by medical professionals (Janke et al. 2016). Additionally, when medical professionals did try to help, they would typically recommend treatment plans that were centered on losing weight, such as a low-calorie diet or exercise, instead of more holistic approaches that would address both the patients' size and comorbid disorders; this strategy which segregates obesity from other medical conditions caused overweight and obese patients to feel as though they were being penalized for living in a larger body (Janke et al. 2016). While not as pervasive, some researchers have also discovered cases where medical professionals have been more explicit in their distaste of overweight and obese patients, such as providers walking out on their patients while they were still speaking rude remarks aimed at overweight patients about how they could "float" given their size (Russell and Carryer 2013).

The effect of weight discrimination from healthcare professionals extends past feelings of marginalization, it also impacts how willing overweight and obese people are to seeking care overall. One study exploring the internalized weight stigmas of overweight and obese patients found that participants' "worthiness" in receiving quality care was linked to providers' conceptions of compliance, that being compliance in maintaining a healthy weight (Ryan et al. 2024). Because they anticipated that their medical providers would relegate their concerns for discussions on weight, the participants reported feeling dejected when thinking about their next appointment with some even claiming that the thought of meeting a medical provider induced a physical reaction out of them (Ryan et al. 2024). In the same vein, patients who did go to visit their providers would note that they were afraid to advocate for

themselves because obesity is seen as a “personal failing” rather than a medical condition that needs special intervention, leading to the perpetuation of poorly-managed health for overweight and obese individuals (Ryan et al. 2024). The dissatisfaction and even fear of healthcare professionals has tremendous consequences, one of which is reluctance to interact with anyone associated with the medical field. According to one study conducted on overweight women who were due for their pelvic examinations, those of higher body weights expressed negative opinions of their appearance and an unease for the procedures that require them to be put in vulnerable positions; they were also more likely to have annual visits rescheduled compared to their normal weight counterparts (Adams et al. 1993). Likewise, other researchers observing the correlation of patients’ body weights and their chances of showing up to an appointment found that 32% of obese patients delayed their appointment and 72% expressed embarrassment over their weight (Olson et al. 1994).

2.3 Issues with Measuring BMI

Because of the obesity epidemic present in many developed nations and social media stressing the importance of idealistic body proportions, more people are being classified as “fat”, however, the system in which adiposity is evaluated is not without flaws. Many studies analyzing the weight of their participants use a metric called the Body Mass Index (BMI) which measures corpulence by assigning numerical values to individuals’ size (Cleveland Clinic ND). It is calculated using the height and weight of a given person then used to sort people into a variety of divisions such as underweight, average weight, overweight, and obese (Cleveland Clinic ND). Cleveland Clinic defines underweight as those with a BMI less than 18.5, optimum weight ranges from 18.5 to 24.9, overweight ranges from 25-29, and

obese is a BMI greater than or equal to 30, and these ranges are consistent among other reputable institutions (Cleveland Clinic ND; CDC 2024a; WHO 2024; NHS 2023). Generally, the higher the BMI, the more likely it is for an individual to develop serious conditions such as hypertension, stroke, cardiovascular diseases, and type 2 diabetes (CDC 2024b). Additionally, there is evidence showing that higher BMI is positively associated with psychiatric disorders such as depression and anxiety and with sleep disorders (Wang et al. 2024; Galler et al. 2024). But the opposite end of the spectrum is also linked to its own set of health risks; those in the underweight category are more likely to develop an underperforming immune system, anemia, osteoporosis, and infertility (CDC ND). Studies have also found that lower BMI was more likely to be linked to sarcopenia, a condition in which an individual experiences the loss of muscle and its functions (Xie et al. 2025).

While this tool may have been convenient for researchers seeking to gather large quantities of data in a standardized process, BMI does not accurately depict the true physical state of a person. One glaring issue with BMI is that it does not factor in gender, age, genetics, and activity levels when assessing body fatness, all of which can impact the likelihood of developing certain disorders (Cleveland Clinic ND). According to the logic of BMI, a short young woman who is plus-size and a tall older man who is muscular may share the same BMI, therefore being sorted into the same weight category. As BMI only accounts for height and weight, it does not consider whether or not the adiposity level of a short young plus-size woman and a tall senior muscular man are different, it just posits that they are in the same classification. Another issue with BMI is that it is not capable of measuring the body fat percentage of each person, it merely makes an assumption that height and weight are the only factors that can reveal corpulence in a person. Some experts have tried to rectify the

problems in the metric by dividing the population into their respective sex and age groups, but because people do not carry their weight in the exact same way, it can fail to distinguish between someone who has a higher body fat percentage and someone who may weigh more because of muscle or skeletal mass. Some research points to race as a distinguishing factor in how people may carry body fat with one study showing that overweight Black individuals may be less at risk for severe conditions despite having the same BMI as their overweight white counterparts, though there aren't many other studies to support it (Fontaine et al. 2003). For the purposes of this study, overweight and obese individuals are those who weigh more than the average person in their gender and age category and are perceived to be bigger than by themselves and others (Rand and Macgregor 1990).

The issue with BMI is important to note because of how prevalent it is in literature regarding not just weight discrimination but weight overall. Trends in obesity have been quick to judge those who are not average weight as those who are in need of medical intervention, and it has also solidified myths regarding what the average person should weigh in order to be healthy. Reputable institutions, despite their determination to remedy the obesity epidemic, may also contribute to misinformation about overweight and obese populations by encouraging medical professionals to use BMI as an efficient way of estimating adiposity, and labelling the average weight category in a way that makes it seem better than the other categories. For instance, the CDC and the British National Health System (NHS) labels the average weight category as the "Healthy" class while Cleveland Clinic describes it as "Optimum range," indicating that those who are average weight are considered to be more fit than those who are underweight, overweight, or obese (CDC 2024a; NHS 2023; Cleveland Clinic ND). Knowing how large organizations have approached

obesity and the influence they have on the acceptable ranges of weight can explain how weight discrimination in the medical field is perpetuated.

2.4 Sociological Theories for Understanding Weight Discrimination

To understand how weight-based bias and discrimination have become ubiquitous, it is crucial to acknowledge how weight is perceived in society, especially what attributes or assumptions are evident when ruminating about those who are overweight or obese. The two theories that are proposed here, social stigma theory and attribution theory, will illuminate distinct social mechanisms that may fuel weight discrimination with the former demonstrating that negative labels impact how individuals are treated and the latter demonstrating how perceptions of controllability create defamatory views of overweight and obese groups.

2.4.1 Social Stigma Theory

In his book "Stigma: Notes on the Management of Spoiled Identity," Erving Goffman (1963) explains that everyone has a social identity which can determine how they are viewed, not just by themselves but by others (Goffman 1963). Every identity contains a series of ideas and characteristics that are expected to be present within the group it applies to, though these features may not always display the group in a good light (Goffman 1963). According to Goffman's social stigma theory, characteristics – whether that be enforced with or without permission of those with the label – that render an identity as inferior, undesirable, or abnormal are called stigmas (Goffman 1963). He explains that "an individual who might have been easily received in ordinary social intercourse possess a trait that can obtrude itself

upon attention and turn those of us (the normal) whom he meets away from him, breaking the claim that his other attributes have on us," exemplifying that the mere existence of a stigma is enough to not just signal a negative quality of a group but to induce a reevaluation of an identity by devaluing the positive or normative aspects in favor of solely focusing on the blemish (Goffman 1963; 5). Consequently, the main function of a stigma is to discredit anyone who it is assigned to and can be classified into three forms: character or personality blots, racial or lineal assignments, and abominations of the body (Goffman 1963).

Particularly relevant to this study is the last category which refers to any deviation in a person's size that is deemed unacceptable by social standards. In the case of overweight and obese people, stereotypes include laziness, over-indulgence, incompetence, noncompliance, and unproductiveness which have all been used to disparage the population (Jackson et al. 2015; Greenleaf and Weiller 2005). While medical professionals such as doctors and nurses are presumed to be neutral when caring for those who are not within the agreeable weight limit, it is still possible for trained workers to be influenced by stigmas because of how widespread anti-fat messages are. People in bigger bodies, such as those who far exceed what society presumes to be healthy, can be examined through Goffman's social stigma theory in order to scrutinize instances of weight discrimination.

2.4.2 Attribution Theory

The previously mentioned social stigma theory provides a general understanding of how the physical aspects of an individual can be perceived as acceptable or intolerable based on how well they conform to their respective society's criterion. But one facet in which this approach falls short lies within the explanation of how stigmas are connected to beliefs about

peoples' personality. This chasm can be addressed using attribution theory, a prominent framework within social psychology. Attribution theory postulates that people make informal deductions about certain causes or events which shapes their reactions in the particular scenario (Robinson et al. 2024). Typically, these inferences are drawn when scrutinizing the motivations behind an outcome and are divided into two forms of attributions: internal, which are dispositional factors, and external, which are circumstantial factors (Weiner and Magnusson 1988). In the context of overweight and obese persons, internal determinants may include negligence or lacking self-restraint while external determinants may include underlying metabolic disorders causing increased fat storage. Depending on the locus of causality, an observer who is making the inferences can either trace a result to an individual's personal temperament or to environmental elements, but it is not the only component of assigning traits.

According to theorist Bernard Weiner, another constituent of attribution theory is controllability, which is described as a person's ability to manipulate a situation (Weiner and Magnusson 1988). If the observer has determined that the motive behind a result is due to a negative feature of the actor or the circumstance, the observer may then contemplate if the actor had the capability to regulate the situation. In the case where the observer has decided that the actor had sufficient agency to manage the outcome, the observer may come to the conclusion that the actor could have prevented the consequence, therefore containing the blame in the actor (Weiner and Magnusson 1988). This process is evident with weight discrimination where people make inferences about the controllability of obesity in order to arbitrate if the condition is worthy of sympathy or not (Weiner and Magnusson 1988). As acknowledged by Weiner, society perceives obesity to be a controllable condition because

the act of overconsumption is interpreted as a lack of discipline (Weiner and Magnusson 1988). Upon further research examining the link between health disorders and perceptions of controllability from the public, he also uncovered in his study that all the tested ailments – such as cancer, Alzheimer's, heart disease, and blindness – were not significantly correlated with ideas of responsibility aside from one: obesity (Weiner and Magnusson 1988). In fact, those who believed that obesity is an internal and controllable result have expressed less sympathy and more anger towards those in larger bodies, conveying how deeply stigmatized the identity of the overweight and obese population is (Weiner and Magnusson 1988).

Recent studies have also shown that people continue to hold stigmatizing views of overweight and obese individuals by ascribing negative traits to the group. Frederick and collaborators (2016) analyzed how participants may change perspectives on corpulence based on the fat-positive or fat-negative content they absorbed (Frederick et al. 2016). The researchers found that people were not more likely to advocate for policies, such as increased funding for obesity treatment programs, that would benefit those in larger bodies despite reading articles about how obesity may pose several health risks (Frederick et al. 2016). In addition, participants were more likely to have unfavorable views of the overweight and obese when consuming anti-fat media, thus sustaining the degrading stereotypes that have been placed on the group (Frederick et al. 2016).

Even within healthcare, medical providers may prescribe treatments that are in line with the impression that excess weight is a symptom of personal failings rather than involuntary side effects (Brown et al. 2006). One study which performed interviews on overweight and obese patients discovered that medical professionals did not adequately support the participants in their wellness journey (Brown et al. 2006). Though their providers

pointed out that they had excess fat which was considered harmful, approximately two-thirds of the respondents stated that their providers did not give an explanation as to why they had gained weight (Brown et al. 2006). Instead of guiding their patients through the steps that would bring them to a healthy weight range, the professionals only suggested low-calorie diets that the patients were already informed about (Brown et al. 2006). The absence of a comprehensive regimen curated specifically for each patient led the participants to believe that they were solely responsible for their size, pushing many to internalize negative stereotypes, such as how they were gluttonous and unintelligent, about themselves (Brown et al. 2006).

2.5 Fatphobia Among college students

A large portion of the literature regarding weight discrimination has been centered on the experiences of adolescents or middle-aged adults, but there is a critical lack of coverage on young adults (in this case, individuals ages 18-29) and how they may navigate the phenomenon. Young adults today occupy a special space in society; they have grown-up alongside the widespread embracement of the internet and other technological advancements that have made the dissemination of information extremely efficient. Consequently, harmful messages about the ideal body, weight expectations, and dieting have been able to infiltrate the younger population at an unprecedented rate. Studies that have explored the reproduction of weight stigmatization amongst children have uncovered that the source of some of their anti-fat attitudes stem from the media, but there have not been any works investigating how weight-based bias can shift once minors are legally considered adults (Jacob and Yoo 2010; Tayyem et al. 2016). Likewise, studies that have included young adults in their sample when

examining weight discrimination have not properly distinguished participants by age and have taken for granted that the perspectives of adults are consistent, even when there is an expansive distribution of life stages (Schafer and Ferraro 2011; Standen et al. 2024).

Though young adults can be located in a variety of settings, this study will focus on a specific group: college students. Academic institutions are mostly comprised of young adults who have recently graduated from high schools and are not immune to the discourse on body image, weight, and marginalization. According to one study examining the prevalence of anti-fat attitudes on campus, researchers discovered that weight-related prejudice was common amongst female college students (Webb et al. 2016). Interestingly, the researchers did not find that students were explicitly biased against those of higher weight categories but that they were actively engaged in discussions fearing fatness for themselves (Webb et al. 2016). Such conversations include reassurance from other students that they weren't overweight or obese and feeling ashamed that their weight was not where they would like it to be, indicating that they believed excess fat was a personal failing (Webb et al. 2016). But there are other studies conducted that have shown that larger students have encountered weight discrimination. Stevens (2018) discovered that overweight and obese students were hyper(in)visible, a term that describes how people are made aware of their physical markers but disrespected and underrepresented in social networks (Stevens 2018). Many of the participants stated that they were excluded from the dating scene because their bodies were not considered attractive and subconsciously anticipated for stigmatization, leading to a heightened fear of gatherings and new people (Stevens 2018).

Drawing on the limited scholarship depicting negative views of the overweight and obese in college, it is crucial to not only explore how these anti-fat attitudes may still exist

amongst young adults but also how weight-based biases can affect the quality of healthcare that students receive. This study will contribute to the overall discourse on weight discrimination by analyzing how young adults – namely college students – can detect stigmatization from medical providers and how their experiences may differ from other cohorts.

2.6 Hypothesis and Research Aims

Based on Goffman's social stigma theory and the attribution theory, it is proposed that young overweight and obese adults will experience more weight discrimination from their medical providers compared to their average or underweight counterparts. Employing Goffman's framework of stigmatized identities creates a foundation for understanding why overweight and obese people are considered objectionable in society. Employing the attribution theory builds upon the former model in order to reveal how certain social characteristics are embedded into the overweight and obese population by shifting the blame onto the affected group. Rather than claiming that one theory holds more significance to weight discrimination than the other, this study will utilize the essence of each approach to make sense of the nuanced phenomenon.

Aside from testing the hypothesis, the goal of this research will be to tackle gaps within the literature by contributing to the sociological scholarship of weight discrimination. First, self-identification of weight categories will be used instead of the BMI to remove instances where the individuals' weight does not accurately represent their health. Second, the sample will be composed of college students as there have not been an abundance of studies examining the prevalence of weight discrimination experienced by this group. Lastly,

the findings from this research will be compared to previous works to see whether or not the results are in line with what has been published already.

3. Data and Methods

3.1 Survey Data

3.1.1 Setting

In order to determine the validity of the aforementioned hypothesis, this study conducted a survey to observe if there is an association between patients' weight categories and their encounters with weight discrimination from medical providers. The research took place in a private academic institution situated in the Southeast with about 8000 undergraduate students, which made reaching the target number of responses (approximately 100) more viable (Emory University N.db). The university's location in the Southeast is particularly important to make note of as it does not reflect the incidence rate of weight discrimination in the U.S. According to the Institute for Health Metrics and Evaluation (IHME), the rate of obesity is higher in Southern states – such as Oklahoma, Alabama, Mississippi, and Texas – and is expected to remain high in the upcoming decades (IHME 2024). While all states are seeing an incline in overweight and obesity rates, the South has a greater population of the overweight and obese group, demonstrating that there may be more instances where people in bigger bodies have interactions with others regarding their weight. These weight-related interactions may be laced with stigmas that can then contribute to higher rates of weight discrimination in the South compared to other regions in the country where overweight and obese people are not as common.

3.1.2 Sample

The survey at hand was completed by 119 college students aged 18 to 23, with an average of 20 years old. It is difficult to actuate if the sample portrayed in this study aligns with the student population because the university did not publish their demographic details; however, the institution has released the racial makeup of the newly admitted class of 2028. 33% of the incoming freshmen are white Americans, 31% are Asian Americans, 13% are Black Americans, 12% are Hispanic or Latine Americans, and 15% are international students (Emory University N.da). While the racial composition of one year of students does not directly represent the entire undergraduate body, it is the only reliable proxy that currently exists for the campus. With this in mind, the sample presented here was able to come close to the statistics shown by the institution.

Instead of adopting the BMI to analyze the participants' weight, this study asked respondents to self-report the weight category that they believe they belong to. As reinforced by Stevens (2018), excess fat is linked to degrading attributes which are made hyper-aware to individuals in bigger bodies (Stevens 2018). The negative experiences embodied by the overweight and obese are unique to that group and are distinguishable to them and to outsiders. For this reason, it is important to note that differential body types are not just descriptive elements but fully-functioning identities in which people create, transform, or maintain through social interactions.

Before beginning the quantitative analyses, the sample was closely inspected in order to remove entries with missing items. Participants who did not report their weight category for either self-weight or medical weight (n=1) were excluded from the final dataset because these were the two key independent variables that will be utilized. Applying the same tactic,

participants who did not answer one or more of the questions that were associated with the dependent variables (general weight discrimination, clinical weight discrimination, fear of medical providers, and penalization of obesity) were omitted as well. The same strategy was taken for participants who did not report their race (n=1) or gender (n=1) because of insufficient demographic information. The last group of respondents to be excluded from the dataset were nonbinary individuals (n=5) because of the small sample size compared to men and women. The total number of respondents after cleaning the data was 105 people.

3.1.3 Data collection

The survey was administered using a platform called Google Forms, where users can create customizable online surveys that can be easily distributed amongst those who have the link. Online surveys were chosen as the main method of gathering information to ensure that participants can complete them in their own time and to increase anonymity as the surveys are not required to be taken within the presence of a researcher. Google Forms is also free to use which proved to be a cost-effective tool for this study.

The survey was divided into four sections and each contained a header that outlined what the participants should expect as well as my contact information for any concerns they had (see appendix #1). The first passage contained two screening questions – specifically "Are you 18 or older?" and "Are you a student at (redacted) University?" – to discern if the participant was eligible for the study. The second passage contained the consent form which detailed a brief description of the study, main objectives, measures of confidentiality, potential risks, and my contact information. The consent process, just like the survey itself, took place virtually and was not supervised by a researcher. Respondents were informed that

participation was voluntary, that there were no physical or financial benefits to completing the survey, and that they do not need to provide their name or initials when consenting to ensure that their privacy was secure. Only those who consented by selecting the "I consent" option at the end of the second passage were allowed to continue with the survey (See appendix #2 for consent form).

The third passage contained questions regarding demographics for each respondent including age, race, gender, and self-reported weight category. Lastly, the final passage was comprised of multiple choice and short answer questions which asked the respondents about their experiences with weight discrimination or adjacent phenomena from medical providers. Short response questions were designed to allow respondents to elaborate on any of the multiple-choice inquiries if they desired. As the primary procedure for this study was to test the dataset quantitatively, the written answers were added to provide a space where participants can add contextual features explaining why they chose a certain response for a multiple-choice question. For instance, one of the short response questions was, "If you stated that you have experienced weight discrimination from your medical providers, how did it happen? If there are multiple incidents or locations, please state all that you would like to share with us." In this particular case, if a participant did experience weight discrimination from their medical providers, they could expand further in this open-ended question.

Data was secured in a Microsoft Excel sheet that was stored on computers that were protected by passwords for approximately two months. This data was only accessible to the researchers who were involved and was deleted once the final version of the study was released. While the dataset did include participants' demographic details, consent forms, and responses, these reports were not accessible to the public and all the data was discarded once

the study was finished. Participants' privacy was protected by the anonymous nature of the survey; they were not asked to share details that they believe can be traced back to them. Likewise, any identifying information that they did provide was subsequently omitted or renamed in order to conceal their identity.

3.1.4 Recruitment

After receiving approval from the Institutional Review Board (IRB) to proceed with the study, authors contacted several professors and faculty members within the university to request help in disseminating the survey amongst their students. There was no preference for departments or disciplines, and professors or faculty members of a variety of fields were inquired to allow for more chances in finding students who were interested in participating. Departments include but were not limited to Sociology, Psychology, History, Human Health, Linguistics, Religion, Political Science, and Biology with most of the professors willing to share the study coming from Sociology. The main mode of communication was through email using a template that consisted of a short explanation of the study, the eligibility criteria, and the steps on how to distribute the survey to students (see appendix #3). Once the professor or faculty member agreed to share the information about the study, I provided them a link as well as a sample email that the professor or faculty member can use to circulate the survey to their students. Out of the 15 professors or faculty members who were contacted, 13 were willing and sent out the survey to their currently enrolled students which contributed to the bulk of the responses.

Respondents were also recruited through the snowball method, where those who have already completed the survey or have heard about it could spread word about the study to

their peers. If the respondents knew of any other student who was interested in participating, they were able to reach out to me so that they could also receive the link to the survey. A smaller percentage of the responses stemmed from this arrangement, though the exact number of those discovering the study from professors and those who heard about it from a peer is unknown as the participants were not asked to state where they received the link from.

Recruitment lasted for approximately a month beginning in January with the overall study taking about 3 months total. This study had relatively low risks for participants as the survey did not ask for any personal information such as name, initials, email, or other identifying materials.

3.2 Measures

3.2.1 Independent Variables

The key independent variables for this study are the self-reported weight category (abbreviated as self-weight) and the weight category that participants believed their medical providers would put them into (abbreviated as medical weight). The former was operationalized to be the size that respondents viewed themselves as. The specific question asked to obtain this information was, “For this question, please consider how you or others may define your body type. Which of the categories below best represents your weight?” The respondents then chose from four categories: underweight, average weight, overweight, obese. Participants were only allowed to choose one of the classifications to reduce confusion when analyzing. While some researchers have isolated the obese category further into class I, II, and III, this technique was not applied for this study because it requires the BMI in order to organize the overall obese participants into each of the classes (Crompvoets et al. 2024).

Mentions of BMI or weight in numerical values were deliberately taken out of the definition to focus on how individuals can identify with weight categories and to minimize instances where one's BMI does not correspond properly to adiposity. The lack of defining criterion for each of the weight categories allowed participants to choose the category that they think best suited their experiences and perceptions.

Medical weight was operationalized to be the size that respondents believed their healthcare providers would sort them into. This does not mean that the respondents' medical providers were asked to state which weight category their participant belongs in as this study did not include responses from professionals. For this variable, participants were asked to report how their providers would have identified their weight category based on prior consultations with healthcare professionals, or if they have not received treatment for an extended period of time, what they assume medical professionals would identify them as. The specific question that was posed to obtain this information was, "How would your medical providers - that being nurses, doctors, medical assistants, etc. - describe your body type?" Similar to the previous variable, the choices that the participants were able to choose from were underweight, average weight, overweight, and obese. Likewise, participants were only allowed to pick one of the four categories.

3.2.2 Sociodemographic Variables

Other variables that may influence the outcomes assessed in this study are those pertaining to race, gender, age, disability status, etc. The social category that was scrutinized in conjunction with the weight variables was gender. The identity was partitioned into three branches: man, woman, and nonbinary. The specific item asked to gather this information

was, “What is your gender?” Participants marked their gender based on the group that they were affiliated with or identified the most with. Separate categories were not created for Transgender persons as the survey did not ask for the sex that the participants were assigned at birth. Respondents who believed that their preferred gender was not listed were able to choose “other.”

While race has been commonly used in the context of differential health outcomes, it will not be applied to the results of this research in order to narrow the scope of the study. As gender has appeared in previous scholarships regarding weight discrimination, this study aimed to produce results that could be compared to past literatures (Kinge 2017; Kihm 2014; Webb et al. 2016). The collection of participants’ races in the survey was primarily meant to confirm that the assortment of respondents in the sample matched the real student population at the university.

3.2.3 Dependent Variables

The research concentrated on four central dependent variables with the first being general weight discrimination. Previously defined as the discernable interactions where individuals face unequal outcomes based on their size, this variable contained all encounters of weight discrimination that the participants noticed throughout their lifetime (Puhl and Brownell 2008). The question that was asked to acquire this information was, “Weight discrimination is defined as prejudice or unfair treatment on the basis of one’s weight or body type. Have you ever experienced weight discrimination before?” Participants were able to choose between three options: “Yes,” “No,” and “Rather not say.” Following this question was a supplementary item that inquired about the frequency of general weight discrimination.

Options ranging from “Never,” “Rarely,” “Sometimes,” “Often,” and “All the time” (See appendix #1).

The next variable, clinical weight discrimination, was defined as the mistreatment or neglect of patients based on their size (Puhl and Brownell 2008; Janke et al. 2016). The question that was asked to acquire this information was, “Have you ever experienced weight discrimination from your medical providers?” Participants were able to choose between three options: “Yes,” “No,” and “Maybe.” Following this question was another multiple-choice item which inquired about the frequency of weight discrimination from healthcare professionals and a short response question which asked participants to explain the specific occurrences of the phenomenon.

The third dependent variable was the fear of medical providers which was defined as feelings of emotional unrest at the thought of seeing a healthcare professional due to one’s weight (Ryan et al. 2024). The question that was asked to acquire this information was, “Do you feel anxious, uneasy, or scared when seeing a medical provider because of concerns with your weight or body image?” Participants were able to choose between three options: “Yes,” “No,” and “Maybe.”

The last dependent variable was the penalization of obesity, which was defined as all cases where healthcare professionals were dismissive of symptoms, unsympathetic, or unwilling to give proper treatments based on their patient’s weight. The question that was asked to acquire this information was, “Have your medical providers ever dismissed your concerns because of your weight?” Participants were able to choose between three options: “Yes,” “No,” and “Maybe.” Following this question was an open-ended response which requested further clarification on the former item if the participants noted “Yes” or “Maybe.”

3.2.4. Data Analysis

All analyses were conducted using STATA (version SE/18.5) excluding answers from the open-ended questions. Two-way cross tabulations were generated using bivariate analysis to examine the link between weight discrimination from medical providers and individuals' weight. The result of these frequencies determined the chi-square statistic, a value that states whether or not a certain outcome is significant. A chi-square value less than or equal to 0.001 is considered significant, therefore indicating that there was a correlation between the variables. A chi-square value that was less than 0.01 was moderately significant, signifying that there may be a correlation between the variables but cannot be stated in confidence. All other chi-square values above 0.05 were considered statistically insignificant. Afterwards, the written answers were examined for patterns that may have emerged, such as medical providers dismissing the concerns of their patients, were coded then noted in the results.

4. Results

4.1 Univariate Statistics

Majority of the sample consisted of women with 70.5% (n=74) of the participants being women, 29.5% (n=31) being men. White respondents made up the largest racial group in the sample at 41.9% (n=44), Asian and Pacific Islanders were the second largest at 29.5% (n=31), Black Americans were the third largest at 10.5% (n=11), Hispanic or Latine were the

fourth largest at 6.7% (n=7), and the remaining 11.4% (n=12) of the respondents were Native, Middle Eastern, or chose not to say.

In terms of self-reported weight, or self-weight, 8.6% (n=9) stated that they were underweight, 66.7% (n=70) stated that they were average weight, 19.0% (n=20) stated that they were overweight, and 5.7% (n=6) stated that they were obese. Then, the respondents were asked to select the weight category that their medical providers would sort them into, or the medical weight. 10.5% (n=11) stated that they would be considered underweight, 59.0% (n=62) stated that they would be considered average weight, 16.2% (n=17) stated that they would be considered overweight, and 14.3% (n=15) stated that they would be considered obese. One pertinent difference between self and medical weight that became apparent with the results is that the average weight group was smaller for medical weight than for self-weight. However, the overweight and obese group was larger for medical weight than for self-weight, conveying that there is a discrepancy between how individuals identify themselves and what their providers would categorize them. Specific frequencies of the sample are listed in Table 1.

Univariate analyses of general weight discrimination revealed that most of the participants did not experience general weight discrimination often (See Table 1). Of the 87 respondents, 33.3% (n=29) stated “Never,” 31.0% (n=27) stated “Rarely,” and 19.54% (n=17) stated “Sometimes” to the item. Less than a quarter of the participants reported that they encounter general weight discrimination often or all the time. Analyses of the frequency of clinical weight discrimination revealed that most of the participants did not experience clinical weight discrimination often (see Table 1). In fact, out of the 66 responses, only 13.7% (n=9) of the participants said they experienced it “All the time,” “Often,” or

"Sometimes." Majority of the respondents (71.2% or n=47) reported not ever facing clinical weight discrimination from their medical providers.

Table 1 here

4.2 Bivariate Analyses Results

4.2.1 General Weight Discrimination

Each of the four dependent variables were tested twice: one in correlation with self-weight and the other in correlation with medical weight. When analyzing general weight discrimination with self-weight, the results showed that all weight categories other than average weight were more likely to report an instance of weight discrimination throughout their lifetime (see Table 2). 77.8% (n=7) of the underweight group, 80.0% (n=16) of the overweight group, and 83.3% (n=5) of the obese group stated that they faced general weight discrimination as opposed to 35.7% (n=25) of the average weight category. While average weight participants made up just under half of all people who encountered general weight discrimination, it is notable to mention that the majority of the participants identified as average weight (66.7% or n=70) and that most of the average weight participants (64.3% of the total average weight category or n=45) did not face general weight discrimination. The chi-square test also conveys that the association between general weight discrimination and self-weight is highly statistically significant ($p < 0.001$), indicating that the null hypothesis should be rejected.

Table 2 here

A small shift can be noticed when testing general weight discrimination with medical weight (see Table 2). The results conveyed that while overweight and obese participants were still much more likely to encounter general weight discrimination, the same could not be said

for underweight individuals. 76.5% (n=13) of the overweight participants and 93.3% (n=14) of the obese participants reported that they faced general weight discrimination as opposed to 54.5% (n=6) of the underweight participants and 32.3% (n=20) of the average weight participants. Though more than half of the underweight respondents still stated that they experienced general weight discrimination, the percentage was lower than what was observed for self-weight frequencies. Another intriguing detail was that those in the overweight category were slightly less likely to experience general weight discrimination compared to the overweight category in the self-weight measure. The only group that saw an increase in general weight discrimination regarding medical weight was the obese. Furthermore, the chi-square test shows the association between general weight discrimination and medical weight is statistically significant ($p < 0.001$), indicating that the null hypothesis should be rejected.

4.2.2 Clinical Weight Discrimination

When examining clinical weight discrimination with self-weight, the results showed that the vast majority of responses (81.9% or n=86) did not experience clinical weight discrimination (see Table 3). Only 12.3% (n=13) of all participants stated that they faced clinical weight discrimination and 5.7% (n=6) stated that they were unsure. The participants who mentioned that they did not know if they faced clinical discrimination were made up of 3 average weight and 3 overweight participants. 4.3% (n=3) of average weight individuals, 30.0% (n=6) of overweight individuals, and 66.7% (n=4) of obese individuals claimed to have encountered clinical weight discrimination with no one from the underweight category stating that they experienced the phenomenon. The group that was most likely encounter weight discrimination were those in the obese category. Despite these frequencies, the chi-

square test shows that the relationship between clinical weight discrimination and self-weight is highly statistically significant ($p < 0.001$), indicating that the null hypothesis should be rejected.

Table 3 here

A similar trend was observed when testing clinical weight discrimination with medical weight (see Table 3). The responses (81.9% or n=86) were predominately made up of those who did not experience clinical weight discrimination. The number of participants who stated that they were unsure remained the same (n=6), however, there was 1 obese individual who stated that they may or may not have encountered clinical weight discrimination. 4.8% (n=3) of the average weight individuals, 5.9% (n=1) of overweight individuals, and 60.0% (n=9) of obese individuals reported that they face clinical weight discrimination; none of the underweight participants reported facing clinical weight discrimination. Interestingly, obese participants were less likely to encounter clinical weight discrimination when referred to by their medical weight instead of their self-weight. According to the chi-square test, this stronger relationship between clinical weight discrimination and medical weight is highly statistically significant ($p < 0.001$), which rejects the null hypothesis.

4.2.3 Fear of Medical Providers

After testing the fear of medical providers and self-weight, it was discovered that 48.3% (n=14) of the average weight group, 37.9% (n=11) of the overweight group, and 13.8% (n=4) of the obese group stated reported feeling emotional distress when visiting a healthcare professional with none from the underweight group (see Table 4). While average

weight individuals made up a greater portion of the responses affirming a fear of medical providers, overweight (55.0% or n=11) and obese (66.7% or n=4) individuals were more likely to state that they felt anxious, scared, or uneasy to see a provider in their respective weight categories. Out of the total 105 participants who filled-out the item, only 27.6% (n=29) stated that they felt anxious, uneasy, or scared to see a provider due to concerns of weight with 16.2% (n=17) participants noting that they were unsure. Within the subsample of those who marked "Maybe," average weight (64.7% or n=11) individuals made up the greatest number of responses with the next highest percentage coming from the overweight category (25.0% or n=5). The chi-square test shows a statistically significant relationship between fear of medical providers and self-weight ($p < 0.01$), which indicates that the null hypothesis should be rejected.

Table 4 here

In line with the results conducted with self-weight, the analysis between the fear of medical providers and medical weight showed that the overweight (47.1% of the total overweight category or n=8) and obese (73.3% of the total obese category or n=11) were disproportionately more likely to state that they had a fear of medical providers because of concerns with their weight (see Table 4). While the total number (n=29 or 27.6%) of those who reported feeling anxious, uneasy, or scared when seeing a healthcare provider was the same as what was observed in the self-weight variable, there was a small decrease in the number of overweight participants who disclosed this fear compared to the small increase in the number of obese participants. Of the 17 (n=16.2%) respondents who marked "Maybe," those in the average weight category (47.1% or n=8) once again made up the bulk of responses; but it is crucial to note that overweight individuals (29.4% of the total overweight

category or n=5) were the most likely to state that they were unsure in their respective weight category compared to the other three. The chi-square test indicates the association between the fear of medical providers and medical weight is highly statistically significant ($p < 0.001$), rejecting the null hypothesis.

4.2.4 Penalization of Obesity

When analyzing the correlation between the penalization of obesity and self-weight, it was found that the vast majority of participants (80.0% or n=84) have not had a medical provider dismiss their concerns on the basis of their weight (see Table 5). All weight categories were more likely to state that their issues were not neglected by healthcare professionals except for the obese participants. 50.0% (n=3) of the obese reported that their concerns were dismissed compared to 40.0% (n=8) of the overweight, 4.3% (n=3) of the average weight, and none from the underweight. Of those who were unsure (3.8% or n=4), there were 3 average weight participants (4.3% of the average weight group) and just one overweight participant (5.0% of the overweight group). There were no obese or underweight participants who stated that they were unsure. The chi-square test shows a statistically significant relationship between fear of medical providers and self-weight ($p < 0.01$), which indicates that the null hypothesis should be rejected.

Table 5 here.

Unsurprisingly, when the association between the penalization of obesity and medical weight was tested, the results showed that most participants (80% or n=84) did not have medical providers dismiss their concerns because of their weight (see table 5). Of those who stated that their concerns have been dismissed, 27.2% (n=3) were underweight, 4.8% (n=3)

were average weight, 11.8% (n=2) were overweight, and 60.0% (n=9) were obese. Compared to the self-weight variable, those who were obese in the medical weight variable were more likely to report that their issues were neglected by healthcare professionals because of their weight. Similar to what was observed with self-weight, there were no obese participants who stated that they were unsure. The chi-square test shows that the relationship between clinical weight discrimination and self-weight is highly statistically significant ($p < 0.001$), indicating that the null hypothesis should be rejected.

4.3 Gender-Stratified Analyses

In this portion of the findings, the impact of gender on the independent and dependent variables will be examined in order to analyze how men and women may experience weight discrimination from their healthcare professionals differently. While general weight discrimination was explored in the previous section, it will not be tested here as to place majority of the research on weight discrimination that is derived from medical providers. Clinical weight discrimination, the fear of medical providers, and the penalization of obesity will still be utilized to monitor the trends in the dataset.

4.3.1 Clinical Weight Discrimination

Observing the frequencies of clinical weight discrimination and self-weight in the context of gender provided a unique insight into how weight discrimination operates distinctly for men and women. The results for men revealed that only 3 (9.7%) out of the 31 participants stated that they faced clinical weight discrimination (see Table 6). Most of the responses came from those who did not experience weight discrimination with 83.9% (n=26)

reporting that they did not encounter negative weight-related instances from their medical providers. Similarly, when examining the relationship between clinical weight discrimination and medical weight, men were still less likely to state that they faced weight discrimination from their medical providers with the same number of participants (n=26 or 83.9%) marking the answer "No." (see Table 13). Moreover, both self-weight and medical weight were not statistically significant at the 5% level, conveying that there was a failure to reject the null hypothesis for both independent variables when looking at clinical weight discrimination.

Table 6 here

The same could not be applied for women in this study (see Table 7). After analyzing the association between clinical weight discrimination and self-weight for women, the results portrayed that all of the obese participants (n=3) encountered clinical weight discrimination as opposed to 35.7% (n=5) of the overweight participants, 3.9% (n=2) of the average weight participants, and none of the underweight participants. However, women were still more likely to state that they didn't experience weight discrimination with 81.0% (n=60) of the group marking "No." These findings were in concordance with the frequency observed when testing clinical weight discrimination and medical weight, where 63.6% (n=7) of the obese women faced clinical weight discrimination compared to 9.1% (n=1) of the overweight women, 4.8% (n=2) of the average weight women, and none of the underweight women (see Table 15). Majority of the participants (81.0% or n=60) still stated that they did not experience clinical weight discrimination, but a common pattern between the self-weight and medical weight variables was that those who were obese were the most likely to report clinical weight discrimination. Correspondingly, the chi-square tests show that the associations between weight discrimination and women's self-weight and medical weight

were statistically significant ($p < 0.001$); this indicates that the null hypothesis should be rejected.

Table 7 here

4.3.2 Fear of Medical Providers

When examining the correlation between the fear of medical providers and self-weight for men, the results revealed that most of the male respondents (77.4% or n=24) did not report feelings of emotional distress when seeing a healthcare professional (see Table 8). Only 5 (16.1% of the men) respondents stated that they held a fear of medical providers and 2 (6.5% of the men) stated that they were unsure. Of the 5 individuals who reported feeling anxious, scared, or uneasy when confronted with a healthcare professional, only 1 was an obese participant out of the three obese men in the dataset.

Furthermore, there was virtually no difference in frequencies when medical weight was tested with the fear of medical providers due to weight concerns (see Table 8). 77.4% (n=24) of the respondents still noted that they did not feel uncomfortable at the thought of meeting a healthcare provider. One minute change was that there were 2 (50.0%) obese men out of the available 4 in the medical weight variable who reported having a fear of medical providers as opposed to the 1 that was noticed with self-weight. Though the chi-square value for self-weight was statistically insignificant at the 5% level, the chi-square value for medical weight was significant ($p < 0.01$). This demonstrated that while there was a failure to reject the null hypothesis for self-weight, the null hypothesis should be rejected for medical weight.

Table 8 here

The frequencies acquired for the fear of medical providers and self-weight depicted a different result for the women in this study (see Table 9). The outcomes showed that 32.4%

(n=24) of the participants felt scared or uneasy when consulting a healthcare provider, which was nearly twice as much as the men. While obese women only made up 12.5% of responses that affirmed the fear of medical providers, it is imperative to mention that there were only 3 obese women in this dataset, all of whom marked "Yes" for this item. Overweight women made up 33.3% (n=8) of those who felt uncomfortable with healthcare professionals because of their weight, which was less than those in the average weight category (54.2% or n=13). However, a larger fraction of overweight women (57.1% of the total overweight category or n=8) reported a fear of medical providers than their average weight counterparts (25.5% of the total average weight category or n=13). The chi-square test shows a moderately significant relationship between fear of medical providers and self-weight ($p < 0.05$), which indicates that the correlation was still significant though not as strong. Given this value, the null hypothesis was to be rejected.

Table 9 here

Upon further analysis of the fear of medical providers using medical weight, the results conveyed that the same percentage of women reported feeling emotional distress when seeing their healthcare professionals (see Table 9). Contrary to the previous frequencies however, obese women contributed to 37.5% (n=9) of all respondents who reported having a fear of medical providers, more than double of what was noted for the self-weight measure. In fact, obese women were the most likely out of all the weight categories to state having a fear of medical providers. Overweight women only made up 25.0% (n=6) of those who marked "Yes" for this item, demonstrating that there were fewer overweight participants who had a fear of medical providers as captured by the medical weight variable. The chi-square test shows a statistically significant relationship between the fear of medical

providers and medical-weight ($p < 0.01$), indicating that the null hypothesis should be rejected.

4.3.3 Penalization of Obesity

After performing an analysis on the penalization of obesity and self-weight for men, it was discovered, once again, that the majority of participants did not encounter negative weight-related interactions with their medical providers (see Table 10). 87.1% (n=27) of the participants marked "No," for this item and 12.9% (n=4) of the participants marked "Yes." Of the 4 men who did report instances where medical providers dismissed them because of their weight, 2 (50.0%) were overweight and 1 (25.0%) was obese, illustrating that most of the responses affirming that they had been neglected by medical providers were those in larger bodies. However, most overweight (66.7% of the total overweight category or n=4) and obese (66.7% of the total obese category or n=2) men in the study did not report inattention from their healthcare professionals. This was echoed by the test conducted using the penalization of obesity and medical weight, where most men did not say that they faced difficulties in addressing their issues with providers due to their weight (see Table 10). Though 50% (n=2) of obese men stated that they had been dismissed because of their weight, only 1 (20.0%) out of the 5 overweight men stated that they also had this experience as well. It is notable to mention that all the average weight men, both in self-weight and medical weight, all selected "No." The chi-square value for self-weight was statistically insignificant at the 5% level, indicating that there was a failure to reject the null hypothesis. On the other hand, the chi-square value for medical weight was significant at ($p < 0.10$), indicating that the null hypothesis was to be rejected.

Table 10 here

The analysis between the penalization of obesity and self-weight revealed a similar trend that was seen with the previous dependent measures for women (see Table 11). Most participants (77.0% or n=57) did not report getting dismissed by medical providers because of their weight, though 17.6% (n=13) did. Overweight women made up the largest fragment of those who had experienced a lack of proper attention from healthcare professionals at 46.2% (n=6). The second largest group to have marked "Yes" were those in the average weight category, though only 7.8% (n=4) of all average weight women reported getting dismissed from their providers. Of their respective weight category, obese women were the only group to have a larger share of respondents (66.7% of the total obese category or n=2) state that their providers neglected them because of their weight. Similarly, when observing the association between the penalization of obesity and medical weight, it was found that the majority of respondents (77.0% or n=57) did not get dismissed by medical professionals on the basis of weight than those who did (see Table 11). As opposed to the self-weight results however, overweight women were less likely to affirm that they were dismissed with 81.8% (n=9) participants noting "No" for the item. Obese women still made up the largest portion of participants who felt dismissed by their medical providers because of their weight at 63.6% (n=7). The chi-square statistic for self-weight was relatively insignificant ($p < 0.05$), but still indicating that the null hypothesis should be rejected. On the other hand, the chi-square statistic for medical weight was statistically more significant ($p < 0.10$), indicating that the null hypothesis should be rejected.

Table 11 here

4.4 Qualitative Entries

While the bivariate analyses uncovered meaningful trends within the dataset, they lack the context behind all the responses. For this reason, the open-ended questions that were linked with the previous dependent variables will be highlighted in this section (see appendix #4). A comprehensive codebook was not developed for these statements because of the low-response rate. The question regarding additional information about clinical weight discrimination only contained 13 entries while the question regarding perceived dismissal from providers had 22 entries.

The most common theme that emerged from the responses was that healthcare providers believed weight-loss was the only treatment that they could prescribe to their larger patients. Selected from the question which asked individuals to elaborate on if they had been dismissed by their providers because of their weight, participant #12 said, “They said that my issues would be solved if I lost weight or were more healthy overall and dismissed me.” A similar narrative can be seen with participant #22 who said, “They tell me that if I lose weight, the co-morbidities will go away but they never analyze why I’m overweight in the first place which isn’t based on my lifestyle,” and with participant #46 who said, “Usually before I would even mention [the] symptoms of what I would be experiencing they [would mention] losing weight and coming back to them after for further help.” Other respondents mentioned similar anecdotes of healthcare professionals concluding that fat-loss was the solution for larger patients to take, even though the respondents had other health issues that they wanted to discuss.

The second theme that became apparent was the disregard of people in bigger bodies suffering from psychological disorders, such as an eating disorder. Derived from the same

question, participant #69 stated, “[medical providers] dismissed concerns of disordered eating because [my] weight had not changed.” This was reiterated by participant #23 who stated, “It was not seen as concerning when I was losing weight rapidly because I was getting “healthier”.” These individuals who were living with an eating disorder not only faced high-levels of apathy for a condition that must be handled with care, they experienced this ignorance from the professionals who the patients were meant to trust.

Another pattern that appeared throughout some of the responses was healthcare professionals’ inconsideration to the opposite end of the weight spectrum. Collected from the question following shortly after the clinical weight discrimination item, participant #57 said, “some providers have dismissed my concerns and have said “eat more” without taking vitals.” Tracing back to the question which inquired about feeling dismissed, participant #32 stated, “[I am] underweight. They (medical providers) thought I was on drugs.” Others wrote that their healthcare professionals would quickly attribute their decline in health, such as issues with respondents’ hearts and menstrual cycles, to their low body fat percentage.

5. Discussion

Findings from the two-way cross tabulations uncovered many important patterns in the dataset, mainly that for all four dependent measures, obese participants were more likely to report facing weight-stigmatizing occurrences than any other weight categories examined in this study. In addition, the prevalence of weight discrimination for obese participants was typically greater when observing medical weight as opposed to self-weight. Results from general weight discrimination portrayed that the percentage of obese individuals who experienced a negative weight-related interaction jumped from 80.0% of all obese

participants in the self-weight measure to 93.3% of all obese participants in the medical weight measure. A similar trend was seen for fear of medical providers, from 66.7% of all obese participants in self-weight to 73.3% of all obese participants in medical weight, and for penalization of obesity, from 50.0% of all obese participants in self-weight to 60.0% of all obese participants in medical weight.

The increase in obese respondents affirming that they encountered weight discrimination from their healthcare professionals is understandable when acknowledging that the perception of one's size is not the same as how providers may view their patients' size. According to the univariate frequencies, the number of average weight and overweight respondents in self-weight was lower than the number of average weight and overweight respondents in medical weight. However, the number of obese respondents more than doubled from 6 in self-weight to 15 in medical weight. These discrepancies display that there were a handful of individuals who perceived themselves to be of a different weight category than what their providers would believe. The variations in self and medical weight also demonstrate that weight categories are more than just a label describing the adiposity of the individual; they are also considered an identity that people feel socially connected to. Medical providers typically refer to the BMI to assess the physical state of their patients which is then used to sort them into the weight categories that match the numerical value that was generated. However, people do not always use the BMI to inform their understanding of their weight. Individuals' perceptions of their own weight category can be influenced by society's embracement of thinness, comments about their size from the people around them, and comparisons of their body to others. This signifies that being overweight or obese is a

unique identity that depends not only on how others perceive an individual but also how that individual acknowledges themselves.

Once a healthcare professional has sorted their patient into the weight category that the professional believes is correct, they may then invoke the attributes that are associated with each weight group as a guide on how the patient should be treated. As discussed with the social stigma theory, people whose identity have been "spoiled" by society' ascription of negative characteristics are discredited by others, even if they have other physical or social features that are conventionally valuable (Goffman 1963). Therefore, individuals who are considered normal, or in this case average weight, may not face criticism for their identity while individuals who are considered nonconforming, the obese, may experience more prejudice. Because overweight and obese people are more likely to bear the brunt in stigmatizing interactions, they may also be more likely to detect weight discrimination than those who are average or underweight. Individuals who perceived themselves to be average weight may not have realized that they encountered weight discrimination while those who were believed to be overweight or obese by medical providers may have been verbally told by said providers that they did not comply with optimal bodily standards, leading to more people stating that they have faced weight-based bigotry.

As shown by past research, providers are capable of holding stigmatizing perspectives of their overweight and obese patients, such as how they lack willpower and are ultimately the cause of their weight (Golub 1982; Phillip et al. 2024). It is possible that these adverse viewpoints of people in larger bodies drove the providers to act in discriminatory ways to the obese participants in this study, such as dismissing the concerns of their patients because obese individuals are in control of their size. Recommended "treatments" from healthcare

professionals noted from the qualitative responses were also in line with Crompovoets and collaborators (2024) discoveries where patients were told to lose weight independently or go on a calorie-restricted diet (Crompvoets et al. 2024).

In light of the negligent actions taken by medical providers who are prejudiced against larger individuals, it is also crucial to mention how some of the overweight or obese participants reported getting dismissed for eating disorders because they exhibited the "wrong" weight. This finding was also supported by another study which explored the prevalence of eating disorder symptoms in overweight and obese patients; researchers noticed that the overweight and obese patients tended to have more extreme disordered symptoms and negative body-image issues than their average weight or underweight counterparts (de Man Lapidoth and von Hausswolff-Juhlin 2014). Applying that result to this study, the medical providers' neglect of their overweight and obese patients with eating disorders is even more alarming for two reasons: one, that the severity of a larger patient's condition may not be enough to persuade providers to take appropriate action, and two, that weight-loss stemming from eating disorders is mistaken to be "healthy" for overweight and obese people.

Uniquely, the percentage of obese individuals affirming that they experienced clinical weight discrimination decreased for medical weight (66.7% in self-weight to 60.0% in medical weight) instead of increasing like the other three dependent variables. These results were in contrast to the preceding research which showed that obese patients were the target of many weight-stigmatizing cases (Russell and Carryer 2013; Janke 2016). One reason for this outcome may have been that even though obese participants were more likely to state that they had a fear of medical providers and were dismissed by healthcare professionals,

they didn't recognize these circumstances as discrimination but one-off instances of medical negligence. This is further supported by the fact that 71.2% of all participants who answered how frequently they felt clinical weight discrimination stated that they "Never" faced it and 15.2% stated that they "Rarely" experienced it.

On the other hand, the overweight people in this study had a more diverse array of answers and had the opposite trend of what was noticed for their obese counterparts. Like the obese group, overweight participants were more likely than not to report general weight discrimination, though there were less for medical weight than self-weight (80.0% for self-weight and 76.5% for medical weight). The same was observed for clinical weight discrimination (30.0% in self-weight to 5.9% in medical weight), fear of medical providers (55.0% in self-weight to 47.1% in medical weight), and for penalization of obesity (40.0% in self-weight to 11.8% in medical weight). As observed here, there was still a good amount of self-weight overweight people who noted weight-stigmatizing events, but the percentage dropped, sometimes significantly, for medical weight. This pattern was also in contrast to the past literature examining weight-related prejudices felt by those existing in larger bodies which showed that they were more likely to report weight discrimination (Ryan et al. 2024; Brown et al. 2006).

This deviance from prior research may be derived from the fact that the sample observed were college students. According to a study conducted by Sohier and collaborators (2025), which analyzed how college students' body weights and experiences may be related, 51.3% of respondents reported feeling embarrassed about their weight on campus and 44.7% of respondents reported having at least one weight stigmatizing encounter in their lifetime (Sohier et al. 2025). However, when comparing their findings to other works, the researchers

noticed that the prevalence of weight-related biases in college was less than other settings, such as in healthcare (Sohier et al. 2025). This was supported by another study which examined the prevalence of weight-stigma attitudes and eating behaviors among college students. Brewis and collaborators (2016) found that there was no significant relationship between weight stigmas and disordered eating which countered what they assumed about the normative nature of unhealthy eating patterns in campuses (Brewis et al. 2016). Colleges and universities, while still susceptible to reproducing anti-fat rhetoric and actions, may have other aspects associated with the institutions that deters weight-stigmatizing behaviors, though researchers have yet to determine what those preventative measures are (Sohier et al. 2025; Brewis et al. 2016).

5.1 Review of the Gender-Stratified Analyses

As made abundantly clear by the data, women were more likely to report weight discrimination than men for all three dependent variables that were tested. More importantly, overweight and obese women were more likely to indicate that they endured a weight-stigmatizing event with majority of responses affirming the phenomenon coming from the obese. Taking the fear of medical providers as an example, all obese and 33.3% of overweight women for self-weight noted that they felt anxious, uneasy, or scared when seeing a provider because of their weight, though these numbers decreased for medical weight (63.6% of the obese and 9.1% of the overweight). More than the overweight female participants, overweight female participants were consistently more likely to have a greater proportion of each weight category report weight discrimination or a weight-stigmatizing experience, and this was in line with the previous studies that have explored the relationship

between weight discrimination and larger women (Sari and Osman 2018; Puhl and Brownell 2008; Udo et al. 2016). According to a study conducted on women receiving gynecological care, researchers discovered that obese women were more likely to have encountered weight stigma from their providers (Wetzel and Himmelstein 2025). Examples of prejudice included professionals refusing to treat obese women or misdiagnosing their obese patients (Wetzel and Himmelstein 2025).

The increase in weight discrimination incidences for overweight and obese women in this study was also supported by research investigating degrees of stigmatization in young adult women (Jach and Kryston 2021). One study that examined experiences of weight-related stigmatization and self-reported body weights uncovered that 87.5% of the young obese women observed were met with discrimination on the basis of their weight at least once in their life (Jach and Kryston 2021). Another important finding from the same study was that many average weight women also stated that they also faced weight discrimination, which indicates that weight discrimination may be more pervasive when combined with sexism (Jach and Kryston 2021).

5.2 Limitations

One limitation that must be addressed is the small sample size of overweight and obese participants in this study, particularly the latter. While the dataset still produced meaningful results, it can be improved by oversampling individuals in larger bodies in order to better compare them against their average weight or underweight counterparts. Additionally, as the survey data stemmed only from one private university, the outcomes mentioned here are not generalizable to the rest of the college student population, let alone

young adults in the U.S. Future endeavors on the subject of weight discrimination experienced by young adults should try to find a sample that spans a wider jurisdiction, such as multiple institutions of higher education in a metropolitan area or a national survey conducted throughout the country. Furthermore, research proceeding this study should expand upon the intersection of gender and larger weight categories, especially how women negotiate their identities in the face of weight-based biases.

5.3 Conclusion

The results presented by this study reveals that overweight and obese patients were more likely to experience weight discrimination from their medical providers. Correspondingly, obese women were the most likely to encounter weight-stigmatizing interactions with their healthcare professionals. With the ongoing obesity epidemic in the U.S., it is crucial to not just analyze the trends and findings presented in this field but to also utilize the information to combat weight- stigmatization. Health crises cannot only be treated with the technical and medical skills of healthcare providers; they also require empathy and understanding from people to diminish the shame that those living with the ailments may feel. Through this research, medical providers are asked to reevaluate the negative weight stigmas that are entrenched within society in order to combat size-based discrimination.

6. Tables

Table 1 – Descriptive Statistics (N=105)

Age			
Range	18-23		
Average	20.1		
STD	1.40		
Gender	**N**	**%**	
Man	31	29.5%	
Woman	74	70.5%	
Race			
White/Caucasian	44	41.9	
Black/African American	11	10.5	
Asian/ Pacific Islander	31	29.5	
Hispanic/Latine	7	6.7	
Native/Indigenous	1	0.01	
Middle Eastern/Arabic	1	0.01	
Mixed-Race	10	9.5	
Self-Weight			
Underweight	9	8.6	
Average Weight	70	66.7	
Overweight	20	19.0	
Obese	6	5.7	
Medical Weight			
Underweight	11	10.5	
Average Weight	62	59.0	
Overweight	17	16.2	
Obese	15	14.3	
Frequency of General Weight Discrimination	N	%	Cum.
All the time	4	4.6	4.60
Often	10	11.49	49.43
Sometimes	17	19.54	100.00
Rarely	27	31.03	80.46
Never	29	33.33	37.93
Total	87	100.00	
Frequency of Clinical Weight Discrimination	N	%	Cum.
All the time	3	4.55	4.55
Often	1	1.52	77.27
Sometimes	5	7.58	100.00
Rarely	10	15.15	92.42
Never	47	71.21	75.76
Total	66	100.00	

Table 2: General Weight Discrimination and Self Weight and Medical Weight (% by row)

General Weight Discrimination (Self-Weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	7	25	16	5	53
Row %	13.2%	47.2%	30.2%	9.4%	100%
Column %	77.8%	35.7%	80.0%	83.3%	
No	2	45	4	1	52
Row %	3.8%	86.5%	7.7%	1.9%	100%
Column %	22.2%	64.3%	20.0%	16.7%	
Total	9	70	20	6	105
Row %	8.6%	66.7%	19.0%	5.7%	100%
Column %	100%	100%	100%	100%	
		Chi2=18.3509	p=0.000		
General Weight Discrimination (Medical Weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	6	20	13	14	53
Row %	11.3%	37.7%	24.5%	26.4%	100%
Column %	54.5%	32.3%	76.5%	93.3%	
No	5	42	4	1	52
Row %	9.6%	80.8%	7.7%	1.9%	100%
Column %	45.5%	67.7%	23.5%	6.7%	
Total	11	62	17	15	105
Row %	10.5%	59.0%	16.2%	14.3%	100%
Column %	100%	100%	100%	100%	
		Chi2=23.9214	p=0.000		

Table 3: Clinical Weight Discrimination with Self Weight and Medical Weight

Clinical Weight Discrimination (Self-Weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	0	3	6	4	13
Row %	0%	23.1%	46.2%	30.8%	100%
Column %	0%	4.3%	30.0%	66.7%	
No	9	64	11	2	86
Row %	10.5%	74.4%	12.8%	2.3%	100%
Column %	100%	91.4%	55.0%	33.3%	
Maybe	0	3	3	0	6
Row %	0%	50.0%	50.0%	0%	100%
Column %	0%	4.3%	15.0%	0%	
Total	9	70	20	6	105
Row %	8.6%	66.7%	19.0%	5.7%	100%
Column %	100%	100%	100%	100%	
		Chi2=32.8160	p=0.000		
Clinical Weight Discrimination (Medical Weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	0	3	1	9	13
Row %	0%	23.1%	7.7%	69.2%	100%
Column %	0%	4.8%	5.9%	60.0%	
No	11	56	14	5	86
Row %	12.8%	65.1%	16.3%	5.8%	100%
Column %	100%	90.3%	82.4%	33.3%	
Maybe	0	3	2	1	6
Row %	0%	50.0%	33.3%	16.7%	100%
Column %	0%	4.8%	11.8%	6.7%	
Total	11	62	17	15	105
Row %	10.5%	59.0%	16.2%	14.3%	
Column %	100%	100%	100%	100%	
		Chi2=39.3146	p=0.000		

Table 4: Fear of Medical Providers with Self Weight and Medical Weight

Fear of Medical Providers (Self-weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	0	14	11	4	29
Row %	0%	48.3%	37.9%	13.8%	100%
Column %	0%	20.0%	55.0%	66.7%	
No	8	45	4	2	59
Row %	13.6%	76.3%	6.8%	3.4%	100%
Column %	88.9%	64.3%	20.0%	33.3%	
Maybe	1	11	5	0	17
Row %	5.9%	6.5%	29.4%	0%	100%
Column %	11.1%	15.7%	25.0%	0%	
Total	9	70	20	6	105
Row %	8.6%	66.7%	19.0%	5.7%	100%
Column %	100%	100%	100%	100%	
		Chi2=22.1237	p=0.001		
Fear of Medical Providers (Medical Weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	2	8	8	11	29
Row %	6.9%	27.6%	27.6%	37.9%	100%
Column %	18.2%	12.9%	47.1%	73.3%	
No	7	46	4	2	59
Row %	11.9%	78.0%	6.8%	3.4%	100%
Column %	63.6%	74.2%	23.5%	13.3%	
Maybe	2	8	5	2	17
Row %	11.8%	47.1%	29.4%	11.8%	100%
Column %	18.2%	12.9%	29.4%	13.3%	

Total	11	62	17	15	105
Row %	10.5%	59.0%	16.2%	14.3%	100%
Column %	100%	100%	100%	100%	
Chi2=33.3968 p=0.000					

Table 5: Penalization of Obesity and Self Weight

Penalization of Obesity (Self-Weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	2	4	8	3	17
Row %	11.8%	23.5%	47.1%	17.6%	100%
Column %	22.2%	5.7%	40.0%	50.0%	
No	7	63	11	3	84
Row %	8.3%	75.0%	13.1%	25.7%	100%
Column %	77.8%	90.0%	55.0%	50.0%	
Maybe	0	3	1	0	4
Row %	0%	75.0%	25.0%	0%	100%
Column %	0%	4.3%	5.0%	0%	
Total	9	70	20	6	105
Row %	8.6%	66.7%	19.0%	5.7%	100%
Column %	100%	100%	100%	100%	
Chi2=19.9918 p=0.003					
Penalization of Obesity (Medical Weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	3	3	2	9	17
Row %	17.6%	17.6%	11.8%	52.9%	100%
Column %	27.3%	4.8%	11.8%	60.0%	

No	7	57	14	6	84
Row %	8.3%	67.9%	16.7%	7.1%	100%
Column %	63.6%	91.9%	82.4%	40.0%	
Maybe	1	2	1	0	4
Row %	25.0%	50.0%	25.0%	0%	100%
Column %	9.1%	3.2%	5.9%	0%	
Total	11	62	17	15	105
Row %	10.5%	59.0%	16.2%	14.3%	100%
Column %	100%	100%	100%	100%	
Chi2=29.8643 p=0.000					

Table 6: Clinical Weight Discrimination with Self and Medical Weight for Men

Clinical Weight Discrimination (Self-Weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	0	1	1	1	3
Row %	0%	33.3%	33.3%	33.3%	100%
Column %	0%	5.3%	16.7%	33.3%	
No	3	17	4	2	26
Row %	11.5%	65.4%	15.4%	7.7%	100%
Column %	100%	89.5%	66.7%	55.7%	
Maybe	0	1	1	0	2
Row %	0%	50.0%	50.0%	0%	100%
Column %	0%	5.3%	16.7%	0%	
Total	3	19	6	3	31
Row %	9.7%	6.1%	19.4%	9.7%	100%
Column %	100%	100%	100%	100%	

Chi2=4.8296 p=0.566					
Clinical Weight Discrimination (Medical Weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	0	1	0	2	3
Row %	0%	33.3%	0%	66.7%	100%
Column %	0%	5.0%	0%	50.0%	
No	1	18	5	2	26
Row %	3.8%	69.2%	19.2%	7.7%	100%
Column %	100%	90.0%	83.3%	50.0%	
Maybe	0	1	1	0	2
Row %	0%	50.0%	50.0%	0%	100%
Column %	0%	5.0%	16.7%	0%	
Total	1	20	6	4	31
Row %	3.2%	64.5%	19.4%	12.9%	100%
Column %	100%	100%	100%	100%	
Chi2=10.2857 p=0.113					

Table 7: Clinical Weight Discrimination with Self and Medical weight for Women

Clinical Weight Discrimination	Underweight	Average weight	Overweight	Obese	Total
Yes	0	2	5	3	10
Row %	0%	20.0%	50.0%	30.0%	100%
Column %	0%	3.9%	35.7%	100%	
No	6	46	7	0	60
Row %	10.0%	78.3%	11.7%	0%	100%

Column %	100%	90.2%	50.0%	0%	
Maybe	0	2	2	0	4
Row %	0%	50.0%	50.0%	0%	100%
Column %	0%	3.9%	14.3%	0%	
Total	6	51	14	3	74
Row %	8.1%	68.9%	18.9%	4.1%	100%
Column %	100%	100%	100%	100%	
		Chi2=33.2624	p=0.000		
Clinical Weight Discrimination	Underweight	Average weight	Overweight	Obese	Total
Yes	0	2	1	7	10
Row %	0%	20.0%	10.0%	70.0%	100%
Column %	0%	4.8%	9.1%	63.6%	
No	10	38	9	3	60
Row %	16.7%	63.3%	15.0%	5.0%	100%
Column %	100%	90.5%	81.8%	27.2%	
Maybe	0	2	1	1	4
Row %	0%	50.0%	25.0%	25.0%	100%
Column %	0%	4.8%	9.1%	9.1%	
Total	10	42	11	11	74
Row %	13.5%	56.8%	14.9%	14.9%	100%
Column %	100%	100%	100%	100%	
		Chi2=29.7313	p=0.000		

Table 8: Fear of Medical Providers with Self Weight and Medical Weight for Men

Fear of Medical Providers (Self-Weight)	Underweight	Average weight	Overweight	Obese	Total

Yes	0	1	3	1	5
Row %	0%	20.0%	60.0%	20.0%	100%
Column %	0%	5.3%	50.0%	33.3%	
No	3	17	2	2	24
Row %	12.5%	70.8%	8.3%	8.3%	100%
Column %	100%	89.5%	33.3%	66.7%	
Maybe	0	1	1	0	2
Row %	0%	50.0%	50.0%	0%	100%
Column %	0%	5.3%	16.7%	0%	
Total	3	19	6	3	31
Row %	9.7%	6.1%	19.4%	9.7%	100%
Column %	100%	100%	100%	100%	

Chi2=10.6560 p=0.100

Fear of Medical Providers (Medical Weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	0	1	2	2	5
Row %	0%	20.0%	40.0%	40.0%	100%
Column %	0%	5.0%	33.3%	50.0%	
No	1	19	2	2	24
Row %	4.2%	79.2%	8.3%	8.3%	100%
Column %	100%	95.0%	33.3%	50.0%	
Maybe	0	0	2	0	2
Row %	0%	0%	100%	0%	100%
Column %	0%	0%	33.3%	0%	
Total	1	20	6	4	31
Row %	3.2%	64.5%	19.4%	12.9%	100%
Column %	100%	100%	100%	100%	

Chi2=17.4324 p=0.008

Table 9: Fear of Medical Providers with Self Weight and Medical Weight for Women

Fear of Medical Providers (Self-Weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	0	13	8	3	24
Row %	0%	54.2%	33.3%	12.5%	100%
Column %	0%	25.5%	57.1%	100%	
No	5	28	2	0	35
Row %	14.3%	80.0%	5.7%	0%	100%
Column %	83.3%	54.9%	14.3%	0%	
Maybe	1	10	4	0	15
Row %	6.7%	62.5%	26.7%	0%	100%
Column %	16.7%	19.6%	28.6%	0%	
Total	6	51	14	3	74
Row %	8.1%	68.9%	18.9%	4.1%	100%
Column %	100%	100%	100%	100%	
Chi2=16.6765 p=0.011					
Fear of Medical Providers (Medical Weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	2	7	6	9	24
Row %	8.3%	29.2%	25.0%	37.5%	100%
Column %	20.0%	11.3%	54.5%	81.8%	
No	6	27	2	0	35
Row %	17.1%	77.1%	5.7%	0%	100%
Column %	60.0%	64.3%	18.2%	0%	

Maybe	2	8	3	2	15
Row %	13.3%	53.3%	20.0%	13.3%	100%
Column %	20.0%	19.0%	27.3%	18.2%	
Total	10	42	11	11	74
Row %	13.5%	56.8%	14.9%	14.9%	100%
Column %	100%	100%	100%	100%	
Chi2=23.5947 p=0.001					

Table 10: Penalization of Obesity with Self and Medical Weight for Men

Penalization of Obesity	Underweight	Average weight	Overweight	Obese	Total
Yes	1	0	2	1	4
Row %	25.0%	0%	50.0%	25.0%	100%
Column %	33.3%	0%	33.3%	33.3%	
No	2	19	4	2	27
Row %	7.4%	70.4%	14.8%	7.4%	100%
Column %	66.7%	100%	66.7%	66.7%	
Maybe	0	0	0	0	0
Total	3	19	6	3	31
Row %	9.7%	6.1%	19.4%	9.7%	100%
Column %	100%	100%	100%	100%	
Chi2=7.2716 p=0.064					
Penalization of Obesity	Underweight	Average weight	Overweight	Obese	Total
Yes	1	0	1	2	4
Row %	25.0%	0%	25.0%	50.0%	100%

Column %	100%	0%	16.7%	50.0%	
No	0	20	5	2	27
Row %	0%	74.1%	18.5%	7.4%	100%
Column %	0%	100%	83.3%	50.0%	
Maybe	0	0	0	0	0
Total	1	20	6	4	31
Row %	3.2%	64.5%	19.4%	12.9%	100%
Column %	100%	100%	100%	100%	
Chi2=14.6867 p=0.002					

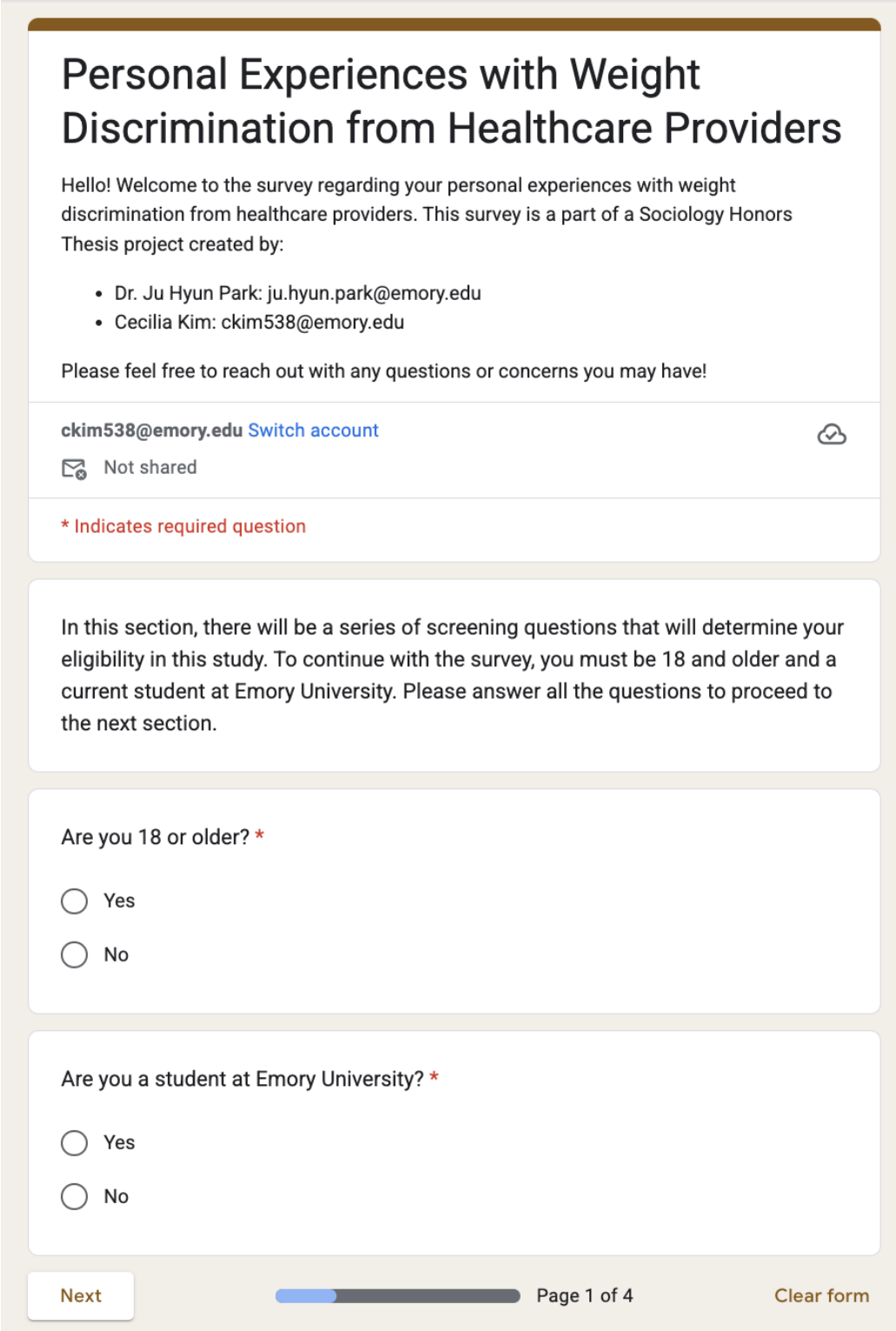
Table 11: Penalization of Obesity with Self and Medical Weight for Women

Penalization of Obesity (Self-Weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	1	4	6	2	13
Row %	7.7%	30.8%	46.2%	15.4%	100%
Column %	16.7%	7.8%	42.9%	66.7%	
No	5	44	7	1	57
Row %	8.8%	77.2%	12.3%	1.8%	100%
Column %	83.3%	86.3%	50.0%	33.3%	
Maybe	0	3	1	0	4
Row %	0%	75.0%	25.0%	0%	100%
Column %	0%	5.9%	7.1%	0%	
Total	6	51	14	3	74
Row %	8.1%	68.9%	18.9%	4.1%	100%
Column %	100%	100%	100%	100%	

		Chi2=15.2162	p=0.019		
Penalization of Obesity (Medical Weight)	Underweight	Average weight	Overweight	Obese	Total
Yes	2	3	1	7	13
Row %	15.4%	23.1%	7.7%	53.8%	100%
Column %	20.0%	7.1%	9.1%	63.6%	
No	7	37	9	4	57
Row %	12.3%	64.9%	15.8%	7.0%	100%
Column %	70.0%	88.1%	81.8%	36.4%	
Maybe	1	2	1	0	4
Row %	25.0%	50.0%	25.0%	0%	100%
Column %	10.0%	4.8%	9.1%	0%	
Total	10	42	11	11	74
Row %	13.5%	56.8%	14.9%	14.9%	100%
Column %	100%	100%	100%	100%	
		Chi2=20.7907	p=0.002		

7. Appendices

Appendix #1



Personal Experiences with Weight Discrimination from Healthcare Providers

Hello! Welcome to the survey regarding your personal experiences with weight discrimination from healthcare providers. This survey is a part of a Sociology Honors Thesis project created by:

- Dr. Ju Hyun Park: ju.hyun.park@emory.edu
- Cecilia Kim: ckim538@emory.edu

Please feel free to reach out with any questions or concerns you may have!

ckim538@emory.edu Switch account

Not shared

* Indicates required question

In this section, there will be a series of screening questions that will determine your eligibility in this study. To continue with the survey, you must be 18 and older and a current student at Emory University. Please answer all the questions to proceed to the next section.

Are you 18 or older? *

- Yes
- No

Are you a student at Emory University? *

- Yes
- No

Next

Page 1 of 4

Clear form

Personal Experiences with Weight Discrimination from Healthcare Providers

ckim538@emory.edu Switch account

Not shared

* Indicates required question

Informed Consent

In this section, you will review the consent form that is associated with this study. You do not need to state your name or initials when stating your consent: please choose between the two options at the bottom of the page. If you do not consent to this study, you will NOT be able to complete the survey.

For any questions about the consent form or the study, please contact either:

- Ju Hyun Park, ju.hyun.park@emory.edu
- Cecilia Kim, ckim538@emory.edu

Informed Consent Form

Ju Hyun Park, ju.hyun.park@emory.edu, 4048249994
Cecilia Kim, ckim538@emory.edu, 7185516635

Description

The following consent form pertains to the surveys that will be conducted. The surveys will be a crucial part of a Sociology Honors Thesis paper that will be presented. It is a research study examining weight discrimination from healthcare providers. The investigators will be Cecilia Kim, a current student enrolled at Emory, and Ju Hyun Park, teaching faculty at Emory University.

You are being asked to volunteer for this study that will ask about your personal experiences of weight discrimination from healthcare workers. The questions posed do not require you to have professional understanding of the healthcare sector or weight discrimination. Those who are under 18, cognitively impaired, pregnant, current prisoners, or not an Emory University student will not be able to participate.

For any questions regarding the study, please reach out to Primary Investigator Ju Hyun Park at ju.hyun.park@emory.edu or Cecilia Kim at ckim538@emory.edu.

If you have questions about your rights as a research participant, or if you have complaints about the research or an issue you would rather discuss with someone outside the research team, contact the Emory Institutional Review Board at 404-712-0720 or 877-503-9797 or irb@emory.edu.

Procedures

Informed Consent Form

Ju Hyun Park, ju.hyun.park@emory.edu, 4048249994
Cecilia Kim, ckim538@emory.edu, 7185516635

Description

The following consent form pertains to the surveys that will be conducted. The surveys will be a crucial part of a Sociology Honors Thesis paper that will be presented. It is a research study examining weight discrimination from healthcare providers. The investigators will be Cecilia Kim, a current student enrolled at Emory, and Ju Hyun Park, teaching faculty at Emory University.

You are being asked to volunteer for this study that will ask about your personal experiences of weight discrimination from healthcare workers. The questions posed do not require you to have professional understanding of the healthcare sector or weight discrimination. Those who are under 18, cognitively impaired, pregnant, current prisoners, or not an Emory University student will not be able to participate.

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Procedures

- The surveys will be taken online and will be flexible in order to match up with your schedule. The results will be anonymous, meaning your personal information will not be asked about or used in the final piece. Any identifying information that you provide will be omitted from the final piece.
- No visuals or audio will be included in the final project.
- You do not need to answer all questions; answer only the ones that you wish to do so.
- Expect the survey to be approximately 15 mins long, you may also take breaks if you would like. No preparation, such as professional attire or a notepad, will be necessary unless you desire to.

Confidentiality

This survey is entirely voluntary and you may opt out at any given time. If you wish to have your responses removed from this piece, please let us know. You may also skip questions if they are uncomfortable. The full survey will NOT be posted anywhere including in this study. All names, if provided, in the study will be changed to conceal your identity.

Risks and Benefits

There will be no compensation for this study. Likewise, there should also be little to no risk involved in the surveys for you. If you believe the surveys pose a threat to you or you wish to be removed from the study, please let us know.

If the above statements are acceptable and you would like to participate, please click the "I consent" option below:

Do you consent to participating in this study? *

- ◯ I consent
- ◯ I do NOT consent

Back Next Page 2 of 4 Clear form

Personal Experiences with Weight Discrimination from Healthcare Providers

ckim538@emory.edu Switch account

Not shared

Demographic Information

In this section, you will be asked about your race, gender, sexuality, etc. If you are uncomfortable with answering any of the questions, please choose "Rather not say."

What is your age?

Your answer

Are you an international student?

- ◯ Yes
- ◯ No
- ◯ Rather not say

What is your race? (You may select more than one).

- [ ] White/Caucasian
- [ ] Black/African American
- [ ] Asian/Pacific Islander
- [ ] Hispanic/Latine
- [ ] Native/Indigenous
- [ ] Middle Eastern/Arabic
- [ ] Rather not say
- [ ] Other: _____

What is your gender? (You may choose more than one)

- [ ] Woman
- [ ] Man
- [ ] Non-binary
- [ ] Rather not say
- [ ] Other: _____

Are you disabled?

- ◯ Yes
- ◯ No
- ◯ Rather not say

Have you worked or are currently working in the Healthcare sector?

- ◯ Yes
- ◯ No
- ◯ Rather not say

For this question, please consider how you or others may define your body type. Which of the categories below best represents your weight?

- ◯ Underweight
- ◯ Average weight
- ◯ Overweight
- ◯ Obese
- ◯ Rather not say
- ◯ Other: _____

How would your medical providers - that being nurses, doctors, medical assistants, etc. - describe your body type?

- ◯ Underweight
- ◯ Average weight
- ◯ Overweight
- ◯ Obese
- ◯ Rather not say

Back Next Page 3 of 4 Clear form

Personal Experiences with Weight Discrimination from Healthcare Providers

ckim538@emory.edu Switch account

Not shared

Experiences with weight discrimination from Medical Providers

This is the final section of the survey. The questions below will be either multiple choice or short response. If you do not want to answer a specific question, you may answer it briefly or leave it blank. There is no word limit for any of the short response questions; please feel free to elaborate on any of the points you want to make. For any questions about the consent form or the study, please contact either:

- Ju Hyun Park, ju.hyun.park@emory.edu
- Cecilia Kim, ckim538@emory.edu

Weight discrimination is defined as prejudice or unfair treatment on the basis of one's weight or body type. Have you ever experienced weight discrimination before?

- ◯ Yes
- ◯ No
- ◯ Rather not say

If you have experienced weight discrimination before, how often did you experience it?

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ All the time

If you have experienced weight discrimination, where did it happen?

- ☐ Work or Occupation
- ☐ School
- ☐ At home or with family and friends
- ☐ Online
- ☐ Public spaces (parks, restaurants, stores, etc.)
- ☐ Other: _____

How often do you see a medical provider?

- ◯ Never
- ◯ Once or twice a year
- ◯ Few times a year
- ◯ Several times a year
- ◯ Very Often
- ◯ Other: _____

How would you describe your relationship with your medical providers?

- ◯ Excellent
- ◯ Very Good
- ◯ Good
- ◯ Neutral
- ◯ Fair
- ◯ Poor
- ◯ Other: _____

How frequently do your medical providers mention your weight?

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ All the time

Have you ever felt that your medical providers were dismissive of your symptoms, unsympathetic, or unwilling to give comprehensive care?

- ◯ Yes
- ◯ No
- ◯ Maybe
- ◯ Other: _____

Do you believe that your medical providers prioritize your well-being?

- ◯ Yes
- ◯ No
- ◯ Maybe

If you stated “No” or “Maybe” to the previous question, please select the options that you believe your medical providers treat you differently on

- ☐ Because of my race/ethnicity
- ☐ Because of my gender
- ☐ Because of my religion
- ☐ Because of my proficiency in English
- ☐ Because of my disability or chronic health problems
- ☐ Because of my weight
- ☐ Other: _____

How frequently does your medical provider suggest or demand you to change your body weight, whether that be to lose weight or to gain weight?

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ All the time
- ◯ Other: _____

Have your medical providers ever dismissed your concerns because of your weight?

- ◯ Yes
- ◯ No
- ◯ Maybe

If you said "yes" or "maybe" to the previous question, please explain why here:

Your answer

Have you ever experienced weight discrimination from your medical providers?

- ◯ Yes
- ◯ No
- ◯ Maybe

If you have experienced weight discrimination from your medical providers, how frequently did it occur?

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ All the time

If you stated that you have experienced weight discrimination from your medical providers, how did it happen? If there are multiple incidents or locations, please state all that you would like to share with us.

Your answer

Do you feel anxious, uneasy, or scared when seeing a medical provider because of concerns with your weight or body image?

- ◯ Yes
- ◯ No
- ◯ Maybe

Have you ever heard of other patients who experienced weight discrimination from medical providers?

- ◯ Yes
- ◯ No
- ◯ Maybe

How confident are you that your medical providers are well-trained or professional enough to treat patients of various sizes?

- ◯ Not confident at all
- ◯ Slightly confident
- ◯ Somewhat confident
- ◯ Moderately confident
- ◯ Very confident

Is there anything else that you would like to mention that has not been asked? Please feel free to elaborate here.

Your answer

Back Submit Page 4 of 4 Clear form

Appendix #2

Informed Consent Form

Ju Hyun Park, ju.hyun.park@emory.edu, 4048249994
Cecilia Kim, ckim538@emory.edu, 7185516635

Description

The following consent form pertains to the surveys that will be conducted. The surveys will be a crucial part of a Sociology Honors Thesis paper that will be presented. It is a research study examining weight discrimination from healthcare providers. The investigators will be Cecilia Kim, a current student enrolled at Emory, and Ju Hyun Park, teaching faculty at Emory University.

You are being asked to volunteer for this study that will ask about your personal experiences of weight discrimination from healthcare workers. The questions posed do not require you to have professional understanding of the healthcare sector or weight discrimination. Those who are under 18, cognitively impaired, pregnant, current prisoners, or not an Emory University student will not be able to participate.

For any questions regarding the study, please reach out to Primary Investigator Ju Hyun Park at ju.hyun.park@emory.edu or Cecilia Kim at ckim538@emory.edu

Procedures

- The surveys will be taken online and will be flexible in order to match up with your schedule. The results will be anonymous, meaning your personal information will not be asked about or used in the final piece. Any identifying information that you provide will be omitted from the final piece.
- No visuals or audio will be included in the final project.
- You do not need to answer all questions; answer only the ones that you wish to do so.
- Expect the survey to be approximately 15 mins long, you may also take breaks if you would like. No preparation, such as professional attire or a notepad, will be necessary unless you desire to.

Confidentiality

This survey is entirely voluntary and you may opt out at any given time. If you wish to have your responses removed from this piece, please let us know. You may also skip questions if they are uncomfortable. The full survey will NOT be posted anywhere including in this study. All names, if provided, in the study will be changed to conceal your identity.

Risks and Benefits

There will be no compensation for this study. Likewise, there should also be little to no risk involved in the surveys for you. If you believe the surveys pose a threat to you or you wish to be removed from the study, please let us know.

If the above statements are acceptable and you would like to participate, please click the "I consent" option below:

- I consent
- I do not consent

Appendix #3

Asking the Professor or Faculty Member to distribute Survey:

Hello Dr._____,

I hope this Email finds you well! My name is Cecilia Kim, I am currently a senior at Emory University doing an Honors Thesis in Sociology. My study is about weight discrimination in the medical field, specifically how overweight or obese patients may feel as though they are discriminated on the basis of weight by their medical providers. To examine how the experiences of overweight or obese patients differ from their normal to underweight counterparts, I have created a survey using Google Forms that participants can fill out in their own time. As the population I want to gather data from are college students at Emory University, I wanted to ask if you could help distribute my survey to your students.

Please let me know if this is something that you would be interested in doing, and I will send further instructions along with the survey after receiving your permission!

Best,

Cecilia Kim
Ckim538@emory.edu
(718)551-6635

When the Professor or Faculty member responds agreeing to distribute survey:

Hello again!

Thank you so much for agreeing to distribute my survey to your students, this will be tremendously helpful for my research!

I was hoping that you could send the survey out through your Emory email or an announcement through Canvas. The message must contain a brief statement about the study, who is eligible to participate, how long the surveys should take and the contact information of the investigators involved. Below, I have created a template of an email that you can use to send to your students; please feel free to tweak the template as long as the requirements that I have listed prior are included.

“Hello All,

I am reaching out regarding a study that you may be interested in participating in. The study, which is for a Sociology Honors Thesis paper, will be examining individuals’ experiences with weight discrimination from medical providers, such as doctors or nurses. The purpose of the study is to analyze how medical providers may treat patients differently on the basis of

their weight. College students above the age of 18 are eligible to participate, and respondents will fill out an online survey that will take approximately 15 minutes. There are no direct benefits to participating (no money or gift cards will be awarded for completing the survey).

If you are interested in participating in the study, see the link to the Google Form that is here: https://forms.gle/ZgQRf5z2asawg8gS6

If you have any questions about the survey or the study, please contact Primary Investigator Dr. Ju Hyun Park at ju.hyun.park@emory.edu or Cecilia Kim at ckim538@emory.edu

Thank you!”

Appendix #4

Open-Ended Question #1: “If you said “yes” or “maybe” to the previous question, please explain why here:”

- Participant #11: “I often deal with chronic pain, and I frequently tell my doctors. Or, I'll mention that I'm always exhausted despite receiving proper nutrient intake and going to bed at a decent time. However, with those issues especially (or any issue in general), they find some way to link it back to my weight. Yes, I figure weight might factor into some of my experiences, but I also feel that my weight might also be a result of something hormonal. I don’t believe that my health issues are a direct result of my weight, but rather my weight AND my health issues are related to something else. I feel when I mention that possibility, my doctor does entertain it, but her tone makes me think that she perceives me as a lazy individual with poor self-control. Yes, I’m a student, and I don’t get to intentionally exercise (go for runs) all the time, but I do make an effort to walk to class and do light lifting when I am not in pain. It’s frustrating when they constantly remind me that I just need to lose weight and how that could explain away my current health. I don’t feel taken seriously.”
- Participant #13: “When I was in high school I was overweight. I noticed my heart was skipping beats randomly so I went to a cardiologist and told me to come back when I had lost weight, and until I lose it they wont examine, and that it was likely a problem of being overweight. I never went back, but I did end up losing weight in college and got to a normal BMI, but I still have an arrythmia.”
- Participant #57: “i've had issues with reproductive health and some of my providers have commented "just gain more weight and you'll be fine" some people (providers and others) have said that i have an eating disorder and have pushed eating disorder treatments (i do not have an eating disorder)”
- Participant #84: “I have struggled with insomnia my entire life. At my first visit with a new doctor, I asked for an updated trazadone prescription. Instead, she ordered a metabolic panel and claimed I was experiencing the onset of diabetes (I was not).”
- Participant #105: “Chronic back pain, gained 15 pounds was told it was due to the weight gain even though according to my bmi i am in the average set of numbers but on the higher end (not overweight) but the pain was there before i gained weight.”
- Participant #1: “I remember some check ups I would ask about some issue I was having and they would usually say it was cause of my weight, like I would say my legs have been aching or have back issues and they say it’s cause of my weight”
- Participant #7: I gained weight after starting antidepressants, but when I expressed issues with not having an appetite and worry about accidental starving, was told clearly not cause I’m “heavier” than I was last appointment”
- Participant #34: “That rapid weight gain was just a result of eating too much and not another condition because my bmi suggests I am slightly overweight (yet my body fat percentage suggests I’m average to almost underweight)”
- Participant #22: “They tell me that if I lose weight, the co-morbidities will go away but they never analyze why I’m overweight in the first place which isn’t based on my lifestyle.”
- Participant #46: “Usually before I would even mention to symptoms of what I would be experiencing they also mentioned losing weight and coming back to them after for further help.”

- Participant #95: “I would say I had an eating disorder in middle school but I was average weight and I was trying to seek help and it was dismissed since I wasn’t underweight”
- Participant #12: “They said that my issues would be solved if I lost weight or were more healthy overall and dismissed me”
- Participant #23: “It was not seen as concerning when I was looking weight rapidly because I was getting “healthier.”
- Participant #99: “I said I hadn’t gotten my period for months after I lost a lot of weight and she dismissed it”
- Participant #86: “because they believe if i lose weight i wont be chronically ill (i have chronic gi problems)”
- Participant #69: “Dismissed concerns of disordered eating because weight had not changed.”
- Participant #2: “I struggle with anxiety but my doctor just tells me to lose weight.”
- Participant #91: “Attributed lack of menstrual cycle to low body fat”
- Participant #32: “Underweight. They thought I was on drugs.”
- Participant #18: “Heart concerns due to underweight”
- Participant #33: “null”
- Participant #5: “null”

Open-Ended Question #2: “If you stated that you have experienced weight discrimination from your medical providers, how did it happen? If there are multiple incidents or locations, please state all that you would like to share with us.”

- Participant #23: “I think it’s complex because I am an overweight person with an eating disorder, so that means that it may look like i’m being healthier but really I am not. Doctors haven’t really approached this the best. I was treated for my eating disorder though an online facility called EquipHealth but I feel like it just made my situation worse because I was forced to think about food way more than I already do. Plus, I wasn’t really showing visible signs of relapsing in their eyes.”
- Participant #11: “It's more so the condescension in their tones and the dismissiveness. Whenever I show that I am making an effort to lose weight, it's always "Well keep up with it, and we'll see if those symptoms persist" or "I understand but you're still not at your target or where you need to be." I feel like they're taking me in circles or not considering my concerns enough. I don't know why they don't understand that I can be overweight but still have issues not caused by weight.”
- Participant #22: “During my preteen years every time I would go to the doctor they would comment on my weight and tell me I needed to lose some, making me anxious about going to the doctor. My parents placed me on a diet as a result and it wasn’t until I was about 16 that they said I showed signs of PCOS which was leading to the weight gain.”
- Participant #69: “As a child the doctor told my mom he had concerns due to my BMI being high. He had not even looked at or spoken with me yet. At the time I had been playing intense sports competitively and had a high % of muscle (which is heavier than fat).”

- Participant #34: “Many side effects I had from other conditions were blamed on my weight such as difficulty breathing, increased heart rate, and fainting. It took years before it shifted from “loose weight” to “you have a heart condition”
- Participant #2: “I experience it the most with my primary care physician. Whenever I go in there they always mention my weight as the reason for any health issue I have.”
- Participant #13: “The cardiologist I mentioned earlier basically refused to run any test or look into what I was describing because of my weight”
- Participant #57: “some providers have dismissed my concerns and have said "eat more" without taking vitals”
- Participant #12: “They dismissed my issues due to my weight.”
- Participant #110: “Saying my weight could go down”
- Participant #28: “I felt unheard”
- Participant #33: “null”
- Participant #5: “n/a”

8. References

Adams, KE; Smith, CH; Wilbur, NJ; Grady, DC. 1993. “The Relationship of Obesity to the Frequency of Pelvic Examinations: Do Physician and Patient Attitudes Make a Difference?” *Women & Health*. Retrieved October 23, 2023 (https://pubmed.ncbi.nlm.nih.gov/8372479/).

Albert, Stephanie L., Rachel E. Massar, Omni Cassidy, Kayla Fennelly, Melanie Jay, Philip M. Massey and Marie A. Bragg. 2024. "Body Positivity, Physical Health, and Emotional Well-being Discourse on Social Media: Content Analysis of Lizzo’s Instagram." *JMIR Formative Research* 8. doi: https://doi.org/10.2196/60541.

Ata, Rheanna N., Alison B. Ludden and Megan M. Lally. 2007. "The Effects of Gender and Family, Friend, and Media Influences on Eating Behaviors and Body Image during Adolescence." *Journal of Youth and Adolescence* 36(8):1024-1037. doi: https://doi.org/10.1007/s10964-006-9159-x.

Brewis, A., Brennhofer, S., van Woerden, I., & Bruening, M. (2016). Weight stigma and eating behaviors on a college campus: Are students immune to stigma's effects?. *Preventive medicine reports*, *4*, 578–584. https://doi.org/10.1016/j.pmedr.2016.10.005

Brown, Ian, Joanne Thompson, Angela Tod and Georgina Jones. 2006. "Primary Care Support for Tackling Obesity: A Qualitative Study of the Perceptions of Obese Patients." *The British Journal of General Practice: The Journal of the Royal College of General Practitioners* 56(530):666-672 https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/scholarly-journals/primary-care-support-tackling-obesity-qualitative/docview/68824163/se-2.

Center for Disease Control. 2024a. “Adult BMI Categories.” *BMI*. Retrieved March 19, 2025 (https://www.cdc.gov/bmi/adult-calculator/bmi-categories.html).

Center for Disease Control. 2024b. “New CDC Data Show Adult Obesity Prevalence Remains High.” *CDC Newsroom*. Retrieved March 19, 2025 (https://www.cdc.gov/media/releases/2024/p0912-adult-obesity.html).

Cleveland Clinic. n.d. “BMI (Body Mass Index): What It Is & How to Calculate.” *Cleveland Clinic*. Retrieved March 19, 2025 (https://my.clevelandclinic.org/health/articles/9464-body-mass-index-bmi).

Cohrdes, Caroline, Claudia Santos-Hövener, Katja Kajikhina and Heike Hölling. 2021. "The Role of Weight- and Appearance-Related Discrimination on Eating Disorder Symptoms among Adolescents and Emerging Adults." *BMC Public Health* 21:1-14. doi: https://doi.org/10.1186/s12889-021-11756-y.

Crampton, Suzanne, and John Hodge. 2012. "Weight in the Workplace: An Employer’s Prerogative Or an Employee’s Right?" *International Journal of Diversity in Organizations,*

Communities, and Nations 11(6):1-10. doi: https://doi.org/10.18848/1447-9532/CGP/v11i06/39055.

Crompvoets, Paige I., Anna P. Nieboer, Rossum Elisabeth F C van and Jane M. Cramm. 2024. "Perceived Weight Stigma in Healthcare Settings among Adults Living with Obesity: A Cross-Sectional Investigation of the Relationship with Patient Characteristics and Person-Centred Care." *Health Expectations* 27(1). doi: https://doi.org/10.1111/hex.13954.

de Man, Lapidoth J., and von Hausswolff-Juhlin Yvonne. 2014. "Eating Disorder Symptoms, Psychiatric Correlates and Self-Image in Normal, Overweight and Obese Eating Disorder Patients." *Eating and Weight Disorders* 19(2):233-240. doi: https://doi.org/10.1007/s40519-014-0112-9.

Dogan, Ozcan, Pinar Bayhan, Arzu Yukselen and Sonnur Isitan. 2018. "Body Image in Adolescents and its Relationship to Socio-Cultural Factors." *Kuram Ve Uygulamada Egitim Bilimleri* 18(3):561-577. doi: https://doi.org/10.12738/estp.2018.3.0569.

Emory University. n.d.a. "Admitted Students: Class of 2028." *Emory University*. Retrieved March 19, 2025 (https://apply.emory.edu/discover/facts-stats/first-year.html).

Emory University. n.d.b "Emory University Facts." Emory.edu. Retrieved March 19, 2025 (https://apply.emory.edu/discover/facts-stats/emory.html).

Flegal, K. M., Carroll, M. D., Ogden, C. L., & Curtin, L. R. 2010. "Prevalence and trends in obesity among US adults, 1999-2008." *JAMA*, *303*(3), 235–241 https://doi.org/10.1001/jama.2009.2014.

Fontaine, K. R., Redden, D. T., Wang, C., Westfall, A. O., & Allison, D. B. 2003. "Years of life lost due to obesity." *JAMA*, *289*(2), 187–193 https://doi.org/10.1001/jama.289.2.187

Frederick, D. A., A. C. Saguy, G. Sandhu and T. Mann. 2016. "Effects of Competing News Media Frames of Weight on Antifat Stigma, Beliefs about Weight and Support for Obesity-Related Public Policies." International Journal of Obesity 40(3):543-549. doi: https://doi.org/10.1038/ijo.2015.195.

Galler, Angela, Angelika Thönnes, Jens Joas, Christine Joisten, Antje Körner, Thomas Reinehr, Markus Röbl, Gerd Schauerte, Wolfgang Siegfried, Daniel Weghuber, Susann Weihrauch-Blüher, Susanna Wiegand, Reinhard W. Holl and Nicole Prinz. 2024. "Clinical Characteristics and Outcomes of Children, Adolescents and Young Adults with Overweight Or Obesity and Mental Health Disorders." *International Journal of Obesity* 48(3):423-432. doi: https://doi.org/10.1038/s41366-023-01449-4.

Golub, S. 1992. "Nurses' Attitudes toward Obese Persons and Certain Ethnic Groups." *Perceptual and Motor Skills*. Retrieved October 23, 2023 (https://pubmed.ncbi.nlm.nih.gov/1408594/).

Greenleaf, Christy, and Karen Weiller. 2005. "Perceptions of Youth Obesity among Physical Educators." *Social Psychology of Education: An International Journal* 8(4):407-423. doi: https://doi.org/10.1007/s11218-005-0662-9.

Hill, Briony, Xochitl D. l. P. Garcia, Joanne A. Rathbone, Zanab Malik, Elizabeth Holmes-Truscott, Blake J. Lawrence, James Kite, Kelly Cooper, Timothy R. Broady and John B. Dixon. 2024. "Supporting Healthcare Professionals to Reduce Weight Stigma." *Australian Journal of General Practice* 53(9):682-685 https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/scholarly-journals/supporting-healthcare-professionals-reduce-weight/docview/3106371015/se-2.

Institute for Health Metrics and Evaluation. 2024. "The Lancet: Without immediate action nearly 260 million people in the USA predicted to have overweight or obesity by 2050." *IHME.* Retrieved April 3, 2025 (https://www.healthdata.org/news-events/newsroom/news-releases/lancet-without-immediate-action-nearly-260-million-people-usa).

Jach, Łukasz, and Sonia Krystoń. 2021. "Self-Reported Body Weight and Weight-Related Stigmatization Experiences among Young Adult women—two Contexts, but Similar Attitudes Related to Body Image, Mental Self-Schemas, Self-Esteem, and Stereotypes of People with Obesity." *PeerJ*. doi: https://doi.org/10.7717/peerj.12047.

Jacob, John, and Jeong-Ju Yoo. 2010. "Adolescent Weight Preoccupation: Influencing Factors and Entertainment Media Exposure." *Journal of Family and Consumer Sciences* 102(2):33-41 https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/scholarly-journals/adolescent-weight-preoccupation-influencing/docview/821709435/se-2.

Jackson, S. E., A. Steptoe, R. J. Beeken, H. Croker and J. Wardle. 2015. "Perceived Weight Discrimination in England: A Population-Based Study of Adults Aged [= Or >, Slanted]50 Years." *International Journal of Obesity* 39(5):858-864. doi: https://doi.org/10.1038/ijo.2014.186.

Janke, E. A., Michelle L. Ramirez, Brittany Haltzman, Megan Fritz and Andrea T. Kozak. 2016. "Patient's Experience with Comorbidity Management in Primary Care: A Qualitative Study of Comorbid Pain and Obesity." *Primary Health Care Research & Development* 17(1):33-41. doi: https://doi.org/10.1017/S1463423615000171.

Kamiński, M., Wieczorek, T., Kręgielska-Narożna, M., & Bogdański, P. 2024. "Tweeting about fatphobia and body shaming: A retrospective infodemiological study." *Nutrition, 125* https://doi.org/10.1016/j.nut.2024.112497.

Kihm, Holly Spencer, PhD,C.C.L.S., C.F.L.E. 2014. "The Friendship Study: An Examination of Weight-Based Stigmatization during the Elementary and Middle School Years." *Journal of Family and Consumer Sciences* 106(2):37-44

Klein, D; Najman, J; Kohrman, AF; Munro, C. 1982. "Patient Characteristics That Elicit

Negative Responses from Family Physicians.” *The Journal of Family Practice*. Retrieved October 23, 2023 (https://pubmed.ncbi.nlm.nih.gov/7077248/).

Kinge, Jonas M. 2017. "Waist Circumference, Body Mass Index, and Employment Outcomes." *The European Journal of Health Economics: HEPAC* 18(6):787-799. doi: https://doi.org/10.1007/s10198-016-0833-y.

National Health Services. 2023. “Measure Your Waist.” *NHS.* Retrieved March 19, 2025 (https://www.nhs.uk/conditions/obesity/).

Olson, CL; Schumaker, HD; Yawn, BP. 1994. Overweight women delay medical care. *Archives of family medicine, 3*(10), 888–892. https://doi.org/10.1001/archfami.3.10.888.

Philip, Samantha R., Sherecce A. Fields, Michelle Van Ryn and Sean M. Phelan. 2024. "Comparisons of Explicit Weight Bias Across Common Clinical Specialties of US Resident Physicians." *Journal of General Internal Medicine* 39(4):511-518. doi: https://doi.org/10.1007/s11606-023-08433-8.

Puhl, R. M., T. Andreyeva and K. D. Brownell. 2008. "Perceptions of Weight Discrimination: Prevalence and Comparison to Race and Gender Discrimination in America." *International Journal of Obesity* 32(6):992-1000. doi: https://doi.org/10.1038/ijo.2008.22.

Rand, AM; Macgregor, CS. 1990. “Morbidly Obese Patients’ Perceptions of Social Discrimination before and after Surgery for Obesity.” *Southern Medical Journal*. Retrieved October 23, 2023 (https://pubmed.ncbi.nlm.nih.gov/2251527/).

Robinson, Kathleen M., Kimberley A. Robinson, Aaron M. Scherer and Melissa L. Mackin. 2024. "Patient Perceptions of Weight Stigma Experiences in Healthcare: A Qualitative Analysis." *Health Expectations* 27(5). doi: https://doi.org/10.1111/hex.70013.

Roehling, Mark V. 1999. "Weight-Based Discrimination in Employment: Psychological and Legal Aspects." *Personnel Psychology* 52(4):969-1016 https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/scholarly-journals/weight-based-discrimination-employment/docview/220138993/se-2.

Russell, Nicola, and Jenny Carryer. 2013. "Living Large: The Experiences of Large-Bodied Women when Accessing General Practice Services." *Journal of Primary Health Care* 5(3):199-205 https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/scholarly-journals/living-large-experiences-bodied-women-when/docview/1429640658/se-2.

Ryan, Leona, Fiona Quigley, Susie Birney, Michael Crotty, Owen Conlan and Jane C. Walsh. 2024. "‘Beyond the Scale’: A Qualitative Exploration of the Impact of Weight Stigma Experienced by Patients with Obesity in General Practice." *Health Expectations* 27(3). doi: https://doi.org/10.1111/hex.14098.

Sari, Nazmi, and Beliz A. Osman. 2018. "The Effect of Body Weight on Employment among Canadian Women: Evidence from Canadian Data." *Canadian Journal of Public Health* 109(5-6):873-881. doi: https://doi.org/10.17269/s41997-018-0097-7.

Schafer, Markus H., and Kenneth F. Ferraro. 2011. "The Stigma of Obesity: Does Perceived Weight Discrimination Affect Identity and Physical Health?" *Social Psychology Quarterly* 74(1):76-97 https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/scholarly-journals/stigma-obesity-does-perceived-weight/docview/917532574/se-2.

Standen, Erin C., Andrew Ward and Traci Mann. 2024. "The Role of Social Norms, Intergroup Contact, and Ingroup Favoritism in Weight Stigma." *PLoS One* 19(6). doi: https://doi.org/10.1371/journal.pone.0305080.

Sohier, Lé, Claudia M. Brearty, Stéphanie LeBlanc, Dominic J. Chartrand, Audrey St-Laurent, Schohraya Spahis, Lé Philibert, Auclair M. Inès, Marie Gagnon-Girouard, Clara Lakritz and Sylvain Iceta. 2025. "Weight Bias among Students and Employees in University Settings: An Exploratory Study." *BMC Public Health* 25:1-9. doi: https://doi.org/10.1186/s12889-025-21922-1.

Stevens, C. 2018. “Fat on Campus: Fat College Students and Hyper(in)visible Stigma.” *Sociological Focus*, *51*(2):130–149. https://www.jstor.org/stable/48546824.

Strauss, Richard S., and Harold A. Pollack. 2003. "Social Marginalization of Overweight Children." *Archives of Pediatrics & Adolescent Medicine* 157(8):746-752 https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/scholarly-journals/social-marginalization-overweight-children/docview/73550153/se-2.

Tayyem, Reema F., Hiba A. Bawadi, Suhad S. Abumweis, Sabika Allehdan, Lana Agraib, Hadeel A. Ghazzawi, Mariam Al-mannai and Abdulrahman O. Musaiger. 2016. "Association between Mass Media and Body Weight Concern among Jordanian Adolescents' Residents of Amman: The Role of Gender and Obesity." *Environmental Health and Preventive Medicine* 21(6):430-438. doi: https://doi.org/10.1007/s12199-016-0543-1.

Thomeczek, Marianna L., Kelsie T. Forbush, Yiyang Chen, Sonakshi Negi, Sarah Johnson-Munguia, Alexa L'Insalata M., Samiya Rasheed, Emily Like and Jacquelyn McDonald. 2024. "Associations between Weight Discrimination, Eating-Disorder-Related Psychiatric Impairment, and Eating-Disorder Treatment Interest Across the Weight Spectrum." *The International Journal of Eating Disorders* 57(11):2292-2298. doi: https://doi.org/10.1002/eat.24277.

Udo, Tomoko, Katherine Purcell and Carlos M. Grilo. 2016. "Perceived Weight Discrimination and Chronic Medical Conditions in Adults with Overweight and Obesity." *International Journal of Clinical Practice* 70(12):1003-1011. doi: https://doi.org/10.1111/ijcp.12902.

Wang, Rong-Ze, Yu He, Yue-Ting Deng, Hui-Fu Wang, Yi Zhang, Jian-Feng Feng, Wei Cheng and Jin-Tai Yu. 2024. "Body Weight in Neurological and Psychiatric Disorders: A Large Prospective Cohort Study." *Nature Mental Health* 2(1):41-51. doi: https://doi.org/10.1038/s44220-023-00158-1.

Webb, Jennifer B., Mallory F. Fiery and Nadia Jafari. 2016. ""You Better Not Leave Me Shaming!": Conditional Indirect Effect Analyses of Anti-Fat Attitudes, Body Shame, and Fat Talk as a Function of Self-Compassion in College Women." *Body Image* 18:5-13. doi: https://doi.org/10.1016/j.bodyim.2016.04.009.

Weiner, B., Perry, R. P., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology*, *55*(5), 738–748. https://doi-org.proxy.library.emory.edu/10.1037/0022-3514.55.5.738

Wetzel, Karen E., and Mary S. Himmelstein. 2025. "Weight Stigma in Gynecological Care among Cisgender Women." *Obesity Science & Practice* 11(1). doi: https://doi.org/10.1002/osp4.70061.

World Health Organization. 2023. “Controlling the Global Obesity Epidemic.” *Who.int*. Retrieved March 19, 2025 (https://www.who.int/activities/controlling-the-global-obesity-epidemic).

World Health Organization. 2024. “Obesity and Overweight.” *Who.int*. Retrieved March 19, 2025 (https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight).

Xie Rong-Zhen, Xu-Song Li,, Fang-Di Zha, Guo-Qing Li, Wei-Qiang Zhao, Yu-Feng Liang & Jie-Feng Huang. "Relationship between Body Mass Index and Low Skeletal Muscle Mass in Adults Based on NHANES 2011–2018."2025. *Scientific Reports (Nature Publisher Group)* 15(1):2596. doi: https://doi.org/10.1038/s41598-025-87176-4.