

Psychological Well-Being in Two Stigmatized Body Conditions: A Comparative Study of Obesity and Motor Disability Among Single Women

¹Dr.DAMARDJI Abderrahmane

Mohamed Lamine Debaghine University - Sétif 2, ALGERIA

Abderrahmanedamardji87@gmail.com

²Dr. Bouredji Chaker Amiredine

University of Khemis Miliana –Algeria-

Clinical Psychology Laboratory, University of Setif2. – Algeria

c.bouredji@univ-dbk.m.dz

³Dr.HAOUI OMAR

University of Relizane, Algeria

omarhaoui@yahoo.com

⁴Dr.Aissa Rouis

Mouloud Mammeri University of Tizi-Ouzou, Algeria

rouisdouc@gmail.com

⁵Dr.Amrouche Mohammed

University of Kasdi Merbah Ouargla, Algeria

amrouchem@yahoo.com

Received: 01/04/2026

Accepted: 23/07/2026

Published: 25/09/2026

Abstract

Body-related stigma can influence psychological well-being through stereotypes, anticipated judgment, discrimination, and internalized social standards. Obesity and motor disability are visible bodily conditions but are often interpreted differently, particularly regarding perceived controllability. This study compared fear of negative evaluation, body appreciation, and quality of life among 84 single adult women, including 42 with obesity ($BMI \geq 30 \text{ kg/m}^2$) and 42 with motor disability. Participants completed the BFNE, BAS-2, and WHOQOL-BREF. Group differences were examined using independent-samples t tests with Cohen's d, and Pearson correlations were calculated separately. Women with obesity reported greater fear of negative evaluation ($M = 49.50$ vs. 36.10 , $d = 1.70$), lower body appreciation ($M = 2.35$ vs. 3.55 , $d = 1.77$), and lower psychological quality of life. Women with motor disability reported lower physical and environmental quality of life. Fear of negative evaluation correlated more strongly with body appreciation in the obesity group ($r = -.75$) than in the motor-disability group ($r = -.42$). These findings suggest distinct psychological profiles across groups. However, the cross-sectional design and absence of direct stigma measures preclude causal conclusions.

Keywords: obesity; motor disability; weight stigma; ableism; fear of negative evaluation; body appreciation; quality of life; single women

1. Introduction

Body image and psychological well-being are shaped not only by individual perceptions of the body but also by the meanings that social environments attach to bodies. A body can be experienced simultaneously as a biological reality, a source of identity, an object of social evaluation, and a marker through which others assign competence, attractiveness, morality, dependence, health, or social value. These meanings become especially consequential when a bodily characteristic is visible and departs from culturally dominant expectations. In such situations, individuals may be exposed to stereotypes, unwanted attention, exclusion, paternalism, blame, discrimination, or repeated reminders that their body is being judged against an external norm. The psychological significance of these experiences cannot be reduced to appearance dissatisfaction alone. It may also involve vigilance toward other people's reactions, anticipation of rejection, changes in social behavior, self-protective avoidance, diminished body appreciation, and impaired quality of life.

The concept of stigma provides a useful framework for understanding these processes. Goffman's classic formulation emphasized the social devaluation that occurs when an attribute becomes discrediting within a particular cultural context (Goffman, 1963). Later conceptual developments stressed that stigma is not a property inherent in a person or a body; rather, it emerges through social processes that connect labeling, stereotyping, separation, status loss, and discrimination within relationships of power (Link & Phelan, 2001). This distinction is important for research on bodily difference. Obesity and motor disability are not themselves psychological deficits, yet social responses to these conditions can influence psychological functioning. The relevant question is therefore not simply whether a person has a particular bodily characteristic, but how that characteristic is socially interpreted, how frequently it becomes salient in interpersonal settings, and whether the person comes to expect or internalize negative evaluation.

Attribution theory offers an additional framework for explaining why different bodily conditions may elicit different social responses. Weiner (1995) proposed that judgments about responsibility and controllability influence emotional and behavioral reactions toward people facing negative outcomes. Conditions perceived as controllable are more likely to generate blame, anger, or withdrawal of support, whereas conditions perceived as uncontrollable are more likely to elicit sympathy, helping, or paternalistic responses. Such judgments need not be scientifically accurate to have psychosocial effects. They operate as social beliefs that shape interpersonal encounters. In the context of obesity, persistent cultural narratives often exaggerate the role of personal choice and understate biological, genetic, socioeconomic, environmental, and developmental determinants of body weight. An international expert consensus has emphasized that portraying obesity primarily as a failure of self-discipline is inconsistent with contemporary scientific knowledge and contributes to harmful weight stigma (Rubino et al., 2020). By contrast, motor disability is more commonly understood as arising from congenital conditions, illness, injury, or other circumstances that are not interpreted as a voluntary choice. This difference in perceived controllability provides a plausible basis for comparing the psychological correlates of the two conditions.

1-1. Obesity, moral attribution, and weight stigma

Obesity is defined clinically using anthropometric criteria, most commonly a BMI of 30 kg/m² or higher, but its psychosocial meaning extends far beyond a diagnostic threshold. People with obesity are exposed to weight-based stereotypes in multiple social domains, including education, employment, health care, family life, media representation, and intimate relationships. Common stereotypes depict people with higher body weight as lacking willpower, discipline, motivation, or personal responsibility (Puhl & Heuer, 2009; Rubino et al., 2020). These stereotypes are particularly consequential because they convert a physical characteristic into a moral judgment. Rather than being treated as one bodily characteristic among many, body weight can become interpreted as evidence about a person's character.

The harmful effects of weight stigma are increasingly recognized as independent psychosocial concerns rather than merely secondary consequences of obesity. Reviews have linked experienced weight stigma to depressive symptoms, poorer self-esteem, maladaptive coping, disordered eating, exercise avoidance, stress, and reduced psychological well-being (Himmelstein et al., 2018; Puhl et al., 2020). Weight bias internalization represents a related but distinct process in which individuals accept negative weight stereotypes and apply them to themselves. Pearl and Puhl's (2018) systematic review concluded that internalized weight bias is consistently associated with poorer mental-health outcomes, while a later meta-analysis found broad associations between weight bias internalization and adverse psychosocial, behavioral, and health-related outcomes (Romano et al., 2023). These findings are important for the present study because they suggest a mechanism through which social judgments can become psychologically self-relevant even in the absence of an immediately discriminatory interaction.

Gender may intensify these processes. Western and increasingly globalized appearance norms often place a disproportionate evaluative burden on women's bodies. Thinness, youthfulness, bodily control, and narrowly defined attractiveness are frequently presented as markers of femininity, desirability, self-management, and social success. Although men also experience weight stigma, women tend to face stronger appearance-based scrutiny and may encounter weight-based judgments at lower levels of body mass. Rubino et al. (2020) noted that reported weight discrimination is particularly common among women and individuals with higher BMI. For women, therefore, obesity may intersect with gendered appearance expectations in ways that amplify concern about external evaluation.

The relevance of single relationship status in the present study should be interpreted cautiously. Being single is not itself a psychological vulnerability, and the present dataset does not measure dating experiences, relationship intentions, or perceived romantic rejection. Nevertheless, limiting the sample to single women creates a more homogeneous social-status context and avoids confounding that might arise if partnership status differed markedly between groups. It may also be relevant to social evaluation because appearance norms can be salient in interpersonal and partner-selection environments, but this remains a theoretical possibility rather than an empirically tested pathway in the present study. The current analysis therefore treats single status primarily as a sampling characteristic rather than as an explanatory mechanism.

Weight stigma may also operate through anticipated judgment. Individuals who have repeatedly experienced criticism, teasing, dismissive treatment, or appearance-related scrutiny may learn to expect negative evaluation even in situations where no explicit rejection occurs. This expectation can produce heightened self-monitoring and social vigilance. A person may enter an interaction already scanning for signs of criticism, interpreting ambiguous cues as weight-related judgment, or avoiding situations where the body is likely to become visible. Such anticipatory processes are conceptually close to fear of negative evaluation and may help explain why weight-related stigma is associated with social anxiety, body dissatisfaction, and reduced psychological quality of life.

1-2. Motor disability, ableism, and social evaluation

Motor disability represents a different form of bodily divergence. The term encompasses limitations in mobility or physical functioning that may result from congenital conditions, neurological or musculoskeletal disorders, chronic disease, or injury. Social responses to motor disability are not uniformly supportive and should not be romanticized. People with physical disabilities may experience exclusion, environmental inaccessibility, occupational discrimination, unwanted assistance, infantilization, desexualization, assumptions of dependence, and social avoidance. Disability scholars have long argued that many disadvantages associated with disability arise not solely from impairment but from social and environmental arrangements that privilege a narrow range of bodily functioning (Oliver, 1990; Shakespeare, 2018).

The concept of ableism is particularly relevant. Ableism refers to social structures, beliefs, practices, and interpersonal attitudes that treat nondisabled functioning as the normative or superior standard and devalue people whose bodies or minds differ from that standard. A recent critical review in population health emphasized that ableism can operate at intrapersonal, interpersonal, institutional, and structural levels and that research often underestimates its role as a social determinant of health (Mannor & Needham, 2024). Thus, the assumption that motor disability elicits compassion rather than stigma would be an oversimplification. Compassion can coexist with paternalism, low expectations, social distancing, or assumptions that a disabled person has a diminished quality of life.

Nevertheless, the content of disability stigma may differ from the content of weight stigma. A motor disability is more likely to be perceived as involuntary, and therefore it may elicit less moral blame for the condition itself. Weiner's attributional framework predicts that lower perceived controllability should reduce anger and blame while increasing sympathy or helping responses. Yet those responses can themselves be psychologically ambivalent. Being treated with pity, being overprotected, or having competence underestimated may threaten autonomy and identity even when the behavior is framed as benevolent. Consequently, motor disability may be associated with stigma-related distress, but the specific psychological pathway may differ from a pathway driven by moralized blame.

Body image among women with motor disabilities is also complex. Physical disability can affect how the body is experienced in terms of function, appearance, independence, sexuality, and social visibility. Early work on psychosocial issues among women with physical disabilities

highlighted the importance of gendered expectations and the interaction between disability and social norms of femininity (Nosek & Hughes, 2003). More recent disability scholarship has emphasized identity development and the potential protective role of positive disability identity. This perspective cautions against interpreting disability exclusively through a deficit model. A person may experience meaningful bodily limitations and social barriers while also developing a coherent, positive, and politically informed disability identity.

These considerations make motor disability a useful comparison condition for obesity. Both involve visible or potentially visible departures from dominant bodily norms and both can elicit stigma. However, they differ in the typical attributions attached to them, the balance between moral judgment and paternalism, and the relative importance of functional versus appearance-based barriers. If fear of negative evaluation is especially responsive to moralized appearance judgment, it may be more pronounced in women with obesity. If physical and environmental quality of life are more strongly affected by mobility limitations and accessibility barriers, women with motor disabilities may report lower scores in those domains. The comparison therefore allows a more differentiated examination of psychological well-being than would be possible by studying either group in isolation.

1-3. Fear of negative evaluation as a social-evaluative mechanism

Fear of negative evaluation refers to apprehension about being judged unfavorably by others and is a central cognitive-affective component of social anxiety (Watson & Friend, 1969). The construct does not require the presence of a psychiatric disorder. It can vary continuously across individuals and may be particularly relevant among people who occupy socially devalued categories. Repeated exposure to stigmatizing experiences can make social evaluation more salient, increase the perceived probability of rejection, and encourage anticipatory monitoring of how one is being seen by others.

In body-related contexts, fear of negative evaluation may function as a bridge between external social norms and internal psychological outcomes. A woman who expects criticism because of her body may devote greater attention to appearance-relevant cues, feel less comfortable in public or interpersonal settings, and evaluate her body from an observer's perspective. Over time, this pattern may undermine body appreciation and psychological quality of life. Evidence from research on weight stigma supports the broader proposition that coping responses and social-evaluative processes mediate associations between stigmatizing experiences and health outcomes (Himmelstein et al., 2018). The current study does not directly test mediation because it does not include a measure of experienced stigma and uses cross-sectional data, but it evaluates a central component of the proposed pathway by examining how fear of negative evaluation covaries with body appreciation and quality of life.

Fear of negative evaluation is theoretically informative in a comparison between obesity and motor disability because it may reflect differences in how social attention is interpreted. If obesity is associated with stronger assumptions of personal responsibility and appearance-based moral judgment, social scrutiny may be experienced as criticism of both the body and the self. If motor disability is more often interpreted as uncontrollable, social attention may still be uncomfortable

or stigmatizing but may carry a different emotional meaning. The expected group difference is therefore not a claim that one group experiences more discrimination in absolute terms; rather, it concerns the form and internal psychological salience of anticipated negative judgment.

1-4. Body appreciation as a positive body-image construct

Body image is multidimensional and includes perceptions, thoughts, emotions, beliefs, and behaviors related to the body. Contemporary research has increasingly distinguished positive body image from the mere absence of body dissatisfaction. Body appreciation, as operationalized by the BAS-2, reflects acceptance of, respect for, and favorable attitudes toward the body, including recognition of its qualities and resistance to narrowly prescribed appearance ideals (Tylka & Wood-Barcalow, 2015). This construct is especially appropriate for the present study because it can be meaningfully assessed across bodies that differ in size, function, and appearance.

Positive body image is not equivalent to believing that one's body perfectly matches cultural ideals. On the contrary, one of its defining features is the capacity to value the body without requiring such conformity. Tylka and Wood-Barcalow (2015) emphasized that positive body image is multifaceted, protective, and shaped by social identities and perceived acceptance from others. Experimental research has also suggested that higher body appreciation can buffer some of the negative effects of idealized appearance exposure (Halliwell, 2013). These findings support the conceptualization of body appreciation as a resilience-related outcome that may vary according to the social meaning attached to bodily difference.

In the context of obesity, body appreciation may be challenged by persistent anti-fat attitudes and by cultural messages that frame weight reduction as a moral and aesthetic obligation. In the context of motor disability, body appreciation may be challenged by ableist ideals that equate bodily worth with physical independence, symmetry, or conventional functioning. The two forms of pressure are not interchangeable. Comparing BAS-2 scores across the groups therefore provides information about whether one social context is associated with a greater erosion of positive body regard in the present sample, while recognizing that the scale cannot identify the specific origin of that difference.

1-4. Quality of life as a multidomain outcome

Quality of life provides a broader perspective than symptom-focused measures because it captures how individuals evaluate their functioning and well-being across multiple life domains. The WHOQOL-BREF distinguishes physical, psychological, social-relational, and environmental domains. This multidomain structure is particularly valuable for comparing obesity and motor disability because group differences may not move in the same direction across all domains. A group may experience greater psychological distress while retaining relatively better physical functioning or environmental access, whereas another group may experience substantial mobility and accessibility limitations while maintaining stronger psychological adaptation.

The present study

Despite extensive research on weight stigma and a substantial literature on disability-related discrimination, direct comparative studies examining obesity and motor disability within the same design remain limited. The present study addresses this gap by comparing single adult women in

two bodily-condition groups on fear of negative evaluation, body appreciation, and four quality-of-life domains. The comparison is theoretically grounded in stigma theory and attribution theory but is deliberately interpreted at the level supported by the data. Because experienced stigma, perceived controllability, and internalized stigma were not directly measured, the study cannot establish that attributional differences caused the observed psychological profiles. Instead, it tests whether the profiles are consistent with the proposed framework and identifies relationships that can guide more direct future tests.

Four hypotheses were specified. First, women with obesity were expected to differ significantly from women with motor disability in psychological quality of life (H1). Second, women with obesity were expected to report lower body appreciation (H2). Third, women with obesity were expected to report greater fear of negative evaluation (H3). Fourth, within both groups, fear of negative evaluation was expected to correlate negatively with body appreciation and quality of life (H4). In addition, exploratory analyses examined whether obesity severity showed a graded association with body appreciation, fear of negative evaluation, and psychological quality of life.

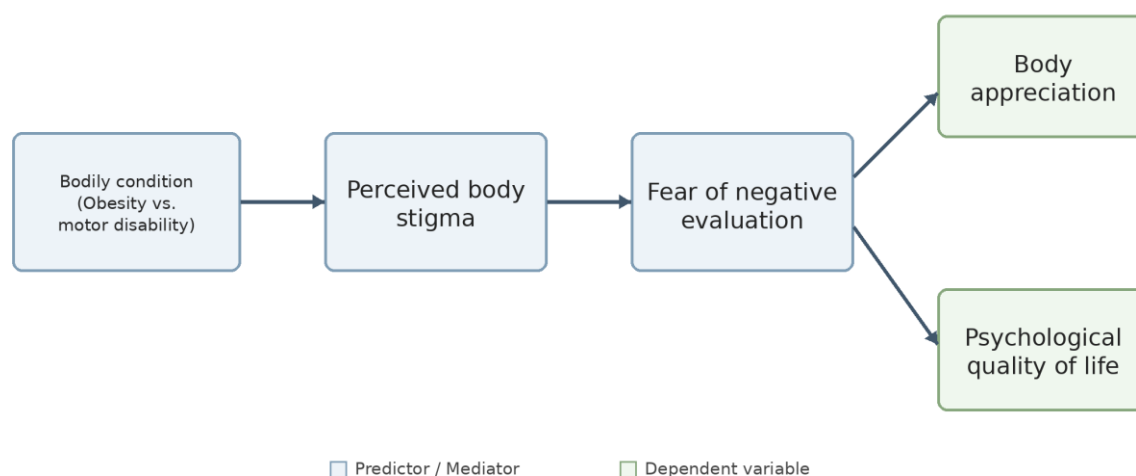


Figure 1. Proposed conceptual model linking bodily condition, perceived body stigma, fear of negative evaluation, body appreciation, and psychological quality of life. Perceived body stigma was not directly measured in the present dataset; the figure represents the theoretical framework guiding interpretation.

2. Method

2-1. Study design

The study used a cross-sectional, between-groups comparative design. Two groups of single adult women were examined: women meeting the BMI criterion for obesity and women living with a motor disability. All psychological and quality-of-life variables were assessed at one time point using standardized self-report instruments. The design was selected to identify group differences and within-group associations rather than to establish temporal or causal relationships.

Accordingly, terms such as association, difference, and relationship are used throughout the manuscript in preference to causal language.

2-2. Participants and recruitment

The initial recruitment pool consisted of 163 women. After application of the study's inclusion and exclusion criteria, 84 participants were retained in the final analytic sample. The two groups were equal in size: 42 women with obesity and 42 women with motor disability. Participants were recruited through community associations, social networks, and health- or disability-related support groups. All participants were at least 18 years old and self-identified as single at the time of participation.

Eligibility for the obesity group required a BMI of at least 30 kg/m², consistent with the conventional World Health Organization threshold used in the source study. Participants in the motor-disability group had a functional limitation affecting physical mobility that resulted from a congenital condition, illness, or accident. The original study excluded women who reported severe psychiatric disorders and women with medical conditions considered likely to have a major independent effect on body image, including certain dermatological conditions or recent surgery. These exclusions were intended to reduce major competing influences on the body-image outcomes, although self-report-based exclusion inevitably provides less diagnostic certainty than structured clinical assessment.

The mean age in the obesity group was 30.09 years (SD = 6.80), and the mean BMI was 36.85 kg/m² (SD = 4.90). In the motor-disability group, mean age was 32.90 years (SD = 7.40), and mean BMI was 25.40 kg/m² (SD = 3.60). The source manuscript reports an independent-samples test of the age difference as $t(82) = 1.90$. A two-tailed t value of 1.90 with 82 degrees of freedom corresponds to p approximately .061; this mathematically consistent p value is used in the revised text. The difference therefore did not reach the conventional .05 threshold, although it should not be interpreted as proof that the groups were equivalent in age. The original reported p value should be checked against the primary statistical output before journal submission.

The two groups were selected to represent bodily conditions that may both be socially stigmatized but differ in typical social attribution. The design does not assume that either group is internally homogeneous. Obesity varies in severity, duration, treatment history, and visibility, while motor disability varies in onset, functional impact, assistive-device use, visibility, and environmental accessibility. The available dataset does not provide sufficient detail to stratify the motor-disability group on these characteristics. This limitation is addressed in the Discussion.

2-3. Measures

a. Brief Fear of Negative Evaluation Scale

Fear of negative evaluation was assessed using the Brief Fear of Negative Evaluation Scale (BFNE; Leary, 1983). The BFNE is a 12-item measure designed to assess apprehension and distress related to the possibility of being judged unfavorably by others. Items are rated on a five-point Likert-type scale, yielding total scores that can range from 12 to 60. Higher scores indicate greater fear of negative social evaluation. In the present sample, internal consistency was high (Cronbach's $\alpha = .89$), supporting the reliability of the total score for group-level analyses.

The BFNE was selected because it captures a general social-evaluative process rather than a condition-specific attitude. This is useful in a comparative design: the same construct can be measured in both groups without assuming in advance that negative evaluation is specifically weight-related or disability-related. At the same time, that generality constrains interpretation. A high BFNE score cannot identify the source of feared evaluation, and the current study cannot determine what proportion of a participant's fear was related specifically to body weight, disability, gender, relationship status, or other personal characteristics.

b. Body Appreciation Scale-2

Positive body image was assessed using the Body Appreciation Scale-2 (BAS-2; Tylka & Wood-Barcalow, 2015). The BAS-2 contains 10 items rated on a five-point response scale. The instrument assesses favorable, accepting, and respectful attitudes toward the body rather than simply the absence of dissatisfaction. Higher scores represent greater body appreciation. Internal consistency in the present sample was excellent ($\alpha = .93$).

The BAS-2 is conceptually appropriate for comparing obesity and motor disability because it does not define a positive body image in terms of thinness, physical performance, or conformity to a specific appearance ideal. Instead, it emphasizes acceptance and respect. Nevertheless, any cross-group comparison assumes that participants interpret the construct in sufficiently comparable ways. The source study did not report formal measurement-invariance testing across the two groups, so observed mean differences should be interpreted as differences in scale scores rather than definitive evidence that the latent construct functions identically in both populations.

c. World Health Organization Quality of Life-BREF

Quality of life was measured with the WHOQOL-BREF (WHOQOL Group, 1998), a 26-item instrument covering four domains: physical health, psychological health, social relationships, and environment. In the present sample, reported internal-consistency coefficients were $\alpha = .82$ for the physical domain, $.80$ for the psychological domain, $.75$ for social relationships, and $.81$ for the environmental domain. Domain scores were transformed to a 0-100 scale, with higher scores indicating better perceived quality of life.

The domain structure permits a differentiated comparison. The physical domain reflects perceived physical functioning and related aspects of daily life; the psychological domain reflects emotional and psychological well-being; the social domain captures perceived social relationships; and the environmental domain includes aspects of the surrounding context and access to resources. Because motor disability may impose functional and accessibility constraints that are not reducible to psychological distress, retaining domain-level outcomes rather than collapsing them into a single total score is particularly important.

2-4. Procedure and ethics

Recruitment occurred through community associations, social-network channels, and support groups related to health and disability. After eligibility screening, participants received information about the study's objectives and procedures and provided written informed consent. Participants then completed the standardized questionnaire battery individually. The mean completion time was approximately 45 minutes.

The source manuscript states that the study was conducted in accordance with the principles of the Declaration of Helsinki and received institutional ethics-committee approval. The name of the approving institution and approval number were not included in the source document available for this revision and should be inserted in the final submission if required by the target journal. No additional procedural details have been invented in this revised manuscript.

2-5. Statistical analysis

Analyses were conducted using SPSS version 26.0 and R version 4.2. Statistical significance was evaluated at $\alpha = .05$. Before inferential analyses, distributions were inspected for their suitability for parametric procedures, as reported in the source manuscript. H1-H3 were examined using independent-samples *t* tests. Effect sizes were expressed as Cohen's *d* so that the magnitude of group differences could be considered alongside statistical significance. In interpreting *d*, conventional benchmarks are used descriptively rather than as rigid thresholds.

H4 was examined using Pearson product-moment correlations calculated separately within the obesity and motor-disability groups. This group-specific approach was appropriate because the study was interested not only in overall associations but also in whether the pattern of relationships appeared stronger in one social context than the other. However, differences in correlation magnitude were not formally tested using Fisher's *r*-to-*z* comparisons in the source analysis. Therefore, statements that one correlation is numerically stronger than another are descriptive and should not be interpreted as proof that the correlations differ statistically between groups.

Exploratory one-way analyses of variance were reported within the obesity group to examine whether psychological outcomes varied across obesity classes. The source table lists 11 participants in Class I, 24 in Class II, and 5 in Class III, which sums to 40, whereas the reported ANOVA denominator degrees of freedom, $F(2, 39)$, would ordinarily imply 42 observations across three groups. The analytic sample size for this exploratory analysis is therefore internally inconsistent in the source manuscript. The revised Results section reproduces the reported descriptive and inferential values but treats the exact analytic *N* as unresolved pending verification against the original dataset and software output.

Given the modest sample size and the number of outcomes examined, the analysis emphasizes effect sizes and coherent patterns rather than relying exclusively on *p* values. The cross-sectional design also means that correlations cannot establish directionality. For example, fear of negative evaluation may contribute to lower body appreciation, lower body appreciation may increase sensitivity to negative evaluation, or both may be influenced by broader stigma-related experiences. The statistical analyses identify associations compatible with the conceptual model but do not establish mediation or causation.

3. Results

3-1. Participant characteristics

The final sample consisted of 84 single adult women divided equally between the obesity and motor-disability groups. Women in the obesity group had a mean age of 30.09 years ($SD = 6.80$), compared with 32.90 years ($SD = 7.40$) in the motor-disability group. Using the reported *t* statistic, the age difference did not reach the conventional level of statistical significance, $t(82) = 1.90$, *p*

approximately .061. The groups therefore appeared broadly similar in age distribution at the descriptive level, although the modest sample limits strong claims of demographic equivalence.

As expected from the group definitions, BMI differed markedly between groups. Mean BMI was 36.85 kg/m² (SD = 4.90) in the obesity group and 25.40 kg/m² (SD = 3.60) in the motor-disability group. BMI is a defining characteristic of the obesity group rather than a covariate that can meaningfully be equated across groups. Consequently, the principal analyses compare psychological profiles associated with the two bodily-condition categories rather than attempting to statistically adjust away the feature that defines one of those categories.

3-2. Fear of negative evaluation and body appreciation

The primary between-group comparisons are presented in Table 1. Fear of negative evaluation differed substantially between groups. Women with obesity had a mean BFNE score of 49.50 (SD = 7.20), whereas women with motor disability had a mean of 36.10 (SD = 8.50). The difference was statistically significant, $t(82) = 7.78$, $p < .001$, with Cohen's $d = 1.70$. The magnitude of this effect indicates extensive separation between the group distributions in the present sample. H3 was therefore supported.

This result is central to the conceptual model because it indicates that social-evaluative apprehension was considerably more pronounced among the women with obesity. The BFNE does not identify what participants believed others were evaluating, so the finding cannot be attributed exclusively to weight stigma. Nevertheless, the direction and magnitude of the difference are consistent with the proposition that women with obesity in this sample experienced stronger concern about unfavorable social judgment.

Body appreciation also differed markedly. Women with obesity reported a mean BAS-2 score of 2.35 (SD = 0.65), compared with 3.55 (SD = 0.70) among women with motor disability. The between-group difference was statistically significant, $t(82) = -8.13$, $p < .001$, and the effect size was very large, $d = 1.77$. H2 was therefore supported. The result indicates that positive, accepting, and respectful attitudes toward the body were substantially lower in the obesity group.

The combination of higher BFNE and lower BAS-2 scores provides a coherent descriptive profile. Women with obesity not only reported more concern about negative social evaluation but also reported less positive body regard. Because the study is cross-sectional, it is not possible to determine whether anticipated judgment contributed to lower body appreciation, whether lower body appreciation increased sensitivity to judgment, or whether both emerged from shared antecedents such as experienced weight stigma or broader appearance pressures. The within-group correlations reported below provide additional evidence that the variables are closely related, particularly in the obesity group, but they do not resolve this temporal question.

Table 1. Between-group comparison of fear of negative evaluation and body appreciation

Variable	Obesity (n = 42) M (SD)	Motor disability (n = 42) M (SD)	t	p	Cohen's d
BFNE (12-60)	49.50 (7.20)	36.10 (8.50)	7.78	< .001** *	1.70
BAS-2 (1-5)	2.35 (0.65)	3.55 (0.70)	-8.13	< .001** *	1.77

Note. M = mean; SD = standard deviation; BFNE = Brief Fear of Negative Evaluation Scale; BAS-2 = Body Appreciation Scale-2. *** $p < .001$.

3-3. Quality-of-life domains

The four WHOQOL-BREF domains showed a differentiated pattern rather than a uniform advantage for either group. This is important because a global statement that one group had a generally worse quality of life would obscure domain-specific differences.

In the physical quality-of-life domain, women with obesity reported a mean score of 52.40 (SD = 14.10), whereas women with motor disability reported a mean of 38.60 (SD = 13.50). The difference was statistically significant, $t(82) = 4.58$, $p < .001$, with $d = 1.00$. Thus, the motor-disability group reported substantially poorer physical quality of life. This pattern is compatible with the defining functional limitations of motor disability, although the study did not collect sufficiently detailed impairment data to link specific mobility limitations to the WHOQOL physical score.

The direction reversed for psychological quality of life. Women with obesity had a mean psychological-domain score of 44.20 (SD = 12.30), compared with 59.80 (SD = 11.90) among women with motor disability. The difference was statistically significant, $t(82) = -5.90$, $p < .001$, with $d = 1.28$. H1 was therefore supported. The magnitude of the difference suggests that psychological well-being was substantially lower in the obesity group despite the motor-disability group's poorer physical quality of life.

For social relationships, the obesity group had a mean of 41.50 (SD = 15.20), and the motor-disability group had a mean of 48.10 (SD = 16.50). The reported test was $t(82) = -1.90$, $p = .06$, $d = 0.41$. Although the motor-disability group had a numerically higher mean and the effect size was not trivial, the difference did not meet the conventional $p < .05$ threshold. This result should not be interpreted as evidence that the groups are identical in social quality of life. Rather, the study did not provide sufficiently strong evidence to reject the null hypothesis at the prespecified threshold.

The environmental domain showed the largest quality-of-life difference. Women with obesity had a mean score of 68.30 (SD = 12.50), compared with 45.20 (SD = 11.80) in the motor-disability group, $t(82) = 8.71$, $p < .001$, $d = 1.90$. The lower environmental quality of life among women with motor disability is consistent with the possibility that accessibility, transportation, physical

infrastructure, or resource barriers affect daily life, although the WHOQOL-BREF domain score does not identify which environmental components were most important in this sample.

Taken together, the quality-of-life findings reveal cross-domain divergence. The obesity group showed a pronounced disadvantage in psychological quality of life, whereas the motor-disability group showed pronounced disadvantages in physical and environmental quality of life. The social-relations domain did not differ significantly at the .05 level. This profile reinforces the value of a multidomain measure: the psychological burden associated with a socially moralized bodily characteristic can coexist with relatively better physical and environmental functioning, while disability-related functional and structural barriers can coexist with comparatively better psychological scores.

Table 2. Between-group comparison across WHOQOL-BREF domains

WHOQOL domain	Obesity (n = 42) M (SD)	Motor disability (n = 42) M (SD)	t	p	Cohen's d
Physical	52.40 (14.10)	38.60 (13.50)	4.58	< .001** *	1.00
Psychological	44.20 (12.30)	59.80 (11.90)	-5.90	< .001** *	1.28
Social relationships	41.50 (15.20)	48.10 (16.50)	-1.90	.06	0.41
Environment	68.30 (12.50)	45.20 (11.80)	8.71	< .001** *	1.90

Note. M = mean; SD = standard deviation. Higher WHOQOL-BREF domain scores indicate better quality of life. *** $p < .001$.

3-4. Within-group correlations

In the obesity group, fear of negative evaluation was strongly associated with lower body appreciation ($r = -.75$, $p < .001$), poorer psychological quality of life ($r = -.68$, $p < .001$), and poorer social quality of life ($r = -.65$, $p < .001$). A weaker association was observed with physical quality of life ($r = -.35$, $p < .05$), whereas the association with environmental quality of life was not significant. Body appreciation was positively related to psychological ($r = .71$, $p < .001$), social ($r = .58$, $p < .001$), and physical quality of life ($r = .41$, $p < .01$), while its association with environmental quality of life was not significant.

In the motor-disability group, fear of negative evaluation was moderately associated with lower body appreciation ($r = -.42$, $p < .01$), psychological quality of life ($r = -.38$, $p < .05$), and

social quality of life ($r = -.34, p < .05$), but not with physical or environmental quality of life. Body appreciation was positively associated with all four quality-of-life domains, with correlations ranging from $r = .31$ to $r = .58$. Physical and environmental quality of life were also strongly correlated ($r = .72, p < .001$).

Overall, H4 received partial support. In both groups, fear of negative evaluation was consistently associated with lower body appreciation and poorer psychological and social quality of life, but not with all quality-of-life domains. Although the BFNE–BAS-2 and BFNE–psychological-quality-of-life correlations were numerically stronger in the obesity group, no formal statistical comparison of the correlation coefficients was performed; therefore, these between-group differences should be interpreted descriptively rather than as statistically established differences.

Table 3. Pearson correlation matrix: obesity group ($n = 42$)

Variable	1	2	3	4	5	6
1. BFNE	1					
2. BAS-2	-.75***	1				
3. WHOQOL-Psychological	-.68***	.71***	1			
4. WHOQOL-Physical	-.35*	.41**	.52***	1		
5. WHOQOL-Social	-.65***	.58***	.68***	.38*	1	
6. WHOQOL-Environment	-.21	.28	.42**	.32*	.48**	1

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

Table 4. Pearson correlation matrix: motor-disability group ($n = 42$)

Variable	1	2	3	4	5	6
1. BFNE	1					
2. BAS-2	-.42**	1				
3. WHOQOL-Psychological	-.38*	.55***	1			
4. WHOQOL-Physical	-.15	.58***	.65***	1		
5. WHOQOL-Social	-.34*	.31*	.51***	.38*	1	
6. WHOQOL-Environment	-.18	.40**	.62***	.72***	.45**	1

Note. * $p < .05$, ** $p < .01$, *** $p < .001$.

3-5. Exploratory obesity-severity analysis

Exploratory analyses examined whether psychological outcomes varied across BMI-defined obesity classes. The source table reports 11 participants in Class I (BMI 30.0-34.9), 24 in Class II (BMI 35.0-39.9), and 5 in Class III (BMI ≥ 40), which sums to 40. However, the reported denominator degrees of freedom for the ANOVAs are 39, which would ordinarily correspond to 42 observations across three groups. The exact analytic N is therefore unresolved in the source material, and the inferential results below should be verified before submission.

Body appreciation declined across obesity classes. Mean BAS-2 scores were 2.80 (SD = 0.60) in Class I, 2.30 (SD = 0.50) in Class II, and 1.70 (SD = 0.40) in Class III. The overall class effect was significant, $F(2, 39) = 12.85$, $p < .001$. Fear of negative evaluation showed the opposite pattern: mean BFNE scores increased from 44.0 (SD = 7.5) in Class I to 51.0 (SD = 6.5) in Class II and 56.5 (SD = 3.0) in Class III, $F(2, 39) = 10.42$, $p < .001$. Psychological quality of life also declined across classes, from 52.0 (SD = 13.0) to 43.0 (SD = 11.5) and 32.0 (SD = 9.0), respectively, $F(2, 39) = 14.33$, $p < .001$.

The monotonic pattern across all three outcomes is consistent with a dose-response interpretation at the descriptive level: greater obesity severity was accompanied by less body appreciation, greater fear of negative evaluation, and poorer psychological quality of life. However, BMI class is not a direct measure of stigma exposure, and several alternative explanations are possible. Higher BMI may be associated with greater visibility of weight difference, more frequent weight-based discrimination, additional physical-health burden, longer duration of obesity, or other unmeasured factors. The cross-sectional analysis cannot determine which mechanism generated the gradient. Moreover, the very small Class III subgroup ($n = 5$) warrants caution. The result is best treated as hypothesis-generating rather than as definitive evidence of a causal dose-response effect of stigma.

Table 5. Reported obesity-severity gradient in psychological outcomes

Variable	Class I (n = 11) M (SD)	Class II (n = 24) M (SD)	Class III (n = 5) M (SD)	Reported F (p)
BAS-2	2.80 (0.60)	2.30 (0.50)	1.70 (0.40)	12.85***
BFNE	44.0 (7.5)	51.0 (6.5)	56.5 (3.0)	10.42***
WHOQOL-Psychological	52.0 (13.0)	43.0 (11.5)	32.0 (9.0)	14.33***

Note. M = mean; SD = standard deviation; *** $p < .001$. BMI Class I = 30.0-34.9 kg/m²; Class II = 35.0-39.9 kg/m²; Class III = ≥ 40 kg/m². Source values are reproduced as reported. The class counts sum to 40, whereas the reported denominator df of 39 would ordinarily imply $N = 42$; verify the original data/output before submission.

4. Discussion

The present study compared fear of negative evaluation, body appreciation, and quality of life in two groups of single adult women whose bodily conditions may both be socially stigmatized but are commonly interpreted through different cultural and attributional frameworks. Four findings were especially notable. First, women with obesity reported substantially higher fear of negative evaluation than women with motor disability. Second, women with obesity reported substantially lower body appreciation. Third, the quality-of-life profile was domain specific: the obesity group reported poorer psychological quality of life, whereas the motor-disability group reported poorer physical and environmental quality of life. Fourth, fear of negative evaluation was negatively associated with body appreciation and with psychological and social quality of life in both groups, with particularly large associations in the obesity group. Exploratory analyses additionally suggested a graded pattern across obesity classes.

These findings are broadly consistent with the conceptual framework linking social attribution, social-evaluative threat, positive body image, and psychological well-being. However, they require careful interpretation. The study did not measure experienced stigma, weight bias internalization, ableism, perceived controllability, or attributional beliefs directly. It therefore cannot demonstrate that different forms of stigma caused the observed group differences. The data instead show that two socially stigmatized bodily-condition groups had markedly different psychological profiles and that the pattern is compatible with, but not sufficient to prove, an attributional-stigma explanation.

The large difference in BFNE scores is one of the strongest findings in the study. Women with obesity reported far greater concern about unfavorable social judgment than women with motor disability, with an effect size of $d = 1.70$. In practical terms, this suggests that social evaluation was a much more salient source of apprehension in the obesity group. The finding aligns with a large literature showing that people with obesity are exposed to pervasive stereotypes and weight-based devaluation across interpersonal and institutional contexts (Puhl & Heuer, 2009; Puhl et al., 2020; Rubino et al., 2020).

Attribution theory offers one plausible interpretation. When body weight is framed as personally controllable, a higher-weight body can be read socially not only as an appearance characteristic but also as evidence of presumed behavioral or moral failure. This is precisely the type of attribution that may intensify negative evaluation because the judgment is directed toward the person as an agent rather than solely toward a condition. Weiner's model predicts more blame and anger when an undesirable state is perceived as controllable (Weiner, 1995). Modern obesity science challenges simplistic controllability assumptions, but social stereotypes can persist even when they are scientifically inaccurate. The resulting discrepancy between scientific understanding and public narrative is a central concern of the international consensus on weight stigma (Rubino et al., 2020).

Fear of negative evaluation may therefore represent an internal psychological signature of repeated or anticipated exposure to moralized judgment. This does not mean that every high BFNE score reflects prior discrimination, and the study cannot establish such a history. General social

anxiety, personality, prior rejection, family criticism, media exposure, or other experiences may also contribute. Yet the magnitude of the between-group difference suggests that a condition-specific social context deserves serious consideration.

The finding also contributes to a more nuanced understanding of how stigma may affect well-being. Stigma is often studied through explicit reports of discriminatory events, but anticipated evaluation can matter even when no overt discriminatory act occurs. If an individual expects criticism, she may avoid social situations, conceal aspects of her body, monitor others' reactions, or approach interpersonal encounters with heightened vigilance. These strategies may reduce immediate exposure to threat while also limiting social engagement or reinforcing the belief that the body is unacceptable. Such processes are consistent with broader stigma and social-identity-threat models (Major & O'Brien, 2005).

The present data cannot determine whether fear of negative evaluation functions as a mediator between stigma and psychological outcomes, because the design lacks both a direct stigma measure and temporal sequencing. Nevertheless, the strong correlations with body appreciation and psychological quality of life identify BFNE as a promising candidate mechanism for future longitudinal research. A more definitive study would measure experienced weight stigma, internalized weight bias, fear of negative evaluation, body appreciation, and quality of life at multiple time points, then test whether changes in social-evaluative fear statistically account for subsequent changes in body image or well-being.

Women with obesity reported markedly lower body appreciation than women with motor disability, with an effect size of $d = 1.77$. This finding extends the interpretation beyond conventional body dissatisfaction. Body appreciation captures an affirmative relationship with the body: respect, acceptance, care, and the ability to resist narrow appearance standards (Tylka & Wood-Barcalow, 2015). Lower scores therefore suggest not merely stronger dissatisfaction but a weaker positive orientation toward the body.

This distinction matters because positive body image has increasingly been conceptualized as a protective psychological resource. A person can experience limitations, health concerns, or dissatisfaction with specific aspects of the body while still maintaining a broader stance of respect and appreciation. Conversely, the absence of severe dissatisfaction does not necessarily imply strong body appreciation. In the present sample, obesity was associated with a considerable reduction in this positive resource.

Weight stigma offers a plausible social pathway. Repeated messages that a larger body is undisciplined, unattractive, unhealthy, or socially unacceptable can be internalized and incorporated into self-evaluation. Pearl and Puhl (2018) found consistent associations between weight bias internalization and poorer mental health, and the more recent meta-analysis by Romano et al. (2023) similarly documented broad adverse psychosocial associations. The current study did not measure weight bias internalization, but the low BAS-2 scores in the obesity group are consistent with the possibility that external weight norms had become self-relevant for at least some participants.

The strong inverse association between BFNE and BAS-2 in the obesity group ($r = -.75$) is particularly informative. It indicates that women who were more apprehensive about others' judgments tended to report substantially less body appreciation. Several directions of influence are possible. Social-evaluative fear may encourage self-objectification and negative body monitoring, thereby undermining appreciation. Low body appreciation may make external judgments feel more credible and threatening. Both may arise from common upstream factors such as weight-based teasing, family criticism, discrimination, or exposure to appearance ideals. A reciprocal process is also possible, with social-evaluative fear and negative body regard reinforcing each other over time.

The comparison with motor disability is instructive because the latter group reported considerably higher body appreciation despite poorer physical and environmental quality of life. This pattern argues against a simple model in which greater bodily limitation necessarily produces poorer body image. Psychological adaptation, disability identity, social attribution, community support, and differences in moral blame may all contribute. Disability research increasingly emphasizes that a positive identity can coexist with impairment and that well-being depends partly on whether bodily difference is interpreted through a deficit model or integrated into a valued sense of self. The present study did not assess disability identity directly, but the relatively higher BAS-2 scores are compatible with the possibility that some women with motor disability had developed adaptive forms of bodily acceptance despite functional challenges.

At the same time, the group comparison should not be used to minimize body-image difficulties among women with disabilities. Ableist beauty standards, desexualization, visible bodily differences, assistive devices, or changes in function can all affect body image. The higher mean in this sample indicates a relative difference, not an absence of difficulty. Future work should examine which disability-related factors predict positive body image and whether disability identity, social support, and environmental inclusion protect against negative social evaluation.

The WHOQOL-BREF results provide one of the most theoretically important aspects of the study because they demonstrate that the groups' difficulties were distributed differently across domains. Women with obesity reported significantly poorer psychological quality of life, whereas women with motor disability reported significantly poorer physical and environmental quality of life. Social quality of life did not differ significantly at the conventional threshold.

The obesity group's lower psychological quality of life is consistent with its higher fear of negative evaluation and lower body appreciation. These variables were also strongly interrelated within the group. BFNE correlated at $r = -.68$ with psychological quality of life, while BAS-2 correlated at $r = .71$. Together, these associations suggest that social-evaluative concern and positive body regard are deeply embedded in how women with obesity assessed their psychological well-being. Although causal direction cannot be determined, the coherence of the pattern strengthens the argument that psychosocial processes deserve attention alongside physical-health outcomes in obesity research.

The motor-disability group's lower physical quality of life is unsurprising given the defining presence of mobility limitations, but the environmental difference is equally important. The

environmental domain was markedly lower in the motor-disability group, with $d = 1.90$. Disability research and the social model of disability emphasize that difficulties arise not only from bodily impairment but from the interaction between impairment and inaccessible environments (Oliver, 1990; Shakespeare, 2018). Barriers in transportation, public spaces, buildings, services, employment settings, or access to resources can transform a functional limitation into a broader restriction on participation. Recent population-health work on ableism similarly argues that institutional and structural factors should be studied as determinants of disabled people's health rather than treating outcomes solely as individual-level consequences (Mannor & Needham, 2024).

The pattern therefore illustrates two distinct pathways to reduced quality of life. In the obesity group, the largest disadvantage appeared in the psychological domain, potentially reflecting social evaluation and internalized appearance norms. In the motor-disability group, the largest disadvantages appeared in physical and environmental domains, consistent with functional limitations and structural accessibility. This differentiation is more informative than a global comparison of total well-being because it avoids collapsing different types of burden into one hierarchy.

The nonsignificant social-domain difference also merits careful interpretation. The motor-disability group had a numerically higher mean, but $p = .06$. With only 42 participants per group, the study had limited precision for smaller or moderate effects. The observed $d = 0.41$ suggests that a potentially meaningful difference cannot be ruled out. At the same time, social quality of life is influenced by many factors beyond bodily condition, including family relationships, friendship networks, community participation, socioeconomic resources, and support-group involvement. Recruitment through associations and support groups could also have affected the social experiences represented in the sample.

The correlation matrices show that fear of negative evaluation and body appreciation were related to quality of life in both groups, but the pattern differed in magnitude and domain coverage. In the obesity group, BFNE was strongly associated with psychological and social quality of life and moderately associated with physical quality of life. In the motor-disability group, BFNE was associated with psychological and social quality of life but not with physical or environmental domains. This distinction is theoretically coherent. Fear of judgment is most directly psychological and interpersonal, whereas environmental accessibility and physical functioning may be determined more strongly by structural and functional conditions.

Body appreciation was positively associated with psychological quality of life in both groups, reinforcing the broader literature that positive body image is linked to well-being. Among women with motor disability, BAS-2 was also strongly related to physical quality of life. One possible interpretation is that feeling more positively toward the body is easier when physical functioning is perceived as less burdensome; another is that an appreciative orientation toward the body may support adaptive engagement despite limitation. Because the data are cross-sectional, these possibilities cannot be separated.

The strong correlation between physical and environmental quality of life in the motor-disability group ($r = .72$) is also noteworthy. It is consistent with the view that functional capacity

and environmental accessibility interact. A mobility limitation may have relatively little effect in an accessible environment and much greater effect in an environment characterized by architectural, transport, or institutional barriers. This relationship supports the relevance of disability models that move beyond purely medical explanations of quality of life.

The obesity-group correlations, by contrast, suggest a tighter coupling between social evaluation and body-related self-perception. The BFNE-BAS-2 association of $-.75$ is large enough to indicate substantial shared variance, although the constructs remain conceptually distinct. This pattern is compatible with a social-evaluative pathway in which anticipated judgment and body appreciation mutually reinforce one another. Formal structural-equation modeling in a larger sample could test a model linking experienced stigma to BFNE, body appreciation, and psychological quality of life while also evaluating alternative pathways.

The exploratory BMI-class analyses showed a strikingly ordered pattern: as obesity class increased, body appreciation decreased, fear of negative evaluation increased, and psychological quality of life declined. This gradient is compatible with the hypothesis that greater visible departure from thinness norms may intensify weight-related social evaluation. Rubino et al. (2020) noted that weight discrimination is more frequently reported at higher BMI levels, and it is plausible that higher-weight individuals encounter more frequent or more explicit stigma.

However, the result should be interpreted conservatively. BMI class is an imperfect proxy for stigma exposure and may be associated with many other factors. Greater obesity severity can correlate with physical symptoms, health-care encounters, long-term weight cycling, socioeconomic disadvantage, or longer exposure to weight-related commentary. The study did not measure these factors. The smallest subgroup, Class III, contained only five participants, making its mean particularly sensitive to individual observations. In addition, the class counts account for only 40 of the 42 women in the obesity group. These limitations make the analysis exploratory rather than confirmatory.

A future study should directly test whether experienced weight stigma increases with BMI and whether that increase explains the gradient in BFNE and body appreciation. Such a design could distinguish a visibility/stigma mechanism from a direct association between obesity-related health burden and psychological quality of life. It would also be important to consider nonlinear effects, because the relationship between BMI and social stigma may not increase uniformly across the entire range.

The findings reinforce the view that bodily stigma should not be treated as a uniform phenomenon. Obesity and motor disability may generate different psychological configurations because they differ in perceived controllability, stereotype content, visibility, and structural consequences. For obesity, moralized beliefs about personal responsibility, gendered appearance norms, and social visibility may intensify fear of negative evaluation and undermine body appreciation. In motor disability, social devaluation may instead operate through paternalism, lowered expectations, ableism, and environmental exclusion. The results also support integrating stigma theory with positive body-image research, as body appreciation was strongly related to psychological well-being in both groups and may represent not only an outcome but also a potential

resilience factor. Attribution theory remains a plausible explanatory framework, but perceived controllability was not directly measured and therefore cannot be considered a confirmed mechanism.

Clinically, assessment should extend beyond body dissatisfaction to fear of judgment, social avoidance, internalized stigma, and the influence of social evaluation on self-worth. Interventions for women with obesity may benefit from addressing internalized weight bias, self-critical beliefs, and body appreciation while distinguishing realistic awareness of discrimination from generalized anticipatory threat. For women with motor disabilities, psychological support should be complemented by attention to accessibility, assistive resources, transportation, and structural barriers. At the public-health level, weight stigma should not be reinforced through shame-based messaging, while disability-related inequalities require accessibility and anti-ableist policies rather than an exclusive focus on individual resilience.

Several limitations constrain interpretation. The cross-sectional design prevents causal inference, and stigma itself was not directly measured. The modest sample limits precision, subgroup analyses, and multivariable adjustment, particularly in the obesity-severity analysis. Additional concerns include inconsistencies in the reported BMI-class counts and age-comparison statistics, limited characterization of motor disability and obesity history, reliance on self-report, possible recruitment bias, restriction to single women, insufficient cultural contextualization, absence of measurement-invariance testing, and the risk of Type I error from multiple comparisons. Future studies should use larger and more diverse samples, direct stigma measures, longitudinal or experimental designs, better clinical characterization, and preregistered analyses.

5. Conclusion

This study compared psychological well-being in single women with obesity and women with motor disability, two stigmatized bodily conditions associated with distinct psychosocial challenges. Women with obesity reported greater fear of negative evaluation, lower body appreciation, and poorer psychological quality of life, whereas women with motor disability showed poorer physical and environmental quality of life. Social quality of life did not differ significantly between groups.

In both groups, fear of negative evaluation was negatively associated with body appreciation and with psychological and social quality of life. These associations were stronger in the obesity group, especially the relationship between fear of negative evaluation and body appreciation, suggesting a close link between anticipated social judgment and body regard. Exploratory analyses also indicated that increasing obesity severity was accompanied by greater fear of negative evaluation, lower body appreciation, and poorer psychological quality of life.

These findings are consistent with theories emphasizing the social meaning of bodily conditions. Obesity is often associated with assumptions of personal responsibility, which may intensify anticipated judgment and self-devaluation. Motor disability may instead involve ableism, paternalism, social exclusion, and environmental constraints. However, these interpretations remain provisional because neither stigma exposure nor perceived controllability was measured directly.

The study does not establish that one form of stigma is more severe than another, but indicates that different stigmatized bodily conditions may be associated with distinct psychological and quality-of-life profiles. Interventions for women with obesity may benefit from addressing fear of negative evaluation, internalized weight bias, and body appreciation, whereas approaches for women with motor disabilities should prioritize accessibility and structural barriers. Future research should use larger, diverse, longitudinal samples and directly assess stigma, attributional beliefs, disability identity, social support, and environmental barriers.

References

- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice-Hall.
- Halliwell, E. (2013). The impact of thin idealized media images on body satisfaction: Does body appreciation protect women from negative effects? *Body Image*, 10(4), 509-514. <https://doi.org/10.1016/j.bodyim.2013.07.004>
- Himmelstein, M. S., Puhl, R. M., & Quinn, D. M. (2018). Weight stigma and health: The mediating role of coping responses. *Health Psychology*, 37(2), 139-147. <https://doi.org/10.1037/hea0000575>
- Leary, M. R. (1983). A brief version of the Fear of Negative Evaluation Scale. *Personality and Social Psychology Bulletin*, 9(3), 371-375.
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363-385. <https://doi.org/10.1146/annurev.soc.27.1.363>
- Major, B., & O'Brien, L. T. (2005). The social psychology of stigma. *Annual Review of Psychology*, 56, 393-421.
- Mannor, K. M., & Needham, B. L. (2024). The study of ableism in population health: A critical review. *Frontiers in Public Health*, 12, 1383150. <https://doi.org/10.3389/fpubh.2024.1383150>
- Nosek, M. A., & Hughes, R. B. (2003). Psychosocial issues of women with physical disabilities: The continuing gender debate. *Rehabilitation Counseling Bulletin*, 46(4), 224-233.
- Oliver, M. (1990). *The politics of disablement*. Macmillan.
- Pearl, R. L., & Puhl, R. M. (2018). Weight bias internalization and health: A systematic review. *Obesity Reviews*, 19(8), 1141-1163. <https://doi.org/10.1111/obr.12701>
- Puhl, R. M., & Heuer, C. A. (2009). The stigma of obesity: A review and update. *Obesity*, 17(5), 941-964.
- Puhl, R. M., Himmelstein, M. S., & Pearl, R. L. (2020). Weight stigma as a psychosocial contributor to obesity. *American Psychologist*, 75(2), 274-289. <https://doi.org/10.1037/amp0000538>
- Romano, K. A., Heron, K. E., Sandoval, C. M., MacIntyre, R. I., Howard, L. M., Scott, M., & Mason, T. B. (2023). Weight bias internalization and psychosocial, physical, and behavioral health: A meta-analysis of cross-sectional and prospective associations. *Behavior Therapy*, 54(3), 539-556. <https://doi.org/10.1016/j.beth.2022.12.003>

- Rubino, F., Puhl, R. M., Cummings, D. E., Eckel, R. H., Ryan, D. H., Mechanick, J. I., Nadglowski, J., Ramos Salas, X., Schauer, P. R., Twenefour, D., Apovian, C. M., Aronne, L. J., Batterham, R. L., Berthoud, H. R., Boza, C., Busetto, L., Dicker, D., De Groot, M., Eisenberg, D., ... Dixon, J. B. (2020). Joint international consensus statement for ending stigma of obesity. *Nature Medicine*, 26, 485-497. <https://doi.org/10.1038/s41591-020-0803-x>
- Shakespeare, T. (2018). *Disability: The basics*. Routledge.
- Tylka, T. L., & Wood-Barcalow, N. L. (2015a). The Body Appreciation Scale-2: Item refinement and psychometric evaluation. *Body Image*, 12, 53-67.
- Tylka, T. L., & Wood-Barcalow, N. L. (2015b). What is and what is not positive body image? Conceptual foundations and construct definition. *Body Image*, 14, 118-129. <https://doi.org/10.1016/j.bodyim.2015.04.001>
- Watson, D., & Friend, R. (1969). Measurement of social-evaluative anxiety. *Journal of Consulting and Clinical Psychology*, 33(4), 448-457.
- Weiner, B. (1995). *Judgments of responsibility: A foundation for a theory of social conduct*. Guilford Press.
- WHOQOL Group. (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological Medicine*, 28(3), 551-558.