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Perceptions of Weight Reduction Surgery: The Role of Stigma and the Attribution of Responsibility

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PERCEPTIONS OF WEIGHT REDUCTION SURGERY: THE ROLE OF STIGMA
AND THE ATTRIBUTION OF RESPONSIBILITY

by

Jessica Marie Behm
Bachelor of Science in Criminal Justice Studies, University of North Dakota, 2005

A Thesis

Submitted to the Graduate Faculty

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for the degree of


Master of Arts

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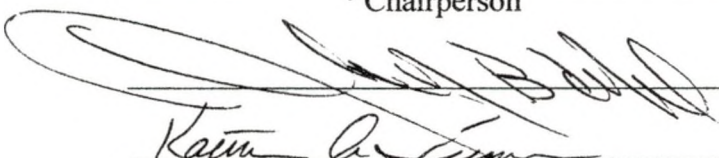
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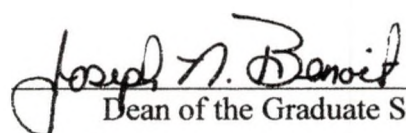


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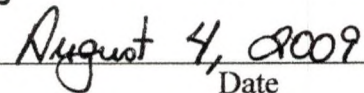


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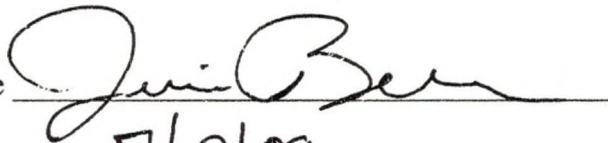
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ABSTRACT

The amount of weight reduction surgeries performed in the United States has increased considerably within the last twenty years. Many people choose to undergo the procedure with the hopes of shedding the negative stigma of being obese and improving their life. The purpose of this study was to investigate how society views individuals who have elected to undergo weight reduction surgery. A questionnaire assessing the influence of three variables (Responsibility, Acceptability, and Stigma) on the perception of weight reduction surgery was developed and administered to 503 Midwestern college students. The respondents were presented with one of two vignettes depicting a character's decision to undergo the surgery. In one vignette, the character indicated that a medical condition was the cause of their obesity and in the other, no medical condition was mentioned. The results revealed that the presence of a medical condition decreased the perceived responsibility for being obese and increased the acceptability of undergoing weight reduction surgery. The results also indicated that respondents who were of normal weight did not have a higher level of perceived stigma when compared to their overweight/obese counterparts. The level of perceived stigma was also found to be higher among respondents who personally knew someone that had undergone weight reduction surgery compared to those who did not. As the amount of surgeries continues to rise, future research on the social and environmental factors surrounding weight reduction surgery will be useful in educating medical providers, insurance companies,

families of patients, and the patients themselves about the ultimate personal and social consequences of undergoing weight reduction surgery.

CHAPTER I

INTRODUCTION

Obesity rates in the United States are at an all time high. From 1960 to 2002, the prevalence of overweight adults increased from 44.8 to 65.2 percent. The prevalence of obesity during the same time period more than doubled among adults from 13.3 to 30.5 percent, with the majority of that increasing in the past twenty years (U.S. Department of Health and Human Services, 2006). This has led many in the medical field to declare that America is having an “obesity epidemic” (Salant and Santry, 2006). Overweight individuals are at a higher risk for many diseases and health conditions, such as type 2 diabetes, heart disease, stroke, and some cancers (Center for Disease Control, 2005). The rise in these chronic conditions affects all members of our society; they lead to an increase in direct health care costs (i.e. physician visits, medication, hospital costs, etc.) as well as economic costs (i.e. wages lost by people unable to work due to illness or disability, strain on corporations due to loss of labor) (U.S. Department of Health and Human Services, 2006).

There is a distinct difference between being “overweight” and being “obese.” Overweight refers to an excess of body weight compared to some set standard while obesity refers specifically to having an abnormally high proportion of body fat (Center for Disease Control, 2005). A person can be overweight without being obese, as in the

case of a body builder or other athlete who has a lot of muscle. However, many people who are overweight are also obese. The most common measure used to distinguish between overweight and obese is the Body Mass Index (BMI). BMI is an index of weight adjusted for the height of the individual. It is the measurement choice used by most obesity researchers and healthcare professionals. The BMI measurement is not gender specific and does not directly measure body fat, but it is a more reliable indicator of being overweight and obese than relying on weight alone (U.S. Department of Health and Human Statistics, 2006).

In 2002, the average BMI for an adult American was 28, which is considered “overweight.” This is an increase from the average measure of 25 in 1960 (Center for Disease Control, 2004). These rising rates have led professionals in the medical and social science fields to question why Americans’ waistlines are increasing. While many in the healthcare field focus on the personal choices of overweight individuals, social scientists highlight that we should direct our attention to the changes in our society since the 1950s.

Sociologists often point out that we have become an increasingly sedentary society within the past forty years. In the 2005 Behavioral Risk Factor Surveillance System study conducted by the CDC, researchers found that over half of Americans did not engage in the recommended minimum amount of physical activity of 30 minutes per day/3 times per week. This lack of physical activity can be due to many other societal changes. The advancement of technology within the past few decades has had a significant impact. The improvements in television, video games, computers and the internet have changed Americans’ definitions of leisurely activities. Instead of engaging

in pastimes of a physical nature like going to the park or playing on the community softball league, the majority of Americans choose to remain in their homes to watch television or surf the internet. One study on the relationship between sedentary behaviors and obesity risks found that each 2 hour per day increment of television watching was associated with a 23 percent increase in the risk of obesity and a 14 percent increase in the risk of diabetes (Hu et al., 2003).

Work related issues also play a part in the inactivity of our society. Prior to the 1950s, jobs often required performing hard, physical labor. Since then we have seen a shift from manual labor, blue collar jobs to more office based, white collar jobs. In the 1950s approximately one third of the U.S. population worked in factories manufacturing everything from clothing to cars. Currently, a little more than one tenth of the population is employed in the same fields (Hagenbaugh, 2002). Instead of lifting heavy objects or working outside for eight hours a day, almost 50 percent of American workers are indoors, sitting at a desk, behind a computer (Columbia Encyclopedia, 2008). In order to get adequate physical activity, individuals are often forced to buy expensive equipment or memberships to health clubs. It used to be that we were paid to exercise at work, now we pay to exercise after work (Lakdawalla et al., 2005).

Not only have the types of jobs changed but the amount of time spent at our jobs has as well. In many industries, standard shifts have been lengthened from eight hours to twelve. The number of people doing shift work, including night and rotating shifts has increased substantially. Many employees are now required to work odd hours or have been reduced to casual, temporary, or part-time work (Josling, 2000). The move of populations into suburban areas has also led to a rise in the amount of time Americans

spend commuting to and from work. A study conducted by the US Census Bureau found that an average daily commute to work was 24.3 minutes in 2004. This amounts to over 100 hours per year that an individual spends sitting in an automobile (US Census Bureau, 2005). Studies have found that each additional hour spent in a car per day was associated with a 6 percent increase in the likelihood of obesity. In contrast, in “walkable” communities, for each kilometer walked there was a 4.8 percent reduction in the likelihood of obesity (Frank et al., 2004).

All of these changes have led to a more stressful and fatigued environment where regular mealtimes and eating habits are disrupted. Many people are too tired or busy to prepare a sit down, homemade meal and increasingly rely on processed, pre-packaged, and easy to cook foods. Fast food restaurants such as McDonald’s, Burger King, and Wendy’s have proliferated within the past forty years. McDonald’s, the largest fast food restaurant in the world, estimates an average of one million American customers per day. The company has also spent an estimated \$2 billion a year in advertisements that promote their food as cheap, tasty, quick, and easily available (Josling, 2000). Fast food may be cheap, convenient, and hard to resist but it also contains high levels of sodium, high fructose corn syrup, oil, low quality carbohydrates, and saturated fat. It also has a very high caloric density; a typical super sized fast food meal can contain 1,600 calories, which is more than most people should eat in an entire day. In one study conducted on the relationship between fast-food habits and changes in bodyweight, researchers found that individuals who eat fast food twice or more a week have a 50 percent greater risk of obesity than do those who eat this way once or less per week (Pereira et al., 2005).

Despite the fact that over half of Americans are overweight our society still promotes and emphasizes the idea of thinness as the pinnacle of health and attractiveness. Overweight individuals are highly stigmatized within our society and are often the victims of discrimination and public ridicule (Carr and Friedman, 2005; Wang et al., 2004). Many studies have found that people associate being overweight with possessing a low level of intelligence, lack of morality, and lower socio-economic status (Puhl and Brownell, 2003; Wang et al., 2004). They are also often seen as lazy, gluttonous, and lacking self-discipline (DeJong, 1980; Wang et al., 2004). Studies have shown that overweight people are less likely to be hired than thin people despite being equally qualified (Roehling, 1999), they receive less financial support for college from their parents compared to thinner siblings (Crandall, 1995), and they are less likely to seek medical care due to fear of judgment by doctors and nurses (Puhl and Brownell, 2003). The stigma associated with being overweight is so intense that many individuals will go to great lengths to prevent gaining weight. In one study researchers found that 24 percent of women and 17 percent of men said they would give up three or more years of their lives to be the weight they want to be; some women reported that they chose not to become pregnant because of fears of fatness; and others assumed the high health risk of smoking in order to remain thin (Puhl et al., 2007).

Along with the high value of being thin, our society also has guidelines on the “appropriate way” to achieve or maintain this type of physique. Many see the traditional diet and exercise method as the acceptable way to lose weight. This has led to a significant increase in the diet and exercise industries within the past 20 years. Today, Americans spend approximately \$40 billion a year on dieting and diet related products

(Soulliere, 2004). The industry promotes “quick”, “easy”, and “convenient” solutions for weight loss that range widely from fad diets like Atkins and South Beach to miracle fat burning pills like Alli and TrimSpa. Commercial structured weight loss programs that emphasize pre-packaged, ready made meals, such as Weight Watchers and Jenny Craig, bring in approximately \$2.1 billion annually (Bonne, 2005). Despite all of the efforts and money spent on dieting products, 95 percent of dieters will eventually re-gain the weight that they have lost and keep returning to the diet industry again and again (Soulliere, 2004).

Aside from the increase in the traditional diet and exercise regime of losing weight, our society has also seen a significant rise in the demands of bariatric weight reduction surgeries. In 1993, 20,000 weight reduction surgeries were performed in the United States. By 2004 this number jumped to 144,000, which is a 600 percent increase in only 10 years (Bariatric Surgery Info, 2006). Weight reduction surgery is usually reserved for individuals who are diagnosed as “morbidly obese.” Morbid obesity refers to patients who are at least 100 pounds over their recommended weight and/or possess a BMI of 40 or greater. Obese individuals (BMI of 30 >) are often eligible for surgery if they possess one or more serious health conditions related to their weight (BannerHealth.com, 2008). The use of bariatric surgery is often regarded as superior to pharmaceutical or behavioral interventions in achieving weight loss and improving overall health (Salant and Santry, 2006). Within the first two years of surgery, a patient can expect lose 50 to 60 percent of their excess weight. This dramatic weight loss can then lead to the improvement or even the elimination of several chronic conditions associated with obesity such as Type 2 Diabetes, High Blood Pressure, High Cholesterol,

Obstructive Sleep Apnea, and Gastroesophageal Reflux Disease (GERD)
(MayoClinic.Com, 2008).

Weight reduction surgeries are commonly performed in two forms: Roux-en-Y Gastric Bypass (RYGB) and Adjustable Gastric Banding (the Lap Band). The RYGB is currently the most common weight loss surgery performed in the United States. This procedure involves surgically reducing the stomach's capacity to intake food. The process begins by dividing the stomach into two compartments by using surgical staples or stitches. The upper compartment or pouch is very small, about 1 to 2 ounces. A Y-shaped section of the small intestines is then detached from the lower, larger compartment and re-routed up to the smaller one (Coulter, 2004). This new, smaller stomach dramatically restricts the amount of food the individual can ingest and calories their body will absorb that, in turn, leads to significant weight loss. The RYGB procedure poses several risks. Individuals who have had RYGB experience nutritional deficiencies due to the re-routing of the small intestines from the duodenum that is where the majority of nutrients are normally absorbed. Patients also experience the process known as "dumping syndrome." Dumping syndrome is due to the bypassing of the pylorus that serves as the gatekeeper between the stomach and intestines. When the pylorus is bypassed, food is rapidly passed through the stomach to the small intestines which often causes diarrhea, nausea, abdominal cramping, rapid heart rate, sweating, weakness, and/or dizziness (Hydock, 2005). Other complications include leaks or rips in sutures (12 percent of patients), abdominal hernias (7 percent of patients), infections (6 percent of patients), pneumonia (4 percent patients), and even death (1-2 percent of patients) (Agency for Healthcare Research and Quality, 2006).

The Adjustable Gastric Banding or Lap Band procedure is the newest weight loss surgery method in the United States. The Lap Band procedure involves positioning a band around the upper section of the stomach. This generates a tiny pouch with a narrow passage down into the remainder of the stomach that aids in the loss of weight by restricting the amount of food intake (Coulter, 2004). This is a less invasive procedure than the traditional RYGB. The stomach and intestines are not surgically cut and then sewn or stapled, thus reducing the risks and recovery time for the patient. The band can later be tightened, loosened, or even removed if desired. Despite the benefits of this procedure, it is still not risk free. Some of the most common surgical complications in Lap Band procedures include bleeding, gastric perforation, food intolerance, and wound infections. Later complications that may occur are band slippage, pouch dilation, band erosion, and dilatation/herniation of the esophagus above the band (Hydock, 2005). Generally, these later complications lead to more corrective surgical procedures, which can be very costly. The average weight loss surgery procedure alone can cost anywhere from \$20,000 - \$40,000 (Pitrowski, 2002). The future costs that may develop for a patient due to complications, more surgeries, illnesses, etc. are unknown and can vary significantly from person to person. Despite the costs and physical hazards of the surgery, many supporters feel that the benefits outweigh the risks (Hellmich, 2004).

The numbers of weight reduction surgeries continue to rise within the United States. The growing popularity of the procedure is evidenced by the influx of specialized bariatric surgery centers, increased media attention through commercial advertisements, and even celebrity endorsements (Salant and Santry, 2006). The normalization of weight loss surgery within our society is very similar to the normalization of cosmetic surgeries

during the 1970s and 1980s. Both types of procedures existed long before they gained widespread popularity through privatization, media, and marketing (Brooks, 2004).

Research on obesity, stigma, and the recent inflation of weight reduction surgery within our society is important. The stigma of being overweight has a powerful affect on a person's life both personally and professionally. Many have weight reduction surgery in the hopes of shedding this negative stigma and improving their life, but is it also possible that the procedure can re-stigmatizes the person? Could they experience a different set of negative attitudes and discrimination? The objectives of my study are to investigate how society views individuals who have elected to have weight reduction surgery.

In this study, I will use sociological theory to examine the relationship between weight stigma, attribution of responsibility, and the acceptability of weight reduction surgery. In Chapter 2, I explain two major theories often utilized within the study of obesity: Stigma and Attribution of Responsibility. By using the theory of Erving Goffman, I will discuss stigma and its three categorized types: tribal, abominations of the body, and blemishes of individual character. I will illustrate why obesity is stigmatized and how its relationship to two of the three categories (body and character) increases its intensity. I will then address the theory known as Attribution of Responsibility and its influence on the stigmatization and prejudice of obesity within American culture. In Chapter 3, I outline the methods used to address my three research questions. In Chapter 4, I discuss the analytical techniques I used as well as provide a detailed report of the findings. Finally, in Chapter 5, I discuss the overall project and its implications to the study of obesity, stigma, and weight reduction surgery.

CHAPTER II

LITERATURE REVIEW

In this chapter I will outline two theories that have often been connected to obesity: Stigma and Attribution of Responsibility.

The Stigma of Obesity

A stigma is a particular characteristic or trait that is deemed undesirable in society. Sociologist Erving Goffman (1963), one of the most influential theorists on the issue of stigma and social identity, defined it as “any personal attribute that is deeply discrediting”(pg. 3). However, he emphasized that it is actually the reactions of others to that attribute that makes it discrediting and not the attribute itself. Certain attributes that hold negative connotations in one setting may elicit a different response in another. Our society establishes guidelines for normality and acceptability and when those guidelines are violated we believe that person to be not quite human. We then treat the individual based on this assumption by applying different variations of discrimination (pg 5).

Being overweight is clearly a stigmatized attribute within our society. Many studies have shown that overweight individuals are devalued and discriminated against in a number of areas. In terms of employment, an overweight candidate is less likely to be hired over a thin candidate, even when they are equally qualified. They also receive fewer wage increases and promotions than their thinner counterparts (Roehling, 1999). In the

educational institution, not only do overweight individuals experience harassment and rejection from their peers, it has been shown that they are subjected to differential treatment based on the negative attitudes of their teachers and administrators (Puhl and Brownell, 2003). This discrimination extends into higher education as well. One study found that overweight individuals had a lower acceptance rate into college and, when in school, had a higher level of wrongful dismissals (Canning, 1966).

One surprising area where weight-based discrimination is prevalent is in the health care setting. According to a study conducted by Puhl and Brownell (2003), negative attitudes about overweight individuals have been found to be held by a broad range of healthcare professionals, including physicians, nurses, psychologists, and medical students. Even those professionals who specialize in treating obesity have been found to hold these types of detrimental attitudes. This has a great affect on the quality of care provided in so much that overweight individuals are reluctant to seek out medical help when needed (Olson et al., 1994).

Goffman emphasizes that it's the attitudes and behaviors of the "normals," those who do not possess the stigma, which lead to the stigmatization of the overweight (pg 5). However, he also illustrates that there are two groups of people who do not engage in the discrimination of the stigmatized known as the "sympathetic others." The first group is composed of the "own" or those who share the stigma. Since these individuals have experienced what it is like to have the particular stigma, they are more understanding, accepting, and willing to offer support (pg 20). People who share a stigma have a tendency to come together into small social groups that provide the stigmatized individual a place to withdraw and find comfort. This is seen throughout the overweight

“community.” Several weight related social groups exist each with their own unique function and ideology. They range from diet and support groups such as Weight Watchers or Overeaters Anonymous to political lobbying groups that emphasize social acceptance such as the National Association to Advance Fat Acceptance (NAAFA).

The second group Goffman discusses is composed of people who possess a special situation that has made them more sympathetic to the stigma. He refers to these individuals as the “wise” (pg 28). The wise are often related to the stigmatized through close, interpersonal relationships such as family members and friends. Due to their close relationships with the stigmatized, the wise are likely to experience “courtesy stigma,” i.e. the same negative attitudes and detrimental treatment as those who carry the stigma; therefore, they are more understanding and sympathetic to the stigmatized person.

Despite the logic surrounding Goffman’s theory on “sympathetic others,” current research has shown that discrimination does exist within the two groups. Many studies have found that negative attitudes about overweight individuals are found within the “wise” group. In a study conducted by Puhl et al. (2007), the researchers discovered that overweight individuals identified close relationship partners, such as friends, parents, or spouses, as the most common source of their stigmatizing encounters. When parents possess negative attitudes towards being overweight they communicate them to their children at a very young age, which leads to serious emotional and health consequences for overweight children (Puhl and Brownell, 2003). In some situations, parents openly treat their overweight children different from other, thinner children. For example, in one study the researchers discovered that parents of overweight children provided them with

less financial support for college than parents of thin children regardless of factors like family size, income, and education (Crandall, 1995).

Even more surprising are the studies which show that this stigma and discrimination extends into the “own” group as well. Several studies designed to measure the influence of one’s own body weight on both implicit and explicit anti-fat bias have found that even though the strength of weight bias decreases as the respondents’ body weight increases, a significant degree of anti-fat bias is still evident even among the most obese individuals. Many overweight respondents showed an implicit preference for thin people relative to fat people as well as stereotyping fat people as lazy compared with thin people (Wang et al., 2004; Schwartz et al., 2006). In another study conducted by Allison et al. (1991), researchers found that anti-fat attitudes were even found to exist among members of the National Association to Advance Fat Acceptance (NAAFA), a group of obese individuals who strive to end size discrimination across the United States.

The level of discrimination a person experiences is often related to the type of stigma they possess. Goffman (1963) categorized stigma into three types: “tribal stigmas,” which is a membership in any disadvantaged or despised racial, ethnic, or religious group; “abominations of the body,” which refers to any physical deformity; and “blemishes of individual character,” which occurs when an individual possesses a character trait that is considered unacceptable (pg.4). The visibility of a stigma is central to its propensity for discrimination. Some stigmas can be easily concealed from others, particularly certain tribal and character stigmas such as religious affiliation, criminal behavior, mental illness, etc. Abominations of the body are not as easy. Although there are some cases where they can be hidden, the physical aspect of bodily stigmas generally

makes them harder to hide. For example, burn scars can be easily concealed on someone's back as opposed to if they were on their face.

Unlike most stigmas, obesity does not fall neatly into just one of Goffman's three categories. "Tribal stigmas" are generally related to membership in a religious, racial, or ethnic group. The connection of obesity to membership within a group can be made, such as the international stereotype that all Americans are overweight; however, being overweight is generally not seen as a tribal stigma. Since weight is a physical trait, it obviously falls into the category of "abominations of the body." In America, possessing a body type that carries excess weight is considered unattractive, unhealthy, and highly undesirable. As a result, overweight individuals elicit negative reactions and stereotypes from others just based on its visually displeasing qualities (Crocker et al., 1993).

Although reactions to other bodily stigmas are generally restricted to the visual features, overweight individuals are further judged as having a "blemish of individual character." Character stigmas bring with them an extra element of prejudice. While bodily stigmas do not always elicit negative responses from others, character stigmas are often explicitly derogatory (Langer et al., 1976). Overweight individuals are frequently seen as lazy, gluttonous, and lacking self-discipline (Abrams, 2004; DeJong, 1980; Marantz Henig, 2006; Wang et al., 2004). The negative judgments extend beyond the individual's personal efforts as well. Studies have found that people associate being overweight with unintelligence, lack of morality, and lower socioeconomic status (Abrams, 2004; Puhl and Brownell, 2003; Wang et al., 2004).

These negative attitudes towards overweight individuals are deeply ingrained within American culture. In a study conducted by Richardson et al. (1961), the

researchers presented a group of 10 and 11 year olds with six drawings. Each depicted a child with one of the following characteristics: no physical handicaps; crutches and a leg brace; sitting in a wheelchair; missing a hand; facial disfigurements; and obesity. The children were then asked to rank the pictures in order of which one they liked best. The test was conducted with six different groups of children and although the rank order varied slightly in each group, two of the drawings consistently held the same positions: the drawing of the child with no physical handicaps was always ranked first and the obese child was always ranked last. This study was effective in not only showing that negative attitudes and discrimination against overweight individuals exist but that they also emerge at a very early age.

In another study conducted by Crandell and Martinez (1996), the researchers compared the level of anti-fat attitudes found within American culture to those found within Mexican culture. A questionnaire was administered to 406 university students in Mexico and the United States. The questionnaire measured three components/factors of anti-fat attitudes: 1) Dislike – a general evaluative scale, 2) Fear of Fat - an individual's concerns about weight and fat's self-relevance, and 3) Will power – the subjects' beliefs about the controllability of weight and fat (Crandall, 1994). The results of the survey showed that anti-fat attitudes were significantly lower in Mexico than in the United States. American students expressed a greater general dislike of fat people and a higher rate of fear of being fat compared to Mexican students. The U.S. participants were also more likely to agree that fat people have little will power and their weight is the result of their own behaviors. The researchers pointed out that this viewpoint is likely due to the strong beliefs concerning self-determination and self-control found within U.S. culture.

This may lead Americans to ignore or distort the scientific evidence that fatness is largely a matter of physiology and genetics and to emphasize the controllable factors of diet and exercise (Crandall and Martinez, 1996).

Body Weight and the Attribution Theory

As the Crandall and Martinez (1996) article illustrated, attribution of responsibility has a significant influence on the stigmatization and prejudice of overweight individuals within American culture. Attribution theory suggests “people attempt to search for information that determines the causes of uncertain outcomes” (Puhl and Brownell, 2003:215). Psychologist Fritz Heider (1958) laid the groundwork of Attribution theory in his book *The Psychology of Interpersonal Relations*. He believed that all behavior is determined by either external or internal factors. External attribution occurs when the causality of the behavior is assigned to an outside factor or agent that is beyond the individual’s control. Internal attribution occurs when the causality of the behavior is assigned to an inside factor within the individual’s control. Bernard Weiner (1986) expanded this theory and focused on the emotional and behavioral consequences of the attribution process. He identified a three-step process individuals follow when they approach a person with a stigmatized condition or behavior. First, they observe the behavior or stigma. Second, they judge the deliberateness of it, i.e. whether or not the behavior or stigma is caused by an internal or external force. Finally, they form their reactions to the person and adjust their behavior accordingly (Badahdah, 2007).

There are several types of stigmas that exist within our culture; however, none of them are associated to the attribution of responsibility more than body weight. Despite the overwhelming amount of evidence that suggests body weight is largely determined by

a combination of biological and environmental factors, there is still a pervasive belief that individuals are personally responsible for being overweight (Puhl and Brownell, 2003). Many see weight as an aspect of personal control and when an individual is overweight it is associated with personal laziness and lack of self-discipline (Crandall and Martinez, 1996; Wang et al., 2004).

Studies have found that when someone is perceived to be at fault for their weight they are degraded and discriminated against by others. In a study conducted by Weiner et al. (1988), the researchers examined the controllability (responsibility) and stability (reversibility) of 10 different stigmas: AIDS, Alzheimer's disease, blindness, cancer, child abuse, drug addiction, heart disease, paraplegia, Vietnam War syndrome, and obesity. Each stigma was presented to the subjects with accompanying information revealing that its onset was controllable by the stigmatized person. They were asked to rate each individual on 5 variables: liking, pity, anger, charitable donations, and personal assistance. They found that mental-behavior or "character" stigmas (including child abuse, drug abuse, AIDS, Vietnam War syndrome, and obesity) were perceived as controllable and evoked feelings of anger, less sympathy, attributions of negative personality characteristics, and low ratings of helping tendencies. Physical or "body" stigmas (Alzheimer's disease, blindness, cancer, heart disease, and paraplegia) were perceived as uncontrollable and received more positive ratings. Surprisingly, even though obesity is clearly a physical condition, it was still perceived to be similar to socially deviant stigmatizing conditions such as child abuse and drug addiction.

As the previous study showed, the ideology that weight is controllable and influenced completely by personal choice has a dramatic effect on the way overweight

individuals are viewed by others. However, there have been several studies that emphasized the medical aspect of being overweight and how it affects personal attitudes towards the stigma. In a study conducted by Crandell (1994), he attempted to persuade subjects that fatness was not caused by a lack of self-control but was rather a matter of uncontrollable physiological and genetic factors. The subjects were divided into two groups: the persuade group and the control group. Subjects in the persuade group were given a two page message that stressed the genetics of weight control. The control group was given a two page message concerning the role of psychological stress on illness. This message was similar in psychobiological content and length but made no references to weight. After each group read through their messages, they were given a survey composed of two kinds of questions: 10 true and false factual questions on the content of the message and 10 opinion items answered on a 0-9 Likert scale. The questions were then analyzed according to three anti-fat attitudes: Will power, Dislike, and Fear of fat. The results showed that those individuals in the “persuade” group scored lower than the control group in both the Will power and Dislike dependent measures. This suggests they were in fact persuaded by the arguments that weight was attributed to biological/genetic (external) factors and not a lack of personal control (internal factors), which lead them to display less anti-fat attitudes towards overweight individuals than the control group.

Another study that addressed the issue of medical conditions and weight was conducted by DeJong (1980). He performed experiments to examine how adolescent girls’ opinions of an obese peer were influenced by their beliefs about her cause of obesity. The subjects were each given a folder containing a picture of a girl and a brief statement of introduction. Half of the subjects received a folder that contained a picture

of an obese girl and the other half received a folder with a picture of a normal weight girl. In the statements that accompanied the folders, half the subjects were told that the girl had a thyroid condition and in the other half no thyroid condition was mentioned. The statements were randomly distributed which resulted in four combinations: Obese girl/Non-Thyroid, Obese Girl/Thyroid, Normal weight girl/ Non-thyroid, and Normal weight girl/Thyroid. When the girl was obese the thyroid condition was the cause of her weight. When the girl was normal weight the thyroid condition was said to be the cause of her extremely pale skin. Each of the subjects was given a questionnaire that asked them to rate the girl on seven traits. Three traits were associated with self-control: self-indulgence, self-discipline, and laziness. Four of the traits were associated with personality dimensions: happiness, friendliness, warmth, and self confidence. They were also asked three questions that included measures of liking: 1) Do you think you would like this person?, 2) If you met this person at a party or in a class, do you think you would become close friends?, and 3) Do you think you would want to introduce this person to your friends? The researchers found that the overweight/ non-thyroid girl had the lowest ratings on all measures and the normal weight/non-thyroid girl had the highest ratings. This showed that the obese girl was more positively evaluated and better liked when her obesity was beyond her control due to her thyroid condition. However, both the obese girls (thyroid and non-thyroid) were still ranked less on all measures than both the normal weight girls.

In summary, several studies have been successful in showing the existence of weight stigma and its relation to perceived personal responsibility. Studies such as the ones conducted by Crandell (1994) and DeJong (1980) took it a step further by

investigating the influence diagnosed medical conditions play on one's perception of overweight individuals. Despite the multitude of studies on obesity, stigma, and attribution of responsibility, none have yet to examine these theories in the context of weight reduction surgery. The significant growth in the U.S. overweight population and the simultaneous rise in weight reduction surgeries have compelled me to address these issues.

CHAPTER III

METHODOLOGY

The objective of this study is to assess student perceptions of people who have elected to undergo weight reduction surgery. The study also examines the relationship between stigma, attribution of responsibility, and acceptability of weight reduction surgery. I will address the following hypotheses: 1) When a medical condition for being overweight is present, perceived personal responsibility will be lower than when no medical condition is present, 2) When a medical condition for being overweight is present, perceived acceptability of weight reduction surgery will be greater than when no medical condition is present, 3) The perceived stigma of undergoing weight reduction surgery will be higher among “normals” than among the “wise” and “own” groups.

The data for the study were collected through online questionnaires. There were 548 participants recruited from three classes offered at a Midwestern university. This sample was selected for the study based strictly on their availability to the researcher. The questionnaires were hosted by SurveyMonkey.com, a professional online survey tool that assists individuals in the design, collection, and analysis of survey data. All of the subjects were provided with a URL link by their professor or teaching assistant during their regularly scheduled class time. The students were recruited on a voluntary basis; they were not required by their professor or teaching assistant to complete the survey nor were they offered any compensation for participating in the project.

Vignettes were used as the core methodology within the surveys. Vignettes are “short descriptions of a person or social situation which contain precise references to what are thought to be the most important factors in the decision-making or judgment-making process” (Alexander and Becker, 1978:94). I used this method because vignettes have proven to be a very successful tool in assessing the attitudes of survey respondents (Schoenberg and Ravdal, 2000). They can be easily modified to be consistent with the research topic; the story-telling nature of the vignette is relaxing, pleasant, and interesting; and since the vignettes contain a fictitious character follow up questions can obtain information beyond the respondent’s personal situation (Schoenberg and Ravdal, 2000). Four vignettes were used in the survey, each described a character who had one of the following elective procedures: Gastric Bypass Surgery, Rhinoplasty (Nose Surgery), Otoplasty (Ear surgery), or Cosmetic Dentistry. The survey was initially developed for a larger project; hence, the three additional procedures. However, for this study I only focus on the responses to the Gastric Bypass Surgery vignettes. For each procedure there were two separate vignettes: one in which the character identified a medical cause for having the procedure and another in which no medical cause was discussed. (The vignettes can be found in Appendix A). Each vignette was carefully written. The characters were gender neutral to prevent bias from the respondents. To ensure the accuracy of each vignette, both the medical and non-medical versions were written almost identically. The only difference that existed within the stories surrounded the medical cause that influenced the character’s decision to have the procedure. Also, when these medical causes were introduced in the story, it was done nonchalantly so as not to draw attention away from the “main theme”, the surgery itself.

groups were “sympathetic others” and did not engage in the mistreatment of the stigmatized. This study was successful in examining whether membership in the three groups had any effect on the perceived stigma of undergoing weight reduction surgery. The initial hypothesis was that those who were not overweight (“normals”) would have a higher level of perceived stigma than those who were (“own”). The results of study showed that this was not an accurate assumption. Even though the level of stigma was slightly higher among the “normals” group, it was not a statistically significant difference. This counters Goffman’s original theory that people who possess the same condition are more sympathetic than those who do not. The same result was found between the “normals” and the “wise” groups. The initial belief was that the perceived level of stigma would again be higher among the “normals” than among those who knew someone who had undergone gastric bypass surgery (“wise”). Surprisingly, the results of the analysis showed that the level was actually higher among the “wise” than the “normals.” Although both results contradicted Goffman’s original theories on the “sympathetic others,” they did correspond with the findings of other research that tested his theory. Studies have shown that there is a level of anti-fat bias among people who are overweight (Allison et al., 1991; Wang et al., 2004; Schwartz et al., 2006). It has also been documented that many overweight individuals identified members of their “wise” groups (friends, parents, and spouses) as the most common source of their stigmatizing encounters (Puhl et al., 2007). This internalization of negative attitudes is not uncommon among stigmatized groups. Studies have been successful in identifying latent prejudices that exist among several stigmatized groups, such as HIV/AIDS patients, the mentally ill, and Gays and Lesbians (Boyd, 2003; Herek et al., 1998; Simbayi et al., 2007).

These findings imply that Goffman's theories on the relationship between the stigmatized individuals and the "sympathetic others" are incorrect; however, perhaps the question that should be asked is "Does the 'sympathetic others' theory apply to all stigmas?" It could be possible that the traditional groups of "sympathetic others" still engage in some negative treatment of individuals who possess stigmas which are viewed to be detrimental to their health or the health of others. It is reasonable to assume that close family members or friends of someone who is morbidly obese may not be as understanding and supportive of the condition because of concern for the person's well being. This may also be said of other health related stigmas such as drug abuse and alcoholism. While this cannot be confirmed through this research study, it would be a significant question to investigate further.

Limitations

One limitation of this study is the use of a convenience sample. The sample for this study was composed of 503 Midwestern college students. Ninety-four percent of the sample was Caucasian with an average age of 19 years old. This is obviously not an accurate representation of the general population. Therefore, this should be considered when interpreting the findings. Even though some studies have found a difference in the level of weight prejudice between children and adults, no studies have been able to show difference between the younger and older adult groups (Puhl and Brownell, 2003; Latner et al, 2005; Wang et al, 2004). Therefore, the young average age of the sample should not affect the overall results of the study. The same does not hold true for socioeconomic status (SES) and race/ethnicity. Some studies have shown the existence of a relationship between obesity prejudice and SES. Individuals with a higher SES are less likely to be

overweight and more likely to possess obesity prejudice than those with a lower SES (Sobel and Stunkard, 1989). Even though college students are generally not considered to be at the higher end of the socioeconomic scale, their ability to afford a higher education does indicate that they are not at the very bottom either. Whether that affects their level of prejudice to obesity is unknown and cannot be tested from this study; however, it is still possible and may affect the results. Several studies have also shown that there is a difference in terms of anti-fat attitudes between Caucasian Americans and those of different racial and ethnic backgrounds. Generally, Caucasian Americans have a higher level of anti-fat attitudes when compared to minorities and other nationalities (Crandell, 1994; Crandell and Martinez, 1996; Crandell et al., 2001). Culture and its effects on internalized stigma towards body weight have been documented through many studies. It has often been shown that African American, Hispanic, and Asian cultures have a less stigmatizing view of body weight when compared to Anglo cultures (Akan and Grilo, 1994; Cash and Henry, 1995). If this sample had been representative of a more diverse racial and ethnic background, then the results of the study could have been very different.

Another limitation to the study involves the measurement of the stigma index. There is some question as to whether it is measuring the perceived stigma of being a weight loss surgery patient or if it is measuring the stigma of the obesity condition. The index was composed of the following questions: 1) This person will be treated more positively after having the procedure; 2) This person will be more accepted by others after having the procedure; and 3) This person will have a better life after having the procedure. Even though there is no specific reference to weight loss in the questions, all of them refer to the character's condition post surgery. Also, at the end of both versions

of the vignettes, the character specifically talks about his/her 150 pound weight loss and the benefits associated with it. Therefore, it is reasonable to assume that the respondents viewed the question in terms of the weight loss than of the actual surgery itself.

Unfortunately, there is no way to know the thought process of each respondent as they answered the questions; so, the chance that the question was answered in reference to the surgery itself is still a possibility.

The issue of the stigma index measurement may also lead to another limitation within the study. If the respondents viewed the questions in terms of the surgery itself, then the analysis between the “normals” and “own” groups would technically be wrong. If the study followed Goffman’s literal definition of each group, then the “normals” and the “own” groups should have been composed of those who had undergone weight reduction surgery themselves and those who did not. Unfortunately, out of the 503 respondents there was only one who had reported having had gastric bypass surgery. This would clearly not be a large enough sample with which to conduct an analysis; therefore, the variables were grouped by BMI scores. If the index was correct in measuring the level of stigma of the obesity condition, then the two original classifications would be correct and the analysis results would be more accurate.

One final limitation which should be mentioned concerns the “wise” variable. According to Goffman’s definition, the “wise” are people who possess some unique situation that makes them more sympathetic to the stigmatized individual. He also highlighted that they are often related to the stigmatized through close interpersonal relationships such as family members and friends. The “wise” variable was created using the question, “Do you know anyone who has had any of the following procedures?” The

respondents who acknowledged that they knew someone who had undergone gastric bypass surgery were grouped as the “wise”; all other respondents were grouped as “normals.” A follow up question then asked the respondents to indicate their relationship to this person (close family member, extended family member, friend, significant other, acquaintance, friend of a friend, or other). However, in the situation where multiple procedures were selected, the follow up question did not address each individual procedure. For example, one respondent may have indicated that they knew people who had undergone “gastric bypass surgery” and “rhinoplasty” but the follow up question did not ask the respondent to indicate their relationship to each surgery patient separately. So, if the respondent selected “family member” and “acquaintance”, it is impossible to connect which personal relationship was associated to which procedure. Therefore, it is possible that many of the respondents who were classified as the “wise” may not have had a close, interpersonal relationship to the gastric bypass surgery patient at all, which would not be an accurate representation of Goffman’s definition. The lack of a close relationship to the gastric bypass surgery patient may have affected the respondent’s attitudes towards the procedure and thus should be taken into account when reviewing the results.

Conclusions

Attribution of responsibility and stigma are two important theories often used in obesity research. In this study these theories were applied to the issue of weight reduction surgery. As the results have shown, the presence of a medical condition for being obese affects the perceived personal responsibility for the condition as well as the acceptability of weight reduction surgery. The relationship one has with the stigmatized condition was

also found to have an impact on how weight reduction surgery patients will be perceived by others. Many have weight reduction surgery in the hopes of shedding negative obesity stigma and improving their lives; however, as this study has shown, there are other factors that may influence whether a person will lose the stigma completely. By being labeled as responsible for their obesity, some weight loss surgery patients may still experience negative attitudes from others because of their decision to have the procedure.

The rise of obesity rates in the United States is a popular topic in the field of social science research; yet, current research concerning weight reduction surgery has generally been conducted in the medical and health care fields. In order to truly understand this issue one must examine the surrounding social and environmental factors. There are many ways in which this topic can be examined in the social context. In this study, the analysis focused on the viewpoints of those who had not undergone the procedure; however, relevant information can come from analyzing those who have personally experienced the effects of obesity stigma and the ramifications of undergoing weight reduction surgery. There are many unanswered questions that should be addressed in further research. Is the procedure eliminating an incurable disease or is it medicalizing a deviant behavior? Is someone electing to have the procedure because of genuine health concerns or are they trying to adhere to some social standard of beauty? What are the positive and negative effects to an individual's personal and social relationships after having the procedure? As the amount of surgeries continues to rise, research on these questions will be useful in educating medical providers, insurance companies, families of patients, and the patients themselves about the ultimate personal and social consequences of undergoing weight reduction surgery.

APPENDICES

APPENDIX A Vignettes

Gastric Bypass Surgery

Medical:

For as long as I can remember, I have struggled with my weight. As a child I was always the heaviest kid in my grade. The problems with my weight continued to get worse as I became older. In college I ballooned up to almost 350 pounds. I've made several attempts to lose weight throughout my life. I've been on every diet imaginable; Weight Watchers, Jenny Craig, Slim Fast, the South Beach Diet, Atkins, etc. Over the years I met with nutritionists and worked out with personal trainers but I still wasn't losing weight. I finally went to see my doctor. She told me that my weight gain was a combination of my genetics as well as a condition known as hypothyroid. Hypothyroid occurs when the thyroid does not produce enough metabolic hormones, so my metabolism is incredibly slow. I was put on medication to regulate my thyroid for almost a year but it had only a minor affect on my weight loss. During that year, I also developed type 2 Diabetes and became increasingly frightened about my health. So, in April of 2005, I decided to have Gastric Bypass Surgery (GBS). Gastric Bypass Surgery is a procedure where the stomach is reduced to the size of an egg which helps an individual regulate their food intake. Since having my surgery, I have lost 150 pounds. I'm eating healthier and exercising more. Also, my medication has finally become successful at regulating my thyroid and my diabetes is not an issue anymore. I feel better and look better too.

Non-Medical:

For as long as I can remember, I have struggled with my weight. As a child I was always the heaviest kid in my grade. The problems with my weight continued to get worse as I became older. In college I ballooned up to almost 350 pounds. I've made several attempts to lose weight throughout my life. I've been on every diet imaginable: Weight Watchers, Jenny Craig, Slim Fast, the South Beach Diet, Atkins, etc. Over the years I met with nutritionists and worked out with personal trainers but I still wasn't losing weight. I finally went to see my doctor. She ran some tests and found that there were no physical restrictions on my body's ability to lose weight. So, I started to look into other weight loss options and I decided to have Gastric Bypass Surgery (GBS). It's been almost two years since I had the surgery and I have already lost 150 pounds. The weight seemed to just melt off. Since the surgery reduced my stomach to the size of an egg, I am physically incapable of eating too much food. So, I still eat the majority of the foods I love, but in much smaller portions. Since the surgery, I've been eating healthier and I'm more physically active than before. Now, I'm thinner and happier.

Rhinoplasty

Medical:

When I was seven years old, I broke my nose when I fell off my bicycle and it was never the same after that. As I grew up, I noticed that my nose was slightly crooked and had a small bump on its' ridge. I became incredibly self conscious because of it. My nose didn't look like anyone else's. Plus, it wasn't something I could easily hide from people. Since it was right on my face, I felt like it was the first thing people noticed about me. I always wanted to have a nice, shapely nose like the ones on TV and in magazines. I also experienced some minor breathing problems due to a deviated septum. When I tried to inhale through my left nostril, it just made a strange squeaking sound. This caused me to breathe excessively through my mouth and put extra stress on my right nostril. I would suffocate if I couldn't breathe through my mouth. Every morning when I woke up, my mouth was bone dry from breathing through it all night. I also got winded easier than I should have when I exercised because I was unable to get enough oxygen through my nose. After twenty years of experiencing this discomfort, I decided to have rhinoplasty surgery (i.e. a nose job). The plastic surgeon that performed my surgery was able to re-open my left nostril so I could breathe easier. He also re-aligned my nose and removed the bump so now my nose is straighter, smaller, and much more attractive.

Non Medical:

Around the time I hit puberty, my nose started to develop a hump on the bridge of it. My Dad always had a "generous" nose himself and it became apparent that I had inherited it. The older I got, the bigger my nose got. The hump became much more pronounced and I noticed that it was slightly crooked. Even though I had never experienced any physical problems with my nose (i.e. breathing problems, headaches, etc.), the size and shape of it really affected my self esteem. My nose didn't look like anyone else's. Plus, it wasn't something I could easily hide from people. Since it was right on my face, I felt like it was the first thing people noticed about me. I always wanted to have a nice, shapely nose like the ones that I saw on TV and in magazines. So, I decided to have rhinoplasty surgery (i.e. a nose job). I originally hoped that my insurance would cover the procedure but since it was only for cosmetic reasons, they refused. So, I saved up my money and paid for the surgery myself. It's been approximately six months since my surgery and I'm pleased with my results. The bump is gone and my nose is now straight. I look much better than I did before.

Otoplasty

Medical:

I was born with a congenital ear deformity commonly known as "lop ear". Basically, the top of my left ear was folded down and forward. This condition caused me a lot of problems throughout my life. The fold in the ear was very uncomfortable and I found it difficult to sleep on that side of my head. It also caused quite a bit of emotional trauma for me growing up. I was often teased and ridiculed by other kids and classmates. After years of dealing with the discomfort and embarrassment, I decided to have otoplasty (ear) surgery. The procedure involved bending back the top of my ear and

securing it against my head. Since having the surgery I've felt much better. I no longer have discomfort from the bent ear and my self esteem has increased significantly.

Non-Medical:

I inherited my large, protruding ears from my family. I didn't really start to notice my ears until I was in grade school. I was often teased and ridiculed by other kids and classmates. The nicknames and derogatory jokes continued on throughout my teenage years. I tried everything to hide my ears. I wore hats or covered them with my hair but it never seemed to work. Back then I always wanted to have my ears fixed but my family could never afford the surgery. My parents tried to have their insurance company cover some of the costs but since there was nothing medically wrong with my ears, the company refused. So, I put off fixing my ears until I was able to save up the money. After years of waiting, I finally had otoplasty (ear) surgery. During the procedure, the doctor literally pinned my ears back to my head with a few stitches. It's been almost six months since my surgery and I've never been happier. I feel much more confident and attractive.

Cosmetic Dentistry

Medical:

My story starts as a passenger in a car accident with a huge wooden object in the road (apparently fallen off of a truck). My injuries were substantial including a broken wrist, knee, and many facial damages including several broken and chipped front teeth. As soon as I was discharged from the hospital, I went to see my dentist. We reviewed several options and concluded that the best option for repairing my teeth were porcelain veneers. Porcelain veneers are thin porcelain shells that are bonded onto the existing teeth. Not only are they strong and durable, they also provide a nice, straight, white smile. The procedure only took a few hours and I was thrilled with the results. If you saw me now you wouldn't be able to tell that I was in a car accident. In fact, I think that my teeth and smile actually look better now than they did before the accident. I'm very satisfied with the procedure.

Non-Medical:

My teeth have been dramatically crooked since I was a child. I always felt awkward about them. In pictures I would try not to show my teeth when I smiled. When I laughed, I would cover my mouth with my hand so no one could see my teeth. Everyone told me that I was being unreasonable and my teeth were not that bad but I still felt uncomfortable. When I was a teenager, I begged my parents for braces but they could not afford them. As I grew older, I resigned myself to the idea that I would never get my teeth fixed. One day I mentioned to my dentist that I was unhappy with my teeth but I felt too old for braces. He suggested that I get porcelain veneers. Porcelain veneers are thin porcelain shells that are bonded over the existing teeth. I decided to have the procedure and I've never been happier. Within a few hours, the dentist completely transformed my teeth. Now I have straight, white teeth and great smile.

APPENDIX B
Survey – Version 1

- 1) What is your gender?
 - a. Male
 - b. Female

- 2) How old are you? _____

- 3) How would you rate your overall health?
 - a. Excellent
 - b. Good
 - c. Fair
 - d. Poor

- 4) What is your race/ethnicity?
 - a. Caucasian/White
 - b. Black
 - c. Hispanic
 - d. Asian
 - e. Native American
 - f. Other
 - g. Prefer not to answer

- 5) What is your major? _____

Vignette #1: Otoplasty

I inherited my large, protruding ears from my family. I didn't really start to notice my ears until I was in grade school. I was often teased and ridiculed by other kids and classmates. The nicknames and derogatory jokes continued on throughout my teenage years. I tried everything to hide my ears. I wore hats or covered them with my hair but it never seemed to work. Back then I always wanted to have my ears fixed but my family could never afford the surgery. My parents tried to have their insurance company cover some of the costs but since there was nothing medically wrong with my ears, the company refused. So, I put off fixing my ears until I was able to save up the money. After years of waiting, I finally had otoplasty (ear) surgery. During the procedure, the doctor literally pinned my ears back to my head with a few stitches. It's been almost six

months since my surgery and I've never been happier. I feel much more confident and attractive.

Questions	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1) I think this person made a good choice:	1	2	3	4	5
2) If I were in this situation, I would do the same thing:	1	2	3	4	5
3) This individual's problem was beyond their control:	1	2	3	4	5
4) This person will be treated more positively after having the procedure:	1	2	3	4	5
5) This person had no other options besides the surgery:	1	2	3	4	5
6) I feel that this person had the surgery done for the right reasons:	1	2	3	4	5
7) This person will be more accepted by others after having the procedure:	1	2	3	4	5
8) This person should have looked for other options besides the surgery:	1	2	3	4	5
9) This person will have a better life after having the surgery:	1	2	3	4	5

Vignette #2: Gastric Bypass Surgery

For as long as I can remember, I have struggled with my weight. As a child I was always the heaviest kid in my grade. The problems with my weight continued to get worse as I

became older. In college I ballooned up to almost 350 pounds. I've made several attempts to lose weight throughout my life. I've been on every diet imaginable; Weight Watchers, Jenny Craig, Slim Fast, the South Beach Diet, Atkins, etc. Over the years I met with nutritionists and worked out with personal trainers but I still wasn't losing weight. I finally went to see my doctor. She told me that my weight gain was a combination of my genetics as well as a condition known as hypothyroid. Hypothyroid occurs when the thyroid does not produce enough metabolic hormones, so my metabolism is incredibly slow. I was put on medication to regulate my thyroid for almost a year but it had only a minor affect on my weight loss. During that year, I also developed type 2 diabetes and became increasingly frightened about my health. So, in April of 2005, I decided to have Gastric Bypass Surgery (GBS). Gastric Bypass Surgery is a procedure where the stomach is reduced to the size of an egg which helps an individual regulate their food intake. Since having my surgery, I have lost 150 pounds. I'm eating healthier and exercising more. Also, my medication has finally become successful at regulating my thyroid and my diabetes is not an issue anymore. I feel better and look better too.

Questions	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1) I think this person made a good choice:	1	2	3	4	5
2) If I were in this situation, I would do the same thing:	1	2	3	4	5
3) This individual's problem was beyond their control:	1	2	3	4	5
4) This person will be treated more positively after having The procedure:	1	2	3	4	5
5) This person had no other options besides the surgery:	1	2	3	4	5
6) I feel that this person had the surgery done for the right reasons:	1	2	3	4	5
7) This person will be more accepted by others after having the procedure:	1	2	3	4	5
8) This person should have looked for other options besides the surgery:	1	2	3	4	5

Questions (Cont.)	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
9) This person will have a better life after having the surgery:	1	2	3	4	5

Vignette #3: Rhinoplasty

Around the time I hit puberty, my nose started to develop a hump on the bridge of it. My Dad always had a “generous” nose himself and it became apparent that I had inherited it. The older I got, the bigger my nose got. The hump became much more pronounced and I noticed that it was slightly crooked. Even though I had never experienced any physical problems with my nose (i.e. breathing problems, headaches, etc.), the size and shape of it really affected my self esteem. My nose didn’t look like anyone else’s. Plus, it wasn’t something I could easily hide from people. Since it was right on my face, I felt like it was the first thing people noticed about me. I always wanted to have a nice, shapely nose like the ones that I saw on TV and in magazines. So, I decided to have rhinoplasty surgery (i.e. a nose job). I originally hoped that my insurance would cover the procedure but since it was only for cosmetic reasons, they refused. So, I saved up my money and paid for the surgery myself. It’s been approximately six months since my surgery and I’m pleased with my results. The bump is gone and my nose is now straight. I look much better than I did before.

Questions	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1) I think this person made a good choice:	1	2	3	4	5
2) If I were in this situation, I would do the same thing:	1	2	3	4	5
3) This individual’s problem was beyond their control:	1	2	3	4	5
4) This person will be treated more positively after having the procedure:	1	2	3	4	5
5) This person had no other options besides the surgery:	1	2	3	4	5
6) I feel that this person had the surgery done for the right reasons:	1	2	3	4	5

Questions (Cont.)	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
7) This person will be more accepted by others after having the procedure:	1	2	3	4	5
8) This person should have looked for other options besides the surgery:	1	2	3	4	5
9) This person will have a better life after having the surgery:	1	2	3	4	5

Vignette #4: Cosmetic Dentistry

My teeth have been dramatically crooked since I was a child. I always felt awkward about them. In pictures I would try not to show my teeth when I smiled. When I laughed, I would cover my mouth with my hand so no one could see my teeth. Everyone told me that I was being unreasonable and my teeth were not that bad but I still felt uncomfortable. When I was a teenager, I begged my parents for braces but they could not afford them. As I grew older, I resigned myself to the idea that I would never get my teeth fixed. One day I mentioned to my dentist that I was unhappy with my teeth but I felt too old for braces. He suggested that I get porcelain veneers. Porcelain veneers are thin porcelain shells that are bonded over the existing teeth. I decided to have the procedure and I've never been happier. Within a few hours, the dentist completely transformed my teeth. Now I have straight, white teeth and great smile.

Questions	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1) I think this person made a good choice:	1	2	3	4	5
2) If I were in this situation, I would do the same thing:	1	2	3	4	5
3) This individual's problem was beyond their control:	1	2	3	4	5
4) This person will be treated more positively after having the procedure:	1	2	3	4	5

Questions (Cont.)	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
5) This person had no other options besides the surgery:	1	2	3	4	5
6) I feel that this person had the surgery done for the right reasons:	1	2	3	4	5
7) This person will be more accepted by others after having the procedure:	1	2	3	4	5
8) This person should have looked for other options besides the surgery:	1	2	3	4	5
9) This person will have a better life after having the surgery:	1	2	3	4	5

Please answer the following questions:

- 1) For the general public, which of the following procedures do you find to be acceptable choices?

Check all that apply:

- Rhinoplasty (nose surgery)
 Otoplasty (ear surgery)
 Gastric Bypass surgery (weight loss surgery)
 Cosmetic Dentistry (teeth procedures)
 None

- 2) If a close friend or family member was considering one or more of these procedures, which ones would you support?

Check all that apply:

- Rhinoplasty (nose surgery)
 Otoplasty (ear surgery)
 Gastric Bypass surgery (weight loss surgery)
 Cosmetic Dentistry (teeth procedures)
 None
 Other

Please list: _____

3) Do you know of anyone who has had: (Check all that apply)

- Rhinoplasty (nose surgery)
- Otoplasty (ear surgery)
- Gastric Bypass surgery (weight loss surgery)
- Cosmetic Dentistry (teeth procedures)
- Other cosmetic surgery

Please list: _____

4) How do you know these individuals?

- Immediate family member (mother, father, brother, sister)
- Extended family member (aunt, uncle, cousin)
- Significant other (boyfriend/girlfriend, husband/wife, partner)
- Close friend
- Acquaintance (from work, class, school)
- Friend of a friend
- Other
- N/A
- I had one (or multiple) procedure(s) myself

If yes, please list which ones: _____

5) Based on the chart below, what is your Body Mass Index (BMI)? _____

Locate your height on the top row and your weight in the left column. Locate the number where your height column and weight row intersect to find your BMI number.

		Height (feet and inches)																	
		5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"	
100	70	19	11	14	17	17	17	17	17	15	14	14	14	13	13	12	12	12	45
105	21	20	19	19	18	17	17	17	17	15	14	14	14	13	13	12	12	12	47
110	21	21	20	19	19	18	17	17	17	15	14	14	14	13	13	12	12	12	50
115	22	22	21	20	20	19	19	18	17	17	16	15	15	14	14	13	13	13	52
120	23	23	22	21	21	20	19	19	18	17	17	16	15	15	14	14	13	13	54
125	24	24	23	22	21	21	20	20	19	18	17	17	16	15	15	14	14	14	57
130	25	25	24	23	22	22	21	20	20	19	19	18	17	17	16	15	15	15	59
135	26	26	25	24	23	22	22	21	21	20	19	19	18	17	17	16	15	16	61
140	27	26	26	25	24	23	23	22	21	21	20	20	19	18	18	17	17	17	63
145	28	27	27	26	25	24	23	23	22	21	21	20	20	19	19	18	18	18	66
150	29	28	27	27	26	25	24	23	23	22	22	21	20	20	19	19	19	18	68
155	30	29	28	27	27	26	25	24	24	23	22	22	21	20	20	19	19	19	70
160	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21	20	19	19	72
165	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21	20	20	75
170	33	32	31	30	29	28	27	27	26	25	25	24	23	22	22	21	21	21	77
175	34	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21	79
180	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	22	82
185	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23	23	84
190	37	36	35	34	33	32	31	30	29	28	27	26	25	24	24	23	23	23	86
195	38	37	36	35	34	33	32	31	30	29	28	27	26	25	25	24	24	24	88
200	39	38	37	36	35	34	33	32	31	30	30	29	28	27	26	26	25	25	91
205	40	39	37	36	35	34	33	32	31	30	29	29	28	27	26	26	25	25	93
210	41	40	38	37	36	35	34	33	32	31	30	29	28	28	27	26	26	26	95
215	42	41	39	38	37	36	35	34	33	32	31	30	29	28	28	27	26	26	98
220	43	42	40	39	38	37	36	34	33	32	32	31	30	29	28	27	27	27	100
225	44	43	41	40	39	37	36	35	34	33	32	31	31	30	29	28	27	27	102
230	45	43	42	41	39	38	37	36	35	34	33	32	31	30	30	29	28	28	104
235	46	44	43	42	40	39	38	37	36	35	34	33	32	31	30	29	29	29	107
240	47	45	44	43	41	40	39	38	36	35	34	33	32	31	30	29	29	29	109
245	48	46	45	43	42	41	40	38	37	36	35	34	33	32	31	31	30	30	111
250	49	47	46	44	43	42	40	39	38	37	36	35	34	33	32	31	30	30	114
	150	152.5	155	157.5	160	162.5	165	167.5	170	172.5	175	177.5	180	182.5	185	187.5	190		

Height (in meters)

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