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Weight-Based Microaggressions Experienced by Obese Women in Psychotherapy

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WEIGHT-BASED MICROAGGRESSIONS EXPERIENCED BY
OBESE WOMEN IN PSYCHOTHERAPY

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ABSTRACT

Weight-Based Microaggressions Experienced by Obese Women in Psychotherapy

by

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A large body of research demonstrates the existence of weight bias in healthcare professionals, including physicians, nurses, and dietitians (Budd, Mariotti, Graff, & Falkenstein, 2011). Very few published studies examine mental health providers' attitudes toward obese clients, but a small body of existing data suggests that mental health providers attribute more negative personal attributes to fictional obese clients and rate them as having more severe symptoms than their average weight counterparts (Agell & Rothblum, 1991; Hassel, Amici, Thurston, & Gorsuch, 2001; Young & Powell, 1985). Given these findings, it is important to understand whether obese clients experience mental health professionals as stigmatizing and, if so, how this impacts clients and the therapeutic work. Consequently, this study explored obese women's experiences with weight-related microaggressions (subtle, perhaps unintentional communications of weight bias) in psychotherapy. Fifteen obese women (mean BMI = 41.52) who were currently attending therapy participated in semi-structured interviews inquiring about general therapy experiences and experiences with weight stigma in psychotherapy. Data were coded using a general inductive approach to identify themes emerging from participants' experiences. Overall, participants reported very few weight-related microaggressions in therapy. Other key findings included participants' responses

regarding whether and how their weight impacts therapy sessions, with an emerging theme of being less forthcoming or more evasive in therapy due to weight. Many participants also reported reactions (often negative and rarely discussed in therapy) to their therapist's body size or appearance. Participants also offered advice to therapists working with overweight clients. They suggested allowing clients to initiate and direct conversations about weight in therapy, but advice otherwise tended to focus on general, non-weight-related interventions. Implications for clinical practice and training and future research are discussed.

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CHAPTER 1

INTRODUCTION

Weight stigma, defined as negative attitudes about overweight and obese individuals, is highly prevalent, drastically increasing, and rarely challenged in the United States and other Western cultures (Andreyeva, Puhl, & Brownell, 2008; Puhl & Heuer, 2009). For example, research suggests that adults commonly characterize obese individuals as lazy, ugly, sloppy, incompetent, stupid, self-indulgent, awkward, and lacking in confidence and self-discipline (Greenleaf, Starks, Gomez, Chambliss, & Martin, 2004; Hilbert, Rief, & Braehler, 2008; Puhl & Brownell, 2001; Puhl & Latner, 2007). Consistent with adult literature, children in the United States demonstrate negative attitudes toward overweight peers as early as age three (Cramer & Steinwert, 1998).

Weight stigma has a range of negative consequences, including discrimination in interpersonal (Chen & Brown, 2005; Puhl & Brownell, 2006), employment (Puhl & Heuer, 2009), and healthcare settings (Mold & Forbes, 2011). For instance, recent research suggests that one-quarter to two-thirds of obese children are victims of weight-based teasing and bullying (Eisenberg, Neumark-Sztainer, & Story, 2003; Griffiths, Wolke, Page, & Horwood, 2006; Neumark-Sztainer et al., 2002). Additionally, obese adults earn lower wages (Judge & Cable, 2011), are less likely to be involved in dating relationships (Sheets & Ajmere, 2005), and report more frequent discrimination from a number of sources (Carr & Friedman, 2005) than average weight adults. Furthermore, experiencing weight stigma and discrimination is associated with negative psychological outcomes, including depression, poor self-esteem, and body dissatisfaction (Friedman et

al., 2005), which may play a role in the increased prevalence of medical problems in the obese population (Puhl & Heuer, 2010).

Given the harmful consequences of weight stigma and related discrimination, it is important to examine its prevalence in healthcare professionals, including physicians, nurses, dietitians, and students in these fields. Existing research consistently demonstrates that healthcare professionals hold biased attitudes and beliefs about obese patients that are similar to those seen in the general population (Budd et al., 2011; Mold & Forbes, 2011; Puhl & Heuer, 2009). In addition to characterizing obese individuals as having a number of undesirable personal attributes (Bagley, Conklin, Isherwood, Pechiulis, & Watson, 1989; Foster et al., 2003), healthcare professionals tend to perceive obese patients as unmotivated and non-compliant (Brown, Stride, Psarou, Brewins, & Thompson, 2007; Campbell, Engel, Timperio, Cooper, & Crawford, 2000; Thuan & Avignon, 2005) and often attribute weight gain to factors within patients' control, such as poor diet and lack of exercise (Foster et al., 2003; Harvey, Summerbell, Kirk, & Hill, 2002; Hoppe & Ogden, 1997). These attitudes do not go unnoticed by patients, who rank healthcare professionals as among the most common sources of weight-based stigma (Puhl & Brownell, 2006). Obese individuals also cite anticipation of stigmatizing experiences as a deterrent to seeking medical treatment (Amy, Aalborg, Lyons, & Keranen, 2006; Drury & Louis, 2002). This is particularly problematic given the importance of preventative care in a population at increased risk for medical comorbidities (Reilly & Kelly, 2011).

Despite a relatively large body of data on weight stigma in other healthcare professionals, mental health practitioners' attitudes, beliefs, and practices toward obese

clients remain largely unstudied. The few published studies that exist yield mixed findings, but generally suggest that mental health providers exhibit less weight stigma than other healthcare professionals. For example, one study found that obese participants ranked mental health professionals as among the least common sources of interpersonal stigma (Puhl & Brownell, 2006). However, bias still exists: Research suggests that mental health professionals tend to 1) ascribe more negative personal attributes to fictional obese clients than average weight clients (Agell & Rothblum, 1991; Hassel et al., 2001), and 2) rate fictional obese clients as having more severe symptoms than average weight clients (Hassel et al., 2001; Young & Powell, 1985).

Given professional emphasis on respecting clients' dignity and self-worth (American Psychological Association [APA], 2010) and the importance of monitoring personal biases in mental health care training and practice (APA, 2002), when weight bias is communicated by mental health providers it is likely communicated in subtle, unintentional, and/or unconscious ways. One way to understand how weight-related messages may be communicated to clients in mental health settings is by examining microaggressions in the therapy context. *Microaggressions* are subtle, often unintentional expressions of negativity toward an individual because of their membership in a marginalized group (Sue et al., 2007). Microaggression research examines the discriminatory experiences of members of many marginalized groups including racial, ethnic, and sexual minorities (Nadal et al., 2011; Solórzano, Ceja, & Yosso, 2000; Sue, Bucceri, Lin, Nadal, & Torino, 2009); women (Capodilupo et al., 2010); individuals in lower social classes (Smith & Redington, 2010); and those with mental, physical, and/or emotional disabilities (Keller & Galgay, 2010). More recently, researchers have also

examined microaggressions experienced by African American and lesbian, gay, bisexual, and queer clients in psychotherapy contexts (Constantine, 2007; Shelton & Delgado-Romero, 2011). Microaggressions described by these two groups in mental healthcare settings were strikingly similar and included themes such as therapists' stereotypical assumptions based on sexual orientation or race, over-identifying with clients, minimizing or avoiding discussions of sexual orientation or race, and denying the existence of systemic oppression.

To date, no published research examines weight-based microaggressions in a therapeutic context. This topic is important because experiencing microaggressions may be more detrimental to individual well-being than overt expressions of prejudice (Salvatore & Shelton, 2007; Solórzano et al., 2000). Theoretically, microaggressions are confusing to the victim because they are subtle enough that the perpetrator can easily dismiss the offense (Sue, Capodilupo, Nadal, & Torino, 2008) and the aggressed individual may be left questioning his or her experience of reality (Sue, 2010). Additionally, the power dynamics inherent in psychotherapy in which the clinician has more power (e.g., makes diagnoses, creates treatment plans) and the client is seeking professional help to navigate a given issue may make a client less likely to speak out against a perceived offense and more likely to doubt his or her own experience. As such, microaggressions occurring in this setting may be particularly damaging to clients (Sue et al., 2007). Further, a small body of research suggests that perceived microaggressions in therapeutic settings are associated with lower ratings of counseling satisfaction and therapeutic alliance and more negative therapy outcome (Constantine, 2007; Owen, Tao, & Rodolfa, 2010).

Consequently, to build upon the limited existing data on mental health professionals' attitudes toward obese individuals, this study used semi-structured interviews to obtain qualitative accounts of weight-based stigma and discrimination experienced by obese women in therapy. Using a general inductive theory approach to data analysis, responses were coded into themes that described participants' general experiences in therapy, the types of weight-based microaggressions obese women experienced in therapy (if any), and advice to therapists working with obese clients. Clinically, this information is useful to alert providers to weight-related biases that may be outside their awareness; how these biases may be communicated to obese clients; and how the communication of such biases may impact therapy from the client's perspective. These data also result in some recommendations to clinicians about engaging in helpful, sensitive treatment with this population.

CHAPTER 2

LITERATURE REVIEW

Weight stigma (also referred to as *anti-fat attitudes*, *weight bias*, or *obesity stigma*) is defined as negative attitudes or beliefs about overweight and obese individuals. Often accompanied by *weight-based discrimination*, in which overweight and obese individuals are treated more negatively because of their weight status, weight stigma is highly prevalent, drastically increasing, and rarely challenged in the United States and other Western cultures (Andreyeva et al., 2008; Puhl & Heuer, 2009). This literature review summarizes the extant literature on weight stigma and discrimination to illustrate the prevalence, types, and consequences of weight stigma. Specifically, Section 1 reviews the prevalence and types of attitudes that adults and children self-report about obese individuals, explores implicit attitudes and attributional theories of weight bias, and summarizes research on weight-based discrimination in interpersonal and employment settings. Section 2 reviews the literature on weight stigma in healthcare settings, including obese patients' reports of stigmatizing experiences, healthcare professionals' (i.e., physicians, nurses, dietitians, and students in these fields) self-reported beliefs about obese patients, and the effects of this stigma on patients. Section 3 summarizes the small body of literature examining weight stigma in mental health care settings, including theoretical writings about and anecdotal accounts of countertransference toward obese clients.

Section 4 focuses on microaggressions, which may be a vehicle through which mental health professionals convey weight stigma to clients. This section reviews a taxonomy of microaggressions; common racial, sexual orientation, and gender

microaggressions; theoretical and quasi-experimental research demonstrating the effects of this form of prejudice; and studies that examine the types and impact of microaggressions in therapeutic contexts. This section concludes with a discussion of the one study that identified weight-based microaggressions in mental health settings and transitions into Section 5, which frames the importance of the current study in the context of the literature reviewed.

Section 1: Weight Bias and Weight-Based Discrimination

Despite the fact that the majority of adults in the United States are overweight or obese¹ (Ogden & Carroll, 2010), these individuals are commonly characterized as possessing a variety of negative personality traits (Hilbert et al., 2008; Puhl & Heuer, 2009; Puhl & Latner, 2007), which may be at least partially due to the perception that they are responsible for their stigmatized condition (Crandall et al., 2001). Furthermore, obese individuals frequently face discrimination in interpersonal, employment, and healthcare settings (Mold & Forbes, 2011; Puhl & Heuer, 2009).

Self-reported Weight Bias

Researchers often employ self-report measures to examine explicit stigmatizing attitudes about obese individuals. Most studies in this area compare participants' ratings of overweight or obese targets (represented as fat, overweight, or obese either pictorially or in writing) to ratings of thin targets. Overall, such studies consistently demonstrate that adults and children rate overweight and obese individuals as lazy, unmotivated, bad, unhappy, unconfident, self-indulgent, unattractive, and lacking in self-discipline compared to average weight or thin individuals (Bell & Morgan, 2000; Brylinski & Moore, 1994; Hebl & Heatherton, 1998; Puhl & Latner, 2007; Robertson & Vohora, 2008; Tiggemann & Rothblum, 1997; Tiggemann & Wilson-Barrett, 1998; Wang, Brownell, & Wadden, 2004). For example, Brochu and Morrison (2007) surveyed 76

¹ *Overweight* refers to individuals with a Body Mass Index (BMI; weight in kilograms divided by height in meters squared) between 25 and 29.9 and *obese* refers to individuals with a BMI greater than 30. Individuals can also be classified as *mildly obese* with a BMI between 30 and 34.9, *moderately obese* with a BMI between 35 and 39.9, and *severely obese* with a BMI greater than 40. I use the terms *overweight*, *obese*, and *fat* throughout this literature review, consistent with the language used by the researchers whose studies I summarize.

Canadian college students, who assigned fewer positive traits (e.g., happy, attractive, hardworking) and more negative traits (e.g., inactive, sloppy, unpopular) to targets described as overweight than those described as average weight. Participants also reported a greater likelihood of engaging in several interpersonal behaviors (e.g., want to get to know them better, ask to copy their notes, invite them to a study group) with average weight than overweight targets.

Another survey required 130 British undergraduates to rate personality characteristics of photographs of women with body sizes ranging from emaciated to obese (Swami et al., 2008). Participants rated individuals as lazier as the weight status of the drawings increased, and ratings of loneliness and the propensity to “get teased” demonstrated a curvilinear relationship such that participants rated the figure representing a BMI of 19 to 20 (within the average weight range) the most favorably and judged figures on either end of the weight spectrum increasingly negatively. Finally, another sample of 356 college students ranked the likeability of figure drawings representing individuals with the following characteristics: healthy, obese, missing a hand, having a facial disfigurement, in a wheelchair, and on crutches. Participants ranked the obese figure drawing as second least-liked (more liked than only the figure missing a hand) (Latner, Stunkard, & Wilson, 2005).

In a highly detailed study of perceived personality attributes and weight status, Greenleaf and colleagues (2004) presented 131 college students with nine human drawings ranging in body size from very thin to obese. When asked to choose one figure that best matched a list of personality characteristics (e.g., lazy, slow, boring, friendly), the majority of participants chose one of the three largest figures to represent the

following characteristics: lazy (86% when rating male figures and 76% when rating female figures), slow (86% for male figures and 71% for female figures), boring (56% for male figures and 44% for female figures), unfriendly (55% for male figures and 46% for female figures), and stupid (49% for male figures and 27% for female figures). In contrast, less than one percent of participants chose any of the three largest line drawings (male or female) as representative of the characteristics “physically fit” or “motivated.” Participants also listed the first three words that came to mind in response to the prompts “overweight,” “fat,” and “obese.” The most frequently generated words included “inactive” (generated by 10 to 30 participants, depending on the weight label), “lazy” (generated by 17 to 27 participants) and “unhealthy” (generated by 16 to 27 participants). Participants also associated the following words with the labels overweight, fat, and obese: gross and disgusting (generated by 2 to 11 participants); sad, unhappy, and depressed (2 to 8); slow (2 to 7); ugly and unattractive (2 to 6); overeater (2 to 6); pig (1 to 5); and bad (2 to 4). It is also noteworthy that participants only generated negatively-valenced words to describe fat or obese individuals, and the only neutral to positively-valenced words used to describe overweight individuals were “average” (by 5 participants) and “athletic” (by 4 participants).

Samples of children also demonstrate weight stigma. In an early study of weight bias (Harris & Smith, 1983), 447 children (preschool through fifth grade) and college students rated figure drawings representing normal weight individuals as happier, less lonely, less mean, better looking, smarter, having more friends, and more desirable as friends than figure drawings representing fat individuals. These findings were true regardless of participant gender, age, ethnicity, or weight status. Another study

demonstrated that such weight-biased attitudes may emerge as early as age three (Cramer & Steinwert, 1998).

Implicit Weight Bias

Despite these compelling self-report data, one limitation of studies that elicit self-reported stigmatizing attitudes is that they may be susceptible to underreporting, due to socially desirable responding or lack of conscious awareness of prejudice (Greenwald & Banaji, 1995). In an attempt to address this limitation, researchers examine implicit attitudes toward overweight and obese individuals (Watts & Cranney, 2009). The Implicit Associations Test (IAT) is a timed word classification task that is less susceptible to socially desirable responding because it assesses attitudes that exist outside of conscious awareness (Greenwald, McGee, & Schwartz, 2008). Participants must categorize words that appear on the screen into one of the following categories: good, bad, fat, or thin. Words are positioned in the middle of the page, with column headings on either side that include the names of two of the categories. The category headings are either “matched” (i.e., thin/good, fat/bad) or “mismatched” (i.e., thin/bad, fat/good) to represent stereotyped or non-stereotyped associations. Participants must categorize each word correctly, as quickly as possible. When performance is better on matched rather than mismatched trials, it theoretically indicates a stronger implicit association between words and their stereotyped associations (e.g., fat and bad) (Greenwald et al., 2008).

One important consideration in interpreting the results of the IAT is that it is difficult to differentiate implicit anti-fat bias from pro-thin bias. Overall, however, a number of studies using the IAT demonstrate associations between fat people and negative qualities in samples including men, women, fitness professionals, college

students, physical education majors, healthcare professionals, and overweight individuals (Schwartz, Vartanian, Nosek, & Brownell, 2006; Watts & Cranney, 2009). For example, Teachman, Gapinski, Brownell, Rawlins, and Jeyaram (2003) conducted several studies on samples of college students and adults in the general population and found significant implicit anti-fat/pro-thin bias for the adjectives of good/bad, lazy/motivated, and worthless/valuable. Utilizing similar methodology, Bessenoff and Sherman's (2000) sample of 127 undergraduates more quickly categorized words representing negative personality traits when they were primed with a photograph of a fat woman compared to a photograph of a thin woman. Participants' implicit attitudes also predicted a behavioral measure of weight discrimination (i.e., how far they chose to sit from a fat woman).

Sociocultural Theories of Weight Bias

Weight bias has been labeled the last acceptable form of stigma in the United States (Puhl & Brownell, 2001). Consistent with this assertion, sociocultural agents such as mainstream media outlets (i.e., film, television, advertising, and news sources) do not hesitate to portray obese individuals in ways that are largely consistent with stigmatizing cultural stereotypes (Himes & Thompson, 2007; Kim & Willis, 2007; Robinson, Callister, & Jankoski, 2008). For instance, a content analysis of 549 images accompanying news stories about obesity revealed that 72% of the images stigmatized obese individuals (Heuer, McClure, & Puhl, 2011). Specifically, compared to photos of non-overweight individuals, photos of obese individuals more often portrayed eating or drinking and depicted stomachs and/or lower bodies only (with heads cropped out). Obese individuals were also less frequently shown fully clothed, wearing professional clothing, or exercising. Overweight and obese individuals are also underrepresented in

television programs (Fouts & Burggraf, 2000; Kaufman, 1980) and, when present, they are rarely main characters, are less frequently involved in romantic relationships, and have less friendships and positive interactions with others than thinner characters (Greenburg, Eastin, Hofschire, Lachlan, & Brownell, 2003). In fact, associations between media utilization and weight-biased attitudes suggest that media portrayals of obese individuals may perpetuate stereotypes of obesity (Latner, Rosewall, & Simmonds, 2007; Lin & Reid, 2009). For instance, McClure, Puhl, and Heuer (2011) demonstrated that adults who viewed stigmatizing images of obese individuals accompanying a neutral news story about obesity reported more anti-fat attitudes than participants who viewed positive images of obese individuals accompanying the same story.

In addition to the apparent acceptability of weight stigma in the media, data also suggests that weight-based discrimination may occur at similar rates or more frequently than other kinds of discrimination (Latner, O'Brien, Durso, Brinkman, & MacDonald, 2008; Puhl, Andreyeva, & Brownell, 2008), supporting the claim that weight bias is relatively socially acceptable in the United States and other Western cultures. For instance, in a sample of 368 undergraduates from Hawaii and New Zealand, participants endorsed more dislike of obese individuals than of homosexual and Muslim individuals (Latner et al., 2008). Additionally, in a nationwide survey of 2297 men and women in the United States, participants reported experiencing weight-based and racial discrimination at similar rates, and classified weight-based discrimination as occurring more frequently than age and gender bias (Puhl, Andreyeva et al., 2008).

Attributional Theories of Weight Bias

In addition to sociocultural normalization of weight bias, attributional theories of weight stigma may explain the social acceptability of weight-based discrimination. Attributional theory asserts that obese individuals are particularly targeted for stigma and discrimination because their condition (i.e., obesity) is perceived as controllable (Crandall et al., 2001). In fact, a number of studies demonstrate a significant, positive relationship between attributions of personal responsibility for obesity and negative attitudes toward obese individuals (Allison, Basile, & Yunker, 1991; Crandall, 1994; Crandall et al., 2001; Ebner, Latner, & O'Brien, 2011; Hilbert et al., 2008). For example, Hilbert and colleagues (2008) found that attributing obesity to factors within personal control was the best predictor of anti-fat attitudes in a sample of 1000 German adults. Negative attitudes toward obese individuals are also positively associated with other variables that signify a belief in individual responsibility, including just-world beliefs (Crandall, 1994; Ebner et al., 2011), ideological values of hard work and self-determination, political conservatism, and blaming poor people for their poverty (Crandall & Biernat, 1990; Crandall, 1994; Morrison & O'Conner, 1999).

Further support for this theory comes from findings indicating that manipulating attributions about controllability results in reduced stigmatizing attitudes (Daníelsdóttir, O'Brien, & Ciao, 2010; Hague & White, 2005; Robinson, Bacon, & O'Reilly, 1993; Weiner, Perry, & Magnusson, 1988; Wiese, Wilson, Jones, & Neises, 1992). For example, Crandall (1994) demonstrated that informing participants that obesity is caused by metabolism and genetics resulted in fewer attributions of responsibility and less dislike of obese individuals than providing participants with no causal information; these

effects persisted for at least one week (Crandall & Reser, 2005). Similarly, high school girls rated obese individuals as more self-disciplined, less self-indulgent, more attractive, more well-liked, more similar to themselves, stronger, and more active when obesity was attributed to a thyroid problem than when no information about the cause of obesity was provided (DeJong, 1980; DeJong, 1993).

Some research suggests that even implicit weight-biased attitudes are susceptible to experimental manipulation. Teachman and colleagues (2003) found that participants who read a summary of research attributing obesity to factors within personal responsibility (i.e., overeating, lack of exercise) more easily associated fat people with “bad” and “lazy” than participants in other experimental conditions. Notably, priming participants with attributions outside of personal control (i.e., genetics) did not result in less implicit bias than was present in the control group, and several studies failed to demonstrate altogether that manipulating attributions of controllability influenced stigmatizing attitudes (Anesbury & Tiggemann, 2000; Harris, Walters, & Waschull, 1991; Hegarty & Golden, 2008).

Experiences with Stigma and Discrimination

One important negative effect of weight stigma is that it results in weight-based discrimination in a variety of settings (Puhl & Heuer, 2009). For example, Carr and Friedman (2005) analyzed data from 3437 men and women in the United States regarding experiences with several kinds of discrimination. Obese individuals in this sample were 40 to 50 times more likely than normal weight individuals to report having experienced major discrimination (i.e., not getting hired, being turned down for a scholarship, being denied or provided inferior healthcare), 1.3 to 1.7 times more likely to report day-to-day

interpersonal discrimination (i.e., being treated with less courtesy/respect, called names/insulted, treated as if stupid/inferior, etc), and 2.3 to 4.7 times more likely to attribute discrimination to weight or appearance.

Discrimination in interpersonal relationships. Overall, research demonstrates that obese individuals experience interpersonal discrimination in a range of settings (e.g., at home, school, work, in public places) and from a variety of offenders, including friends, family members, spouses, and strangers (Puhl, Moss-Racusin, Schwartz, & Brownell, 2008). For example, Lewis and colleagues (2011) interviewed 141 obese Australian men and women (mean BMI = 39.3), 86% of whom reported experiencing interpersonal weight stigma. About two-thirds of participants reported overt incidents, including unsolicited weight loss advice and mean comments relaying assumptions about overeating. In an extreme example, one participant reported being told by a friend that her miscarriage was for the best because she was too heavy to have a child. Additionally, nearly three-fourths of participants described subtle, more subjective forms of interpersonal stigma, including being stared at while eating, feeling judged while exercising in public, being ignored by customer service workers, and witnessing friends mocking other obese individuals.

A qualitative analysis of the experiences of 31 postoperative gastric bypass patients revealed that participants perceived changes in how others responded to them before and after significant weight loss (Meana & Ricciardi, 2008). Participants reported feeling “invisible” before surgery and being more frequently acknowledged by others after surgery. They also described fewer negative reactions (e.g., stares, negative comments from children, judgment while eating) and more positive reactions (e.g., eye

contact and smiles, attentive customer service) post-surgery compared to pre-surgery.

Several participants noted that they were unaware of the weight bias aimed at their obese selves until they lost weight and experienced others' increased interest and receptiveness.

Several researchers examined stigma using the Stigmatizing Situations Inventory (Myers & Rosen, 1999), which requires participants to rate how frequently they encounter a variety of explicitly stigmatizing experiences in interpersonal interactions (e.g., comments from children, family members, doctors) on a 10-point scale (0 = never, 1 = once in your life, 2 = several times in your life, 3 = once per year, etc.). In a sample of 146 obese individuals (mean BMI = 49.5), participants most frequently encountered negative weight-related comments from children ($m = 2.88$); negative assumptions about their personal abilities and/or emotional health ($m = 2.49$); and physical barriers, such as difficulty fitting into seats or finding clothes that fit ($m = 2.14$), with these experiences occurring several times throughout participants' lives to once per year. Participants also reported the following experiences occurring between once to several times in their lives: being stared at ($m = 1.9$); receiving nasty comments from family members ($m = 1.88$); hearing negative weight-related comments from strangers ($m = 1.83$); being avoided, excluded, or ignored ($m = 1.78$); and knowing that loved ones are embarrassed by their size ($m = 1.53$). Severely obese participants (i.e., BMI greater than or equal to 40) in this sample reported encountering stigma more frequently than mild to moderately obese participants.

Similarly, Friedman and colleagues (2005) administered the Stigmatizing Situations Inventory to 93 men and women in a residential weight-loss facility (mean BMI = 42.3). In addition to subscale means, they reported the percentage of participants

who had ever experienced each type of interpersonal stigma. Nearly the entire sample reported receiving nasty comments from family members (98%; $m = 1.47$) and encountering physical barriers due to their size (97%; $m = 1.78$). Over three-fourths of the sample reported receiving stigmatizing comments from strangers (89%; $m = 1.24$), knowing that loved ones were embarrassed by their size (86%; $m = 1.56$), experiencing negative assumptions based on their size (78%; $m = 1.79$), and hearing negative comments from children (76%; $m = 1.62$). Additionally, over half reported being stared at (57%; $m = .71$) and being avoided, excluded, or ignored (56%; $m = 1.63$).

Finally, Puhl and Brownell (2006) administered an adapted version of the Stigmatizing Situations Inventory to 2449 women who belonged to a national, non-profit weight-loss support group (mean BMI = 37.6). Participants rated items on a modified 4-point scale (i.e., 0 = never; 1 = once in your life; 2 = more than once in your life; 3 = multiple times in your life), and the majority endorsed encountering the following at least once in their life: negative assumptions based on their weight (68%; $m = 1.58$); negative comments from children (63%; $m = 1.38$); negative comments from family members (51%; $m = 1.05$); physical obstacles due to their size (50%; $m = 1.16$); and loved ones being embarrassed by their size (50%; $m = .98$). Participants also rated how frequently they experienced stigma and/or discrimination from a list of potential interpersonal sources. The majority of participants reported feeling stigmatized from the following sources (at least once during their lifetime or multiple times during their lifetime, respectively): family members (72% lifetime, 62% multiple times), classmates (64% lifetime, 56% multiple times), sales clerks (60% lifetime, 47% multiple times), friends (60% lifetime, 42% multiple times), and mothers (53% lifetime, 44% multiple times).

Over 40% of participants reported experiencing stigma from spouses (47%, 32%), servers at restaurants (47%, 35%), strangers (46%, 35%), and fathers (44%, 34%). Over one-third reported stigma from sisters (37%, 28%) and brothers (36%, 28%); less frequently endorsed sources of stigma included teachers (32%, 21%), authority figures (e.g., police officers; 23%, 15%), sons (20%, 13%), and daughters (18%, 12%). Overall, visual comparisons of data from Puhl and Brownell (2006) and Friedman and colleagues (2005) support Myers and Rosen's (1999) finding that participants with higher BMIs more frequently encountered interpersonal stigma.

Interpersonal discrimination of children. Children and adolescents also experience weight-based discrimination from peers and family members. For example, compared to drawings of children who appeared healthy, were on crutches, were in a wheelchair, were missing a hand, or had a facial disfigurement, three-fourths of a sample of fifth and sixth graders ranked a drawing of an obese same-sex child as least well-liked (Latner & Stunkard, 2003). Dislike of obese peers may translate into weight-based teasing, which is highly prevalent in childhood and adolescence (Eisenberg et al., 2003). For example, research suggests that at least one-quarter to two-thirds of obese children are victims of weight-based teasing and bullying (Eisenberg et al., 2003; Griffiths et al., 2006; Neumark-Sztainer et al., 2002). Large-scale surveys of adolescents demonstrate that over one-quarter of moderately overweight girls and boys (i.e., BMI between 85th and 95th percentile for gender and age) have experienced overt weight-based bullying at least once (Neumark-Sztainer et al., 2002). Furthermore, 34% to 50% of obese adolescent girls (i.e., BMI at or above the 95th percentile for gender and age) and 36% to 45% of obese adolescent boys report weight-based teasing or bullying at frequencies of a few

times per year to more than once per month (Griffiths et al., 2006; Neumark-Sztainer et al., 2002).

Of note, a full 96% of the 50 overweight and obese high school girls interviewed in one study reported stigmatizing interactions with family members and/or friends (Neumark-Sztainer, Story, & Faibisch, 1998). Participants identified overt, seemingly intentionally hurtful comments as the most common stigmatizing experiences and male peers as the most frequent perpetrators. Participants perceived others to hold a number of negative assumptions of them based on their weight, including that they ate too much and/or ate the wrong foods, were unable to engage in certain physical activities (e.g., dancing), were strong and tougher than others, enjoyed fighting, were inactive/lazy, had no feelings, would react passively when teased, were unclean, and were unable to get a boyfriend. Self-report data from adolescent girls also indicate that weight-based teasing from family members is at least as frequent as weight-based teasing from peers (Eisenburg et al., 2003; Neumark-Sztainer et al., 2002).

Discrimination in interpersonal relationships: Sex differences. Some data suggests that women are more adversely affected by weight stigma than men (Fikkan & Rothblum, 2011). For example, one survey found that participants rated fat women as less happy, self-confident, self-disciplined, and attractive than fat men (Tiggemann & Rothblum, 1997). One area in which sex differences in weight stigma are particularly notable is the realm of heterosexual dating and/or sexual relationships. Regan (1996) surveyed 97 undergraduate men and women regarding their perceptions of sexual characteristics and behaviors of male and female targets whose height and weight descriptions placed them in either average weight or overweight categories. Findings

indicated that overweight women are particularly stigmatized on a number of sexual dimensions. Although participants rated overweight male targets similarly to normal weight men on nearly all variables (with the exception of perceiving overweight men as less sexually attractive/desirable and less likely to have a current sex partner), they rated overweight women more negatively than average weight women on nearly all variables. Participants characterized overweight women as less sexually attractive and desirable; less sexually skilled, warm, and responsive; less likely to have a current partner; more likely to be a virgin; less likely to experience sexual desire; and less likely to have a number of sexual encounters (e.g., intercourse, making out, kissing).

In a study asking 449 undergraduates to rank the sexual desirability of an array of figures, participants designated the obese figure as the least desirable, compared to figures labeled as healthy, missing an arm, in a wheelchair, having had a successfully treated STD, and having a history of suicide attempts and self-harm (Chen & Brown, 2005). Although this finding held true for both male and female participants, men ranked the obese figure as significantly less desirable than women. The authors did not report the rates at which participants ranked same-sex or opposite-sex figures, but assuming that most male participants were heterosexual suggests that obese women were especially stigmatized in this sample as well.

Self-reported dating prevalence further suggests that weight status influences whether a woman is involved in a dating relationship. Sheets and Ajmere (2005) found that half of undergraduate women with a BMI of 27 or higher had never dated, compared to only 25% of women with a BMI of 19 or lower. Men who were dating, on the other hand, had a higher average BMI than non-dating men. Further, in women who were in a

relationship, there was a marginally significant negative correlation between BMI and relationship satisfaction, although men exhibited a significant positive correlation between BMI and relationship satisfaction. Overall, surveys of adolescent boys and girls similarly demonstrate that increased BMI is associated with less likelihood of dating in girls, but not boys (Halpern, King, Oslak, & Udry, 2005; Pearce, Boergers, & Prinstein, 2002).

Finally, the stigma of obesity may be so strong that merely being near an overweight woman elicits negative judgments from others. Hebl and Mannix (2003) found that participants were less likely to recommend an average weight male confederate for hiring if he was seated near an overweight woman than if he was seated next to an average weight woman. Participants in the experimental condition additionally rated him as having poorer interpersonal skills and professional qualifications. These results held true regardless of the perceived depth of his relationship with the woman (i.e., dating vs. simply sitting next to one another) and even when participants were provided with information about the overweight woman that was expected to improve their impression of her (i.e., mentioning that she had won a prestigious award).

Discrimination in employment settings. Overweight and obese individuals also face discrimination in employment settings (Roehling, 1999; Rudolph, Wells, Weller, & Baltes, 2009). This fact is somewhat unsurprising given that federal laws do not protect against weight discrimination and only one state (Michigan) and three cities in the United States (Washington, DC; San Francisco, CA; and Santa Cruz, CA) have laws prohibiting weight discrimination (Yale Rudd Center, 2012). A number of experimental studies demonstrate that participants rate fictional obese job candidates as having less desirable

personal and professional qualities than normal weight job candidates (Puhl & Brownell, 2001). For example, ratings from 1024 adults in southern Central Europe less frequently designated overweight and obese female candidates for hiring or promotion and more frequently chose them for firing compared to normal and underweight female job candidates (Swami, Pietschnig, Stieger, Tovée, & Voracek, 2010).

Obese individuals generally endorse job discrimination less frequently (i.e., less than once per lifetime on average) than discrimination occurring in interpersonal or healthcare settings (Myers & Rosen, 1999; Puhl & Brownell, 2006). However, a significant portion of obese women (mean BMI = 42) surveyed by Puhl & Brownell (2006) reported experiencing weight stigma in the workplace from employers (43% once, 26% multiple times) and co-workers (54% once, 38% multiple times). Similarly, in a nationwide sample of 3437 adults in the United States, Carr & Friedman (2005) found that overweight individuals were 26% more likely to report job discrimination (i.e., not hired, not promoted, fired) than normal weight individuals. Furthermore, mildly obese individuals were 50% more likely and moderately to very obese individuals were 84% more likely to report job discrimination compared to normal weight individuals. The postoperative gastric bypass patients interviewed by Meana and Ricciardi (2008) described a number of ways in which their work experiences improved after surgery and significant weight loss. Specifically, they noted increased job opportunities, more respect from bosses and colleagues, and greater consideration of their professional ideas and contributions.

In addition to perceived job discrimination, surveys requiring participants to self-report wages and employment status point to weight-based discrimination on these

variables, particularly for women (Baum & Ford, 2004; Brunello & D'Hombres, 2007; Judge & Cable, 2011). In a sample of 6601 adults in the United States, for example, mildly obese women earned 5.8% less than their average weight counterparts, morbidly obese women earned 20-24% less, and morbidly obese men earned 4-20% less than average weight men (Maranto & Stenoien, 2000). Further, survey data from longitudinal and population-based samples in the United States and Canada indicate that obese individuals experience reduced employment than average weight individuals after controlling for a number of demographic, socioeconomic, and health variables (Klarenbach, Padwal, Chuck, & Jacobs, 2006; Tunceli, Li, & Williams, 2006).

Section 2: Weight Stigma in Healthcare Providers

To date, an emerging body of research suggests that healthcare professionals hold stigmatizing attitudes and beliefs about overweight and obese patients with regard to general personal attributes (e.g., intelligence, attractiveness, laziness), treatment-related factors (e.g., motivation and compliance), and beliefs about the causes of obesity (Brown, 2006; Budd et al., 2011; Mold & Forbes, 2011; Puhl & Heuer, 2009). For example, Carr and Friedman (2005) analyzed data from a nationwide sample of 3437 adults in the United States and found that very obese individuals (BMI > 40) were three times as likely as normal weight individuals to report being denied or provided inferior healthcare services. It is thus important to understand healthcare professionals' attitudes toward obese patients, particularly those frequently in contact with obese patients, including physicians, nurses, dietitians, and students in these fields.

Physicians and Medical Students

Surveys of physicians indicate that they perceive obese patients to have a variety of negative personal qualities (Puhl & Heuer, 2009). Foster and colleagues (2003) asked 620 physicians in the United States to rate obese patients on various continuous adjective pairs (i.e., lazy/motivated). Although mean scores were neutral, 62% of participants rated obese patients as awkward, 50% as ugly, 44% as weak-willed, 35% as sloppy, and 30% as lazy. Additionally, one-third of participants reported having a negative reaction to the appearance of obese patients. Similarly, in a sample of 348 American physicians, two-thirds characterized obese patients as lacking self-control and over one-third rated them as lazy and sad (Price, Desmond, Krol, Snyder, & O'Connell, 1987). In another study,

25% of military physicians characterized obese patients as lacking self-control and 18% as sad (Loomis, Connolly, Clinch, & Djuric, 2001).

Physicians also report frustration when working with obese patients and pessimism about their response to treatment. Samples of French, Israeli, and American physicians experienced obese patients as non-compliant, doubted their ability to lose weight, and believed them to have less willpower and motivation than average weight patients (Bocquier et al., 2005; Fogelman et al., 2002; Foster et al., 2003). In a sample of 607 French physicians, for example, the most common frustrations related to obesity treatment or management were patients' lack of motivation and/or poor compliance (33%), lack of weight loss success (26%), and underlying psychological issues (22%) (Thuan & Avignon, 2005). Similarly, Huizinga and colleagues (Huizinga, Bleich, Beach, Clark, & Cooper, 2010; Huizinga, Cooper, Bleich, Clark, & Beach, 2009) studied 40 physicians' impressions of 240 patients after an initial appointment. Results indicated that physicians' respect for patients and their predictions regarding patients' medication adherence were inversely related to patient BMI.

Qualitative methods also reveal physicians' frustrations with obese patients. For example, Mercer and Tessier (2001) interviewed 10 physicians in Scotland about their work with obese patients. Participants frequently described lack of enthusiasm about obesity management and treatment, frustration about the lack of success experienced with obese patients, and a perception that obesity management is not an appropriate use of their time. Overall, participants were more enthusiastic about this work if it occurred in the context of a comorbid medical condition, such as diabetes or heart disease. Similarly, interviews with 21 physicians in England revealed that they experienced obese patients as

being in denial about their weight problem and unable to change their behaviors to initiate and maintain weight loss (Epstein & Ogden, 2005). Finally, one-third of a sample of 389 Australian physicians complained that obese patients are non-compliant with lifestyle change recommendations (Campbell, Engel, Timperio, Cooper, & Crawford, 2000). Less frequently reported frustrations included patient lack of motivation (15%), lack of weight loss success (13%), and weight regain (12%). In fact, such negative attitudes described by physicians may be apparent to others: Wright (1998) interviewed 10 nurses in Northern Ireland who noted that male physicians provide insensitive weight-related feedback to obese female patients, occasionally treat them in a discriminatory manner, and often frame stigmatizing behavior as necessary for the patients' health.

In addition to negative attitudes about obese individuals' personal traits and cynicism about treatment, physicians tend to attribute obesity to factors within patients' control (Puhl & Heuer, 2009). For example, physicians rate lifestyle factors (e.g. physical inactivity, overeating, a high fat diet) as the most important causes of obesity (Foster et al., 2003) and as more important risk factors than biological or situational factors (e.g., hormonal problems, stress, unemployment) (Bocquier et al., 2005). Qualitative research similarly suggests that physicians often believe patients' poor diets cause obesity and that, consequently, patients should be responsible for managing their own weight (Epstein & Ogden, 2003). Understanding beliefs about the causes of obesity is particularly important because causal attributions may influence treatment recommendations (Harvey et al., 2002) and are key in theories of weight stigma (Crandall & Martinez, 1996).

Research also suggests that healthcare professionals hold implicit, stigmatizing attitudes about obese individuals. For example, administering the IAT to 389 researchers and health professionals specializing in obesity (including 122 physicians) demonstrated implicit bias for obese individuals as lazy, stupid, and worthless, which was consistent with participants' self-reported explicit bias (Schwartz, Chambliss, Brownell, Blair, & Billington, 2003). Similarly, Teachman and Brownell (2001) found a strong implicit anti-fat bias for obese individuals as bad and lazy in a sample of 84 healthcare specialists (74% of whom were physicians).

Although the large majority of existing data indicates a high degree of stigma in physicians, it is important to note that some physicians endorse relatively lower frequencies of several potentially stigmatizing attitudes. For example, in a sample of military physicians, only 4% endorsed items characterizing obese patients as lazy, and 61% agreed that they are "the same as others" (Loomis et al., 2001). Another survey of physicians revealed less stigmatizing attitudes about treatment-related factors: Only 7% reported difficulty feeling empathy for obese patients, and just 10% reported feeling uncomfortable examining these patients (Foster et al., 2003). Qualitative research also suggests that, despite their frustration, at least one sample of physicians was aware of the incongruence between doctor and patient beliefs about obesity and noted a desire to find common ground in order to maintain a helpful relationship with patients (Epstein & Ogden, 2003).

Research on medical and dental students generally reveals attitudes toward obese patients that are similar to those expressed by their professional counterparts. For example, in a sample of 75 first-year medical students, 62% of participants characterized

obese patients as lacking self-control; 57% as lazy; and 52% as sloppy (Wiese et al., 1992). A sample of 420 dental and dental hygiene students endorsed comparatively less stigma: One-third reported negative reactions to the appearance of obese patients and characterized them as lazier than their normal-weight counterparts, and one-quarter agreed that they lack willpower and motivation (Magliocca, Jaber, Alto, & Magliocca, 2005). A smaller proportion of participants (17%) reported difficulty feeling empathy for obese patients, and 14% endorsed discomfort while examining these patients.

Experimental studies also support the existence of weight stigma in medical students. For example, medical students who viewed case summaries of fictional patients differing only by weight status rated an obese patient as more depressed and less attractive than an average weight patient (Wigton & McGaghie, 2001). They also rated the obese patient as less compliant to treatment recommendations, less responsive to weight management counseling, and less likely to successfully implement dietary changes. In a unique experimental manipulation using virtual reality software, Persky and Eccleston (2011) examined whether medical students' clinical impressions differed by patient weight status. Compared to an average weight female patient, participants rated an obese female patient as less healthy, possessing more overall negative attributes, more responsible for potentially weight-related conditions (i.e., knee problems and shortness of breath), and less likely to follow through with treatment recommendations. Additionally, students recommended more lifestyle changes and fewer methods of symptom management (e.g., use of an inhaler) to obese patients compared to average weight patients. Interestingly, the virtual reality headgear also revealed that participants spent

significantly less time looking at the obese patient (29% of total appointment time) than at the average weight patient (37% of the time).

One unique study used a qualitative focus group approach to elicit the types of derogatory comments 58 medical students heard and/or made about patients (Wear, Aultman, Zarconi, & Varley, 2006). Participants noted that professional norms dictated that it was acceptable to comment about patients who were judged responsible for their medical problems, and that obese patients top this list. Derogatory humor at the expense of obese patients included referring to them using vulgar terms, telling stories about items stuck in obese women's rolls of fat, and placing bets on the weight of fat removed during a hysterectomy. Participants attributed this anti-fat behavior to several factors, including providers' disgust with obese patients' bodies and distaste for the extra work required to perform surgery on these patients (i.e., procedures are often more difficult and may require equipment accommodations). They also noted resentment about fixing problems often attributed to patients' lack of personal responsibility and pessimism about patients' ability to manage their health in the future.

In sum, despite some notable exceptions, quantitative and qualitative research suggests that physicians and medical students tend to implicitly and explicitly perceive obese patients as having a variety of negative personal attributes. They also tend to attribute obesity to causes within patients' control; experience frustration with patients' perceived lack of motivation, non-compliance, and treatment failure; and feel unenthusiastic about this work. Medical students endorse similar beliefs and attitudes, which is unsurprising given that they report professional socialization in a setting in which obese patients are considered fair targets of derogatory humor.

Nurses

Research conducted with nurses and nursing students suggests that their attitudes about obese patients echo predominant cultural stereotypes (Brown, 2006). The most frequently utilized measure of nurses' attitudes is the Nurses' Attitudes Toward Adult Obese Patients scale (Bagley et al., 1989), which inquires about personal characteristics of obese individuals, treatment-related factors, and causes of obesity. Bagley and colleagues (1989) surveyed 67 Canadian nurses and found that about one-half characterized obese patients as over-indulgent and lacking confidence; over one-third as less successful than normal weight patients; and over one-quarter as unlikely to express their true feelings or to be desirable for marriage. One-quarter of participants rated obese patients as lazy and nearly one-fifth as experiencing unresolved anger. Maroney and Golub (1992) administered the same scale to 107 American nurses with generally similar results: Two-thirds of nurses characterized obese patients as unlikely to express their true feelings, nearly one-half as over-indulgent and lacking confidence, one-third as having unresolved anger issues, nearly one-quarter as less successful than normal weight patients, and one-fifth as lazy and undesirable for marriage.

Regarding attitudes directly related to treatment, the majority of Bagley and colleagues' sample (1989) preferred not to care for obese patients and characterized this work as physically exhausting. One-third of participants agreed that nurses often feel impatient and uncomfortable caring for obese patients and one-quarter endorsed being repulsed by and having difficulty feeling empathy for these patients. Similarly, 70% of Maroney and Golub's (1992) sample agreed that caring for obese patients is physically exhausting; 48% that nurses feel uncomfortable doing this work; 38% that it is stressful;

31% that nurses would prefer not to work with this population; and 15% that they feel impatient when caring for obese patients.

Like physicians, nurses report frustration about obese patients' perceived lack of motivation and compliance. For example, half of a sample of 398 nurses surveyed in England rated obese patients as unmotivated to change (Brown, Stride, Psarou, Brewins, & Thompson, 2007), and a sample of 586 nurses in London rated patient non-compliance as the most important cause of weight loss failure and inadequacy of current methods as the least important factor (Hoppe & Ogden, 1997). Brown and Thompson (2007) conducted semi-structured interviews with 15 female nurses in England who expressed ambivalence about patients' motivation for change: Although most participants stressed that motivation cannot be generalized to all patients, they also tended to express frustration about patients' lack of readiness for change. The 10 Scottish nurses interviewed by Mercer and Tessier (2001) also reported frustration with obesity management work and reported that they feel more positively about this work when patients have a comorbid medical condition.

Finally, nurses tend to endorse beliefs about weight loss and obesity causes and prevention that stress personal responsibility. For example, although the nurses interviewed by Brown and Thompson (2007) identified multiple causes of obesity, they ultimately tended to emphasize lifestyle factors and downplay genetic causes. Further, in a sample of 586 female nurses in London, participants rated lifestyle factors (e.g., excessive calorie intake, lack of exercise) as more important in causing obesity than biological factors (e.g., genetics, metabolism) (Hoppe & Ogden, 1997). Over two-thirds of the nurses surveyed by Brown and colleagues (2007) attributed obesity strongly to

personal choices about food and physical activity, and one-fourth agreed that obesity is associated with a certain personality type. Over half of these nurses also agreed that excess weight is the cause of most of an obese person's health problems. Regarding beliefs about weight loss and obesity prevention, over two-thirds of Canadian nurses agreed that obesity could be prevented by self-control; nearly two-thirds that most obese adults could lose weight if they changed their eating habits; and one-third that weight loss is only a matter of lifestyle change (Maroney & Golub, 1992). Bagley and colleagues (1989) found somewhat lower rates of endorsement in their sample: Over two-thirds of nurses agreed that obesity can be prevented by self-control; nearly half that weight loss is only a matter of changing one's lifestyle; and 17% that most obese adults could lose weight if they changed their eating habits.

Notably, this body of research also yields some instances of nurses holding less biased attitudes toward obese patients. For example, in some studies, only 4-6% of nurses reported feeling repulsed or disgusted by obese patients (Brown et al., 2007; Marony & Golub, 1992), 8% believed that obese patients are lazier than other patients (Brown et al., 2007), and 8-9% reported difficulty feeling empathy for these patients (Brown et al., 2007; Marony & Golub, 1992). In contrast to data emphasizing causal factors related to personal responsibility, half of the nurses surveyed by Brown and colleagues (2007) agreed that family history is an important causal factor of obesity and just 10% attributed obesity to a lack of personal control.

Furthermore, several qualitative explorations demonstrate nurses' sensitivity to the needs and experiences of this population. For example, responses from 119 nurses revealed themes that included feeling overwhelmed by the special needs of obese

patients, dreading the physical demands associated with care, worrying about personal safety due to these demands, and feeling shocked by the physical size of very obese patients (Zuzelo & Seminara, 2006). However, participants also noted sympathy for obese patients, a desire to provide them with equal treatment, recognition of their unique health needs, and care to avoid stigmatizing comments and behaviors. Nurses also experience ambivalence about discussing the delicate topic of weight with obese patients (Brown & Thompson, 2007; Wright, 1998). In one sample, nurses specified that discussing weight is potentially awkward and that sensitivity is important when broaching this topic (Brown & Thompson, 2007). Specifically, participants feared damaging rapport by discussing weight, which they attributed to patient sensitivity resulting from weight-based stigma, in addition to the frustration associated with weight loss interventions for both nurses and patients. They stressed the importance of feeling empathy, building the nurse-patient relationship, and individualizing treatment. Interestingly, both overweight and underweight nurses perceived their own body weight to influence their interactions with obese patients and many reported avoiding the term “obese” in favor of discussing “weight loss.”

In sum, nurses appear to attribute negative personal characteristics to obese individuals that are consistent with cultural stereotypes. Nurses consistently attribute obesity to lifestyle factors within patients’ control and agree that working with obese patients presents challenges that make them uncomfortable. However, they endorse other negative attitudes (e.g., disgust, difficulty feeling empathy) toward these patients at much lower rates than some other health professionals (e.g., physicians) and qualitative explorations reveal sensitivity to the special needs of obese patients.

Dietitians and Dietetics Students

Research investigating weight stigma in samples of dietitians (who frequently work with obese individuals) similarly indicates stigmatizing attitudes regarding obese patients' personal attributes and causes of obesity and frustration when working with this population. For example, Stone and Werner (2012) conducted focus groups with 23 female Israeli dietitians about their experiences working with obese patients. Emerging themes included beliefs that patients were responsible for and could control their weight status, frustrations toward obese patients, and behavioral manifestations of weight stigma. For example, each participant expressed the belief that patients' obesity and failure to lose weight was explained by personal choices, such as poor diet and lack of exercise. They conveyed frustration about patients who attribute their weight problems to external factors, make excuses for their inability to follow treatment recommendations, or seem less invested in weight loss than their dietitian. Participants reported feeling empathy or pity for patients early in treatment, with more negative emotions taking over as treatment progressed with little success. They admitted that these negative feelings sometimes manifested behaviorally in the form of recommending a less effective treatment in favor of one that required less effort on the part of the dietitian. They also acknowledged showing their negative emotions via tone of voice, facial expressions, and direct expressions of frustration, in some cases with the hope that patients would not return for another appointment.

Harvey and colleagues (2002) examined whether dietitians' attitudes toward and beliefs about patients differed by patient weight status. They administered a survey to a sample of 158 British dietitians, with instructions inquiring about attitudes toward either

overweight (defined as BMI between 25 and 30) or obese patients (BMI > 30). Although mean ratings for both categories of patients were neutral to positive, participants reported significantly less positive attitudes about obese patients. Specifically, they rated these patients as less healthy, more ashamed about their weight, less desirable to marry or associate with, and less likely to be successful workers or to lead normal lives. The most negative ratings (for both overweight and obese patients) were for items concerning self-esteem, sexual attractiveness, and health. Results indicated no significant differences in beliefs about causal factors of weight status: For both overweight and obese patients, participants ranked as the most important causes lack of physical activity, eating too much of the wrong foods, mood, interpersonal factors, and repeated dieting. Although participants rated both overweight and obese patients as highly responsible for their weight status, they rated obese patients as more responsible overall.

However, not all research suggests dietitians hold stigmatized attitudes toward obese patients. McArthur and Ross (1997) surveyed 439 American dietitians, who demonstrated neutral to positive attitudes overall. Participants were aware of patients' tendency to blame themselves (57% of sample endorsed this item) and/or their emotional problems (45%) for their excess weight. They believed that obese patients work hard to try to lose weight (43%) and only 3% to 7% of participants (depending on patient demographics) characterized obese patients as lacking willpower. Although they rated obese patients as unskilled at setting realistic weight loss goals (42%), the majority of dietitians (48% to 82%) reported enjoying weight management work.

Visual comparisons of studies suggest that dietetics students endorse negative attitudes toward obese individuals at higher rates than dietitians. For example, when 38

undergraduate dietetics majors and 38 non-dietetics majors completed the Fat Phobia Scale (Bacon, Scheltema, & Robinson, 2001), both groups scored in the moderate range and did not differ significantly from one another (dietetics $m = 3.66$; non-dietetics $m = 3.69$; Berryman, Dubale, Manchester, & Mittelstaedt, 2006). More specifically, 90% of dietetics students agreed that obese individuals like food; nearly three-fourths rated them as inactive and slow; two-thirds agreed that they overeat and are insecure and shapeless; over 60% rated them as having low self-esteem and no endurance; half agreed that they are self-indulgent, lazy, unattractive, and lacking willpower; and over one-third rated them as weak.

Puhl, Wharton, and Heuer (2009) surveyed 182 undergraduate dietetics majors, who similarly obtained moderate mean scores ($m = 3.7$) on the Fat Phobia scale. The overwhelming majority of participants (80%) agreed that obese people like food, overeat, and are insecure; about three-fourths agreed that they have no endurance, low self-esteem, and are inactive; about two-thirds rated them as being slow and having poor self-control; and over half rated obese individuals as unattractive. Over 40% of participants rated obese individuals as lazy, self-indulgent, and lacking willpower, and nearly one-third as weak. Participants also read case studies of patients who differed only by weight status. They rated fictional obese patients as having a poorer diet and health status and being less compliant to treatment recommendations than average weight patients.

In sum, similar to other healthcare providers, dieticians appear to hold stigmatizing weight-based attitudes regarding personal characteristics and causes of obesity, and to experience frustration when working with this population. Studies using

samples of dietetics students suggest that they rate obese patients less favorably regarding personal traits than do dietitians.

Patients' Reports of Weight Stigma in Healthcare Settings

Patients' own descriptions and ratings of healthcare experiences suggest that they frequently experience unsatisfying weight-related interactions with healthcare professionals, many of which can likely be attributed to weight bias. For example, in a sample of 146 overweight and obese individuals (BMI range = 27 - 81, $m = 50$), the mean for the doctor subscale on the Stigmatizing Situations Inventory was 1.88, suggesting that clients experienced explicit weight stigma from doctors once to several times throughout their lives on average (Myers & Rosen, 1999). In a sample of 93 obese individuals who presented to a residential weight loss facility (BMI range = 30 - 74, $m = 42$), participants' mean score on the doctor subscale was 1.29, and 89% of participants endorsed having experienced this type of stigma (Friedman et al., 2005).

Puhl and Brownell (2006) administered an adapted version of the Stigmatizing Situations Inventory to 2449 overweight and obese women (mean BMI = 37.6) recruited from a national non-profit weight loss group. Mean scores of 1.12 on the doctor subscale indicated that participants had experienced inappropriate weight-related comments from doctors an average of once during their lifetime, and 53% of participants reported experiencing the kinds of inappropriate comments included on this subscale. Participants also rated a list of 22 potential sources of weight stigma, with results indicating that doctors were among the most common sources of interpersonal stigma (second only to family members). Over two-thirds of the sample reported experiencing weight stigma from doctors at least once, and over half reported experiencing stigma from this source

more than once or multiple times. Higher rates of endorsement on this scale (as compared to the Stigmatizing Situations Inventory) may suggest that participants experienced subtle bias from doctors that was not captured on the doctor subscale, which is comprised of items inquiring about fairly explicit expressions of bias. Participants reported less stigma from nurses (34% experienced stigma from this source more than once) and dietitians (26% more than once), although these healthcare professionals still appear to be a significant source of weight stigma.

The frequency of stigmatizing healthcare experiences may vary depending on patient weight status. Rand and MacGregor (1990) surveyed 57 bariatric patients (averaging 137 pounds overweight) about their experiences with weight-based discrimination. Before surgery, 95% of patients reported sometimes, usually, or always being treated disrespectfully by medical professionals (78% usually or always). After surgery and an average weight loss of 112 pounds, only 32% of patients reported disrespectful treatment (2% usually or always). Anderson and Wadden (2004) found a similar pattern of larger participants encountering more weight stigma in their sample of 105 bariatric patients (mean BMI = 55) and 214 applicants to a weight loss trial (mean BMI = 38). Specifically, 87% of bariatric patients reported that doctors sometimes, usually, or always provided unsolicited comments about the necessity of weight loss (compared to 58% of non-surgical patients), 64% that doctors did not believe their claims of not eating that much (37% non-surgical), 43% that doctors treated them with disrespect (23%); 43% that doctors made comments about their weight that upset them (23%), 28% that doctors have made critical comments about their weight (14%), and 25% that doctors criticized them for not trying harder to maintain a weight loss (11%).

Over 70% of both groups agreed that doctors do not understand how difficult it is to be overweight.

Qualitative research clarifies the types of stigma overweight and obese patients experience from healthcare professionals. In interviews with eight overweight and obese women, Merrill and Grassley (2008) found an emerging theme of physical barriers in healthcare environments. For example, participants reported difficulty fitting into standard gowns, blood pressure cuffs, and waiting room seating and feeling vulnerable and defensive immediately upon entering healthcare settings due to anticipating such problems. They also reported putting special effort into their clothing and appearance before appointments in an attempt to compensate for their weight and appear more acceptable. Another emergent theme was that of feeling “not quite human” because of weight status. Participants reiterated that they were more than just their weight and noted that they do not feel equal to thin women in their healthcare interactions. Finally, a theme emerged around participants feeling dismissed due to their perceptions that providers do not believe reports of food intake, do not want to listen to their problems with weight, and/or focus on weight rather than on presenting complaints. For example, one participant described presenting to a chiropractor for treatment for arthritis, being told that weight loss was her only treatment option, and consequently perceiving the message that she deserved to suffer until she could lose weight.

Similarly, Furber and McGowan (2011) conducted semi-structured interviews with 19 obese pregnant women (BMI range = 35-54 at 28 weeks’ gestation) who described healthcare professionals’ persistent focus on their weight, including stressing the high risk nature of the pregnancy, noting difficulty assessing aspects of the pregnancy

(e.g., the fetus' position and heartbeat), and doing so in a way that left participants feeling lectured. They described providers focusing solely on the well-being of the fetus, disregarding the mother's experience. Participants noted that these interactions resulted in guilt, self-blame, and dread of maternity care visits. Other qualitative reports from overweight and obese patients revealed humiliating and/or derogatory comments from healthcare professionals (Thomas, Hyde, Karunaratne, Herbert, & Komesaroff, 2008). Comments included a physician stating, "If you were my wife, I would not let you eat that much," an obese patient being told not to worry about scarring because she would "not be wearing a bikini any time soon," and a surgeon suggesting that losing the 20 pounds necessary before knee surgery should not be very difficult (Rogge, Greenwald, & Golden, 2004).

Finally, another set of interviews with 28 obese patients (BMI > 30) revealed a primary theme of ambivalence about interactions with healthcare professionals, despite denying weight-based stigma or discrimination from providers (Brown, Thompson, Tod, & Jones, 2006). Participants reported feeling ashamed and uncertain about addressing weight concerns and perceived that healthcare professionals also felt uncomfortable with this topic. Participants almost unanimously took personal responsibility for their weight and perceived unfair negative reactions from others regarding their weight. Although they reported worry about healthcare providers' stereotypical perceptions of them, they denied experiencing weight discrimination from providers. They described good relationships and satisfaction with healthcare professionals in general but were dissatisfied with services related to weight management. Although these participants were frustrated about their perception that healthcare professionals attribute all problems to weight, they were

also dissatisfied about providers paying insufficient attention to this issue and providing unhelpful, general suggestions for managing weight.

In sum, data from samples of overweight and obese patients consistently demonstrate that most patients report stigmatizing experiences with healthcare professionals. These experiences appear to occur most frequently in interactions with doctors (as opposed to other healthcare professionals) and increase as patient weight increases. Overall, the most commonly-occurring stigmatizing experiences include healthcare providers attributing all health problems to weight or overfocusing on weight, not believing patients' reports of food intake, providing unsolicited weight loss advice, and having equipment that does not accommodate larger bodies. On the other end of the spectrum, patients also perceive providers as feeling uncomfortable discussing weight, spending too little time on the topic, and providing unhelpful suggestions for weight management. Taken as a whole, this body of literature provides a picture of overweight and obese patients generally feeling dissatisfied with at least some aspect of weight-related interactions with healthcare professionals.

Effects of Weight Stigma

Perceived weight stigma and discrimination are associated with negative psychological outcomes, including depression, poor self-esteem, body dissatisfaction, and greater mental health symptoms, even after accounting for the impact of age, gender, age of onset of obesity, and BMI on these outcomes (Friedman et al., 2005; Myers & Rosen, 1999; Puhl & Brownell, 2006; Puhl & Latner, 2007). For example, Carr and Friedman (2005) found that moderately to severely obese participants exhibited lower self-acceptance compared to normal weight participants, and this difference was accounted

for by experiences of perceived weight-based discrimination. Furthermore, interviews with 141 obese women in Australia revealed that experiences of weight-based stigma resulted in reduced self-esteem, self-confidence, and agency and increased feelings of depression, anxiety, and loneliness (Lewis et al., 2011). They also noted social consequences of weight stigma, including social avoidance and isolation, reduced social support, and difficulty forming and maintaining close relationships. Participants who cope with stigmatizing situations by utilizing negative self-talk, crying, or isolation may be at risk for poor body image and self-esteem and increased mental health symptoms (Myers & Rosen, 1999). Unfortunately, one study found that nearly three-fourths of obese individuals utilized these coping mechanisms at least once when faced with stigma (Puhl & Brownell, 2006).

Further, despite claims that weight stigma is beneficial because it motivates obese individuals to lose weight (Brownell, 2005), stigmatizing experiences may elicit coping mechanisms that increase or maintain obesity (Lewis et al., 2011; Myers & Rosen, 1999). For example, of the 2449 mildly to severely obese women surveyed by Puhl and Brownell (2006), 79% reported coping with weight-based stigma by eating and 75% by refusing to diet. Nearly half of another sample of obese women indicated that they avoid exercise in public because of an expectation of judgment (Lewis et al., 2011), and a recent experimental study demonstrated that overweight women who viewed a video including stigmatizing content ate almost three times as many calories as those who watched a neutral video (Schvey, Puhl, & Brownell, 2011). Moreover, stigmatizing experiences may result in eating disordered behaviors: Significantly more adolescents who were victims of weight-related teasing reported bingeing and engaging in unhealthy

weight control behaviors compared to those who were not teased (Neumark-Sztainer et al., 2002). Longitudinal studies of children and adolescents also demonstrate that weight-related teasing at baseline predicts binge eating (in boys) and purging (in girls) five to seven years later (Field et al., 2008; Haines, Neumark-Sztainer, Eisenberg, & Hannan, 2006).

The frequency with which obese patients report encountering weight stigma in healthcare settings, in and of itself, suggests that many of these patients receive inadequate healthcare (Puhl & Heuer, 2010). Moreover, the experience or expectation of weight-based stigma influences healthcare utilization. For example, although this population has higher rates of diagnoses of and risk of mortality from multiple types of cancer (Calle, Rodriguez, Walker-Thurmond, & Thun, 2003; Reeves et al., 2007), overweight and obese women are more likely than normal weight women to delay routine cancer screening, even after taking into account other barriers to care such as age, gender, ethnicity, education, health insurance, access to care, self-reported health status, and smoking status (Aldrich & Hackley, 2010; Drury & Louis, 2002; Meisinger, Heier, & Loewel, 2004; Rosen & Schneider, 2004; Wee, McCarthy, Davis, & Phillips, 2000). Amy and colleagues (2006) surveyed 498 overweight and obese women (BMI range = 25 to 122) to investigate why this occurs. They found that 41% of the sample reported delaying cancer screenings or other health care appointments due to their weight. Specifically, nearly three-fourths of this subsample reported experiencing at least one weight-related barrier to appropriate healthcare, including disrespectful treatment by a provider, equipment not large enough to accommodate them, or embarrassment about being weighed. As BMI increased, so did endorsement of delaying screening due to weight and

of having experienced a barrier to appropriate healthcare. Notably, nearly 70% of women with a BMI > 55 reported delayed screenings, and these women were significantly more likely than women with a lower BMI to delay a Pap smear by five years.

Additional samples of obese women report delaying healthcare due to other weight-related factors, including not wanting to be weighed and having gained weight since the last appointment (Drury & Louis, 2002; Olson, Schumaker, & Yawn, 1994). Although not necessarily indicative of experiences with stigma in healthcare settings, these concerns likely represent some degree of experience with general weight-based shame and stigma.

Section 3: Weight Stigma in Mental Health Providers

The research reviewed thus far demonstrates that weight stigma is prevalent among healthcare providers. Given that mental health professionals are part of the healthcare field and of a larger society that denigrates fatness, it seems unlikely that clinicians are exempt from the weight-biased attitudes and beliefs that are prevalent in other healthcare professionals. However, very limited data on mental health care providers' attitudes toward obese clients exists to date.

Mental Health Treatment Provider Data

Only five published studies examine mental health providers' weight bias (i.e., Agell & Rothblum, 1991; Davis-Coelho, Waltz, & Davis-Coelho, 2000; Hassell et al., 2001; Puhl, Latner, King, & Luedicke, 2014; Young & Powell, 1985). Most of these studies utilized experimental designs in which mental health professionals provided clinical impressions after reviewing a written case presentation that included a description or visual representation of the fictional client's weight and/or weight status. For instance, Hassel and colleagues (2001) provided 163 mental health professionals with a written vignette and a drawing of a therapy scene that included either an average weight or overweight client. Participants provided diagnostic interpretations, ranked the client on a list of adjectives, and completed a questionnaire measuring attitudes toward obese individuals, with results indicating that participants ascribed more negative adjectives to overweight clients than average weight clients. Female providers also assigned significantly lower Global Assessment of Functioning (GAF) scores to overweight than average weight clients (61 vs. 64, respectively, rendering the clinical meaningfulness of this difference quite small). Participants were also significantly more likely to diagnose

overweight clients with an adjustment disorder and to diagnose average weight clients with relational problems, although the implications of this finding are also unclear.

Utilizing a similar research design, Davis-Coelho and colleagues (2000) provided 200 psychologists with a written case study accompanied by a photo of a woman whose weight status was altered with makeup and padding so she appeared either average weight or overweight. Participants provided clinical impressions, diagnoses, and treatment recommendations for the fictional client. Results indicated that participants diagnosed the overweight client with adjustment and eating disorders more frequently than the average weight client and that treatment goals included improving body image and increasing sexual satisfaction more frequently for the overweight client than the average weight client. Additionally, younger participants and those with less clinical experience identified facilitating self-acceptance as a treatment goal for the overweight client more frequently than for the average weight client. These participants also rated the overweight client's treatment prognosis and effort more negatively than did older/more experienced treatment providers.

Young and Powell (1995) examined 120 mental health professionals' impressions of clients based on identical case histories and a photo representing them as either average weight, overweight, or obese. Participants attributed more severe symptoms (e.g., agitation, emotional behavior, impaired judgment, inadequate hygiene, inappropriate behavior, obsessive-compulsive behavior, self-injury, stereotyped behavior) to obese clients than to average or overweight clients. Differences between ratings of obese and non-obese clients were more pronounced in younger participants, and ratings were influenced by participant weight such that overweight participants were less critical than

average weight participants on some outcome measures. Agell and Rothblum's (1991) sample of 282 psychologists rated clients described as "markedly overweight" as more embarrassed, softer/kinder, and less attractive than average weight clients.

Finally, Puhl and colleagues (2014) notably demonstrated that weight bias is present even in mental health providers who work with clients with eating disorders. They sampled 329 professionals recruited through organizations specializing in the treatment of eating disorders, over two-thirds of whom were mental health professionals, and 87% of whom reported working with patients with obesity. Participants' responses on the Fat Phobia Scale ($m = 3.16$) indicated the presence of negative stereotypes about obese individuals; specifically, participants agreed that obese individuals overeat (55%), are insecure (50%), are inactive (38%), have no self-control (33%), are unattractive (24%), have no willpower (16%), and are indulgent (15%). Participants also indicated that they believe obese patients deserve compassionate, respectful treatment (94%), they feel confident (88%) and prepared (84%) to provide treatment to obese patients, and they find this work professionally rewarding (72%). However, significantly fewer professionals reported confidence in treatment outcomes for obese patients: 53% reported a belief that obese patients could be successful in making behavioral changes, 51% that they are motivated to change their diets, 36% that they are compliant with treatment recommendations, and 24% that they can maintain achieved weight loss. Finally, participants also reported on their perception of colleagues' attitudes toward obese clients, and these findings indicated that 56% had observed other professionals in their field making negative comments about obese individuals, 42% believed providers who treat clients with eating disorders have negative stereotypes about obese clients, 35%

reported that providers feel uncomfortable caring for obese clients, and 29% reported that their colleagues have negative attitudes about obese clients.

In addition to peer-reviewed publications, one unpublished doctoral dissertation examined the effect of client weight on the clinical impressions of mental health professionals. For her master's thesis, Aza (2009) conducted semi-structured interviews with 12 mental health professionals (e.g., clinical psychologists, licensed clinical social workers, licensed practicing counselors) regarding their work with overweight and obese female clients. Overall, experiences with this client population were characterized by confusion, ambivalence, and a lack of understanding about how attitudes toward obese individuals in general might influence therapeutic interactions. Nearly all participants ($n = 10$) expressed contradictory attitudes toward overweight and obese clients at some point during the interview. On one hand, participants believed that being overweight is unhealthy, described unpleasant personal experiences with obese individuals, and generally expressed weight bias (i.e., explicitly reporting prejudiced attitudes or displaying affect while discussing obese individuals that suggested negative attitudes). However, the same participants denied countertransference in session and/or claimed to be immune from weight stigma due to personal experiences with overweight. Another emerging theme involved participants reacting to overweight and obese clients (and obesity in general) with negative emotions that included judgment, anger, confusion, shame, and fear of personal weight gain. Finally, a theme around health and weight loss emerged, including participants expressing worry about client health, confusion about how to help clients lose weight (even if this was not a presenting concern), and speculation about what weight status indicated about clients' willpower and motivation.

Finally, two studies examined how client weight influences counseling graduate students' clinical impressions. Pascal and Kurpius (2012) sampled 76 master's level counseling students, 70% of whom had less than one year of clinical experience. Participants read one of four case outlines describing clients who differed only on weight (i.e., weighing 235 pounds or 135 pounds) and job status (office bookkeeper or hotel executive manager) and completed measures rating the client's personal characteristics and work efficacy. They found that those who read a vignette about an obese client rated her as having significantly more negative personal characteristics, including inactivity; lack of endurance, willpower, and self-control; insecurity; low self-esteem; unattractiveness, and problems with overeating, compared to students who read a vignette about an average weight client. Although there was no significant main effect of weight on ratings of work efficacy, they found that these two variables were significantly positively related for obese clients, but not for normal weight clients.

An unpublished dissertation also compared counseling graduate students' impressions of fictional clients who differed only by weight status. Adams (2008) examined written responses from 56 counseling graduate students (two-thirds of whom had no clinical experience) regarding the clinical impressions of a fictional average or overweight client. Qualitative analyses indicated that participants appeared to subtly differentiate between overweight and average weight clients by including more qualifying statements to positive comments about the overweight client than the normal weight client (e.g., implying that prognosis would be good *if* the client was willing to work hard, etc.). Other emergent themes included participants more frequently identifying barriers to treatment for the overweight client, less frequently identifying a

spouse as a potential source of social support for the overweight client, and using less tentative language around diagnosing the overweight client.

Overall, these findings suggest that client weight influences clinicians' initial clinical impressions. Specifically, mental health professionals and/or students tend to 1) ascribe negative personal attributes to obese individuals or fictional obese clients (Agell & Rothblum, 1991; Hassel et al., 2001; Pascal & Kerpius, 2012; Puhl et al., 2014), 2) rate obese clients as having more severe symptoms than average weight clients (Hassel et al., 2001; Young & Powell, 1985), and 3) experience complicated and subtle reactions to these clients that are likely to influence treatment (Aza, 2009). Stigmatizing attitudes and beliefs appear to be more prevalent in younger and/or less experienced treatment providers (Davis-Coelho et al., 2000; Young & Powell, 1995). Despite these findings, mental health professionals' self-reports indicate low rates of stigma on some variables (e.g., interest, confidence, and competence in working with obese clients, ratings of obese individuals' job skills) (Pascal, 2012; Puhl et al., 2014; Young & Powell, 1995). Overall these data appear relatively less negative than data on weight stigma in other health professionals.

Client Reports of Weight Stigma in Mental Health Care

To date, only one client self-report study included ratings of stigma experienced in mental health settings, and this research supports the finding that weight stigma may be less prevalent in mental health providers (Puhl & Brownell, 2006). In this study, 2449 overweight and obese women (mean BMI = 37.6) rated the extent to which they have experienced stigma from a number of sources. Participants' mean rating of mental health professionals indicated that they experienced stigma from this source less than once per

lifetime on average. Although mental health professionals were ranked among the least frequent sources of stigma, 21% of the sample indicated experiencing stigma at least once from a mental health professional, and 13% of the sample indicated experiencing stigma from this source more than once or multiple times. It is also important to note that, unlike other potential sources of stigma with whom all participants have likely interacted (e.g., doctors, family member, friends), it is likely that some participants who reported never experiencing stigma from this source have never interacted with a mental health professional.

Countertransference toward Obese Clients

Although there is little empirical evidence documenting weight stigma or discrimination in mental health professionals or their clients, feminist and psychoanalytic clinicians have explored countertransference toward obese clients in theoretical writings (Drell, 1988, Ingram, 1973). Notably, Laura Brown (1989) described receiving negative feedback when encouraging female feminist therapists to explore their internalized fat oppression, despite feminist therapists' value around acknowledging and confronting personal biases (i.e., regarding gender roles, race, and class). She hypothesized the following explanation for this pushback:

What I am saying, in essence, is that their diets have had no meaning, that their repetitive struggles to be “just ten pounds thinner” are probably futile...I am asking them to feel “out-of-control”...I am telling them that all their work with clients to help the latter lose weight have been oppressive and are likely to generate further difficulties for those clients somewhere in their lives; I am pointing out to feminist therapists how they have colluded with sexism and the

hatred of women. I am asking my female colleagues to challenge the foundations upon which their sense of personal attractiveness and desirability has been built.

(p. 24)

Brown's writing on this topic powerfully demonstrates the mixed messages associated with weight stigma in psychotherapy—namely, even when a therapist strives to help a client accept her current size, the therapist herself may have strict internalized personal beauty standards.

Anecdotally, Irvin Yalom's (1989) compilation of case studies, *Love's Executioner and Other Tales of Psychotherapy*, includes the notorious chapter "Fat Lady" which explores his countertransference to an obese female client, Betty. Regarding his reaction to Betty, he writes:

I have always been repelled by fat women. I find them disgusting: their absurd sidewise waddle, their absence of body contour—breasts, laps, buttocks, jawlines, cheekbones, *everything*, everything I like to see in a woman, obscured in an avalanche of flesh. And I hate their clothes—the shapeless, baggy dresses or, worse, the stiff elephantine blue jeans with the barrel thighs. How dare they impose that body on the rest of us? (p. 88)

Throughout the chapter, Yalom becomes more compassionate toward and committed to this client. Although the resolution of his countertransference occurs as his client begins to relate more intimately and authentically, it also corresponds with her initiation of a drastic diet and significant weight loss. Though Yalom acknowledges that his reaction to obese women "surpasses all cultural norms" (p. 88), this story serves as a powerful reminder that even a master clinician can have countertransference reactions to obese

clients.

It is important to note that guidelines for mental health professionals regarding working with obese clients do not currently exist, although the American Psychological Association (APA) has formed a panel to develop guidelines for treating obesity across the lifespan (Kurtzman & Bufka, 2012). It seems likely that this document will include attention to the impact of stigma, consistent with guidelines for treating other marginalized client populations (APA, 2002). Given professional guidelines emphasizing respect for clients' dignity and worth and the necessity of monitoring personal biases (APA, 2002; APA, 2010), mental health providers are likely to communicate weight stigma subtly, unintentionally, and/or largely unconsciously. Thus, when therapists hold stigmatizing attitudes toward obese clients, these attitudes may be transmitted via microaggressions.

Section 4: Microaggressions, Psychotherapy, and Weight Stigma

Understanding bias from a microaggressions framework offers a potentially unique way to explore weight-based stigma and discrimination in mental health settings. Sue (2010) defines *microaggressions* as “everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership” (p. 3). The concept of microaggressions is similar to other conceptualizations of day-to-day prejudice or discrimination that is expressed unintentionally or unconsciously, sometimes by well-intentioned perpetrators, such as *subtle/covert racism and sexism, aversive racism, and benevolent sexism* (Capodilupo et al., 2010; Sue et al., 2007).

Although originally referring to slights committed against members of marginalized racial or ethnic groups, the definition of microaggressions has since been extended to describe offenses aimed at other marginalized groups, including women; lesbians, gay men, bisexuals, and transgender individuals; individuals with mental, physical, and/or emotional disabilities; individuals in lower social classes; and religious minorities, among others (Nadal, Issa, Griffin, Hamit, & Lyons, 2010; Nadal et al., 2011; Smith & Redington, 2010; Solórzano et al., 2000; Sue et al., 2009). Research in this field elicits the qualitative experiences of potential victims of microaggressions (rather than surveying offenders about their stereotyped attitudes and/or discriminatory behaviors) and typically employs a focus group approach to promote greater discussion of sensitive issues and inspire participants to recall incidents that they might not have initially remembered (Firth, 2000; Litosseliti, 2003).

Types and Effects of Microaggressions

Sue and colleagues (2007) created a taxonomy of microaggressions that consists of three broad categories, each of which can be communicated verbally, non-verbally/behaviorally, or environmentally. *Microassaults* are conscious, deliberate efforts to communicate prejudicial sentiments. Despite their similarity to overt bigotry, microassaults are considered microaggressions because they tend to occur only when the offender feels “safe” expressing prejudicial attitudes (i.e., due to anonymity or believing they are in the company of others with similar opinions). The remaining two categories of microaggressions generally convey prejudicial attitudes the offender is not consciously aware of harboring, does not consider harmful, and/or does not intend to communicate. As such, these kinds of microaggressions are rarely expressed explicitly and directly; rather, they capture the “hidden messages” inherent in comments, behaviors, or the environment (Sue, 2010). For example, *microinsults* are comments or behaviors that convey stereotyped, often insulting attitudes about a person based on group membership, such as implying that a non-majority individual was hired because of affirmative action or crossing the street to avoid meeting an African American man. *Microinvalidations* are committed when the offender dismisses, negates, or denies the thoughts, feelings, or reality of a member of an oppressed group. A common microinvalidation is denying personal or systemic racism, homophobia, or sexism (Sue et al., 2007).

Microaggressions often leave a victim questioning his or her experience of reality, as he or she must figure out whether a microaggression actually occurred (i.e., Was I subtly insulted, and was it due to my race, sexual orientation, etc.?), whether to respond, and how to respond (Sue, 2010). Even when a victim decides to respond to a

microaggression, these offenses are subtle enough that the perpetrator can easily dismiss the offense (Sue et al., 2007). When confronted, offenders may become defensive and accuse victims of being overly sensitive or hostile, resulting in victims often feeling caught in a lose-lose situation (Sue et al., 2007). Because of these dilemmas, researchers argue that microaggressions may be more detrimental to well-being than overt expressions of prejudice (Solórzano et al., 2000). In fact, Salvatore and Shelton (2007) found that Black² participants who read vignettes with ambiguous prejudicial scenarios performed more poorly on a high-level cognitive test than those who read blatantly prejudicial scenarios. Samples of African Americans connect experiencing microaggressions to feeling powerless, discouraged, frustrated, invisible, exhausted, intimidated, suspicious, cynical, forced to conform to White norms and expectations, and pressured to represent their race favorably (Solórzano et al., 2000; Sue, Nadal et al., 2008). Overall, then, the pervasive and ambiguous nature of microaggressions is emotionally and cognitively taxing for victims.

Racial microaggressions. The first researchers who studied microaggressions used this framework to examine racism experienced by African Americans, Latino/a Americans, and Asian Americans. Overall, some common themes emerged among these American ethnic groups. For example, African Americans, Latino/a Americans, and Asian Americans all report microaggressions in the form of expectations to conform to White values (i.e., of behavior, appearance, and communication), being treated as inferior or second-class citizens, minimization of their racial reality (i.e., denying systemic or interpersonal racism), and assumptions that their individual experience is representative

² In this section, I switch between ethnic and racial terms to remain consistent with the language used by different researchers.

of the entire race (Rivera, Forquer, & Rangel, 2010; Solórzano et al., 2000; Keller & Galgay, 2010; Sue et al., 2009; Sue, Capodilupo, & Holder, 2008; Sue, Nadal et al., 2008; Yosso, Smith, Ceja, & Solórzano, 2009).

One theme discovered in racially-based literature is that microaggressions typically correspond with commonly-held stereotypes about the oppressed group of which the victim is a member (Sue, Nadal et al., 2008). As such, both Latino/a Americans and African Americans report microaggression themes including assumptions of criminality and intellectual inferiority and being avoided and made to feel out of place in higher education settings (Rivera et al., 2010; Solórzano et al., 2000; Sue, Capodilupo, & Holder, 2008; Sue, Nadal et al., 2008; Yosso et al., 2009). Additionally, Asian Americans and Latino/a Americans often describe themes of being viewed as foreigners—assumptions that they were not born here and do not speak fluent English (Rivera et al., 2010; Sue et al., 2009). Further, African Americans report experiencing assumptions of lower social and job status (Sue, Capodilupo, & Holder, 2008; Sue, Nadal et al., 2008) and being deemed more acceptable if they are judged as not “acting” like other African Americans (Solórzano et al., 2000). Latino/a Americans report exposure to racial slurs and racist “jokes” and assumptions of undocumented status (Rivera et al., 2010; Yosso et al., 2009). Finally, Asian Americans describe a number of unique microaggression experiences, including assumptions of intelligence, exoticization and objectification of Asian American women, and underrepresentation in dialogues about racial issues (Sue et al., 2009).

Sexual orientation microaggressions. Lesbian, gay, and bisexual (LGB) individuals comprise another group who frequently experience microaggressions. Some

of the microaggressions described in this research are similar to those aimed at racial groups, including denials of personal or systemic heterosexism or homophobia, exposure to homophobic language, expectations to conform to heteronormative behavioral norms, and assumptions of universal experiences amongst all members of the LGB community (Nadal, 2011). LGB individuals also report that others exoticize their lifestyles (e.g., believe that gay men have very active social lives, fantasize about bisexual women), assume that they are oversexed or sexually deviant (e.g., HIV positive, child molesters), and do not take them seriously if they do not “look” LGB or if they identify as bisexual. Finally, individuals frequently report perceived disapproval of LGB relationships from others (on both individual and systemic levels) and verbal and physical harassment (Nadal, 2011).

Gender microaggressions. Gender- or sex-based microaggressions (i.e., discrimination committed against women or behavior typically associated with feminine gender presentation) share some common themes with racial and sexual orientation microaggressions. For example, women describe being treated as second-class citizens (e.g., being paid less than men), being assumed physically and mentally inferior, and encountering sexist language (Capodilupo et al., 2010). Microaggressions that are more specific to the female experience include sexual objectification (e.g., catcalling) and expectations to conform to traditional feminine gender roles. Less developed themes of gender microaggressions include denials of the reality of sexism and undervaluing of traditionally feminine traits (e.g., in work settings).

Microaggressions in Therapeutic Contexts

In addition to examining everyday experiences of microaggressions, a small body of recent research examines microaggressions experienced by female, African American, and sexual minority clients in psychotherapy contexts (Constantine, 2007; Owen et al., 2010; Owen et al., 2011; Shelton & Delgado-Romero, 2011). For example, Constantine (2007) conducted focus groups with 24 African American college students who were former counseling clients regarding their experiences of racial microaggressions communicated by counselors. Participants described microinvalidations, including counselors minimizing the influence of racial or cultural issues on presenting concerns, denying personal racism and the deleterious effects of systemic racism, accusing participants of hypersensitivity to racial issues, and providing treatment recommendations that were insensitive to cultural norms. Other microinvalidations included counselors claiming “colorblindness” (i.e., stressing that they do not think about race during therapeutic interactions) and counselors from other marginalized groups overidentifying with participants’ experiences of racial oppression. Several microinsults also emerged, including stereotypic racial assumptions (e.g., regarding religiosity, intelligence, and demographic characteristics), assumptions that positive traits exhibited by clients were uncharacteristic of most African Americans, and idealization (e.g., assuming that African American women are strong). Participants also described counselors accepting less than optimal behaviors or outcomes, presumably because more preferred outcomes were assumed to be unattainable. Finally, participants noted patronizing attempts at help, such as an unsolicited offer to waive a session fee.

Similarly, Shelton and Delgado-Romero (2011) conducted focus groups with 16 self-identified lesbian, gay, bisexual, and queer (LGBQ) individuals to examine sexual orientation microaggressions experienced in therapy. Many of the emerging themes represented microinvalidations, including therapists warning about the dangers of identifying as LGBQ, denying the existence of systemic homophobia, overidentifying with clients (e.g., referring to LGBQ individuals in the therapist's own life, appearing overly excited to discuss LGBQ topics), and verbally and environmentally communicating heteronormative attitudes. Microinvalidation themes also emerged around discussions of clients' sexual orientation: Participants reported that therapists focused both too much (i.e., assuming that sexual orientation is the cause of all emotional difficulties) and too little on sexual orientation (i.e., avoiding or refusing to discuss it altogether). Participants also described microinsults in that therapists communicated stereotypical beliefs about LGBQ individuals (e.g., regarding physical appearance and quality of relationships with family of origin).

Impact of Microaggressions in Therapeutic Settings

Understanding the manifestation and types of microaggressions experienced in therapeutic settings is critical because they are associated with a number of negative outcomes. For example, Constantine (2007) conducted a survey of 40 African American college students engaged in counseling with White counselors and found that racial microaggression experiences were negatively associated with ratings of counseling satisfaction, strength of the therapeutic alliance, and counselors' general and multicultural competence. Similarly, a survey of 121 women regarding their retrospective accounts of counseling revealed a negative association between gender-based microaggressions and

ratings of therapeutic alliance and psychological well-being (Owen et al., 2010). Further, qualitative accounts from 16 individuals who identified as LGBTQ regarding their experiences of sexual orientation microaggressions in counseling indicated that these experiences left clients feeling confused, uncomfortable, powerless, invisible, rejected, invalidated, frustrated, and misunderstood (Shelton & Delgado-Romero, 2011).

Participants stated that perceived therapist bias led them to withhold information, avoid discussing sexual orientation even when it seemed important to do so, and deceive therapists in order to get their needs met. Experiencing microaggressions also caused these participants to doubt their therapists' competence and investment in therapy. In theory, microaggressions in therapeutic contexts may be particularly damaging because therapist bias could inform diagnoses and treatment decisions. Further, the power dynamic in the therapeutic relationship may amplify dilemmas regarding identifying and responding to microaggressions (Sue et al., 2007).

Weight-Based Microaggressions in Psychotherapy

To date, no studies explore overweight or obese clients' experiences with microaggressions in therapeutic contexts. However, related research on microaggressions and weight stigma lend theoretical support for its importance and possible manifestation in a therapeutic context. In her dissertation, Aza (2009) identified three instances in which the countertransference toward fat clients described by participants (12 mental health providers) manifested in the form of microaggressions. For example, she identified a microinsult in which a clinician reported giving a fat client unsolicited warnings about the association of obesity and health problems. She also identified two microinvalidations: One clinician responded to a client's description of a weight-based

insult by encouraging her to focus on managing her reactions to others' behaviors.

Another clinician realized throughout the interview that her insistence that she does not focus on body size is similar to claims of "colorblindness." If obese clients were asked about microaggressions experienced in therapy, these might be the sorts of examples they would provide. Interestingly, in the case of Yalom's (1989) countertransference to Betty's body size, he thought he had managed to conceal his bias throughout their 18-month therapeutic endeavor. However, in a frank discussion at termination, Betty revealed that she was aware of his distaste: "Do you know that for the first six months you hardly looked at me? And in a whole year and a half, you've never—not once—touched me? Not even for a handshake!" (p. 115). In the intimate setting of a therapy room, it seems unlikely that weight-based microaggressions go unnoticed.

Section 5: Current Study

Despite a large body of research demonstrating that other healthcare professionals hold stigmatizing attitudes and beliefs toward obese individuals (Puhl & Brownell, 2001), little research focuses on mental health professionals' attitudes toward their obese clients. In fact, the mental health field is generally lacking formal guidelines that address the unique concerns of obese individuals, and theoretical writings and anecdotal accounts suggest that there is no reason to assume that mental health providers are exempt from weight stigma (Brown, 1989; Yalom, 1989). Given clinicians' charge of respecting clients' dignity and worth and professional guidelines emphasizing the importance of monitoring personal biases (APA, 2002; APA, 2010), any weight stigma that exists in the therapy room may be transmitted via microaggressions. Understanding the manifestation and types of microaggressions experienced in therapeutic settings is critical because they are associated with a number of negative outcomes, including weaker therapeutic alliance, lower therapist competency ratings, and poorer treatment outcome (Constantine, 2007; Owen et al., 2010). Further, clients connect experiencing microaggressions in therapy with a number of undesirable emotional states and in-session thoughts and behaviors that likely interfere with treatment (Shelton & Delgado-Romero, 2011). If weight-based microaggressions occur in therapy, it is particularly important to obtain obese clients' perspectives of biased therapy interactions (data that is nearly nonexistent at present), as the very nature of microaggressions is such that offenders are often unaware of their transgressions (Sue, 2010).

Consequently, to build on existing research, this study explored weight-based microaggressions in therapeutic contexts from the perspective of obese women. Given the

highly underexplored nature of this topic, I used semi-structured interviews to obtain qualitative accounts of the weight-based microaggressions obese women experience in therapy. Using a general inductive approach to qualitative data analysis, I coded emergent themes to describe participants' general experiences with weight and weight-related stigma, general therapy experiences, and experiences with weight-related microaggressions in therapy. These data are important because understanding clients' weight-related experiences in therapy can alert clinicians to biases that may be outside their awareness and suggest how these biases might be unintentionally communicated to obese clients. Findings also allow for recommendations regarding how to intervene with obese clients in a sensitive, helpful manner.

CHAPTER 3

METHOD

Qualitative Approach

Consistent with previous microaggression research (Lau & Williams, 2010), the current project utilized a qualitative approach to obtain rich, subjective experiences via one-on-one interviews. Previous research demonstrates that, although members of most marginalized groups describe overlapping microaggression experiences that fit into Sue and colleagues' (2007) taxonomy, themes also arise that are unique to each group (i.e., Capodilupo et al., 2010; Rivera et al., 2010). As such, a qualitative, inductive approach was appropriate for the current project to gather emergent themes around weight-based microaggressions that may not have been identified in previous research.

Participants

Participants were recruited through mental health clinics and private practices in the Las Vegas area. The researcher contacted local therapists to request that they advertise the study to their clients. Some assenting therapists hung a recruitment flier in their waiting area (see Appendix I) while others spoke individually to clients they thought might qualify for the study. Information about the study was also posted on the psychology undergraduate subject pool and on Craigslist, but no eligible participants were recruited through these mediums. Eligibility requirements included being a woman age 18 or older, having a BMI of 35 or higher (based on findings that this is the BMI cutoff at which individuals experience significantly more discrimination and its negative psychological effects; see Carr & Friedman, 2005; Lewis, 2011), having had at least one 45-60 minute counseling session with a mental health professional (i.e., psychologist,

psychiatrist, clinical social worker, counselor, marriage and family therapist, etc.) within the past six months, and consenting to participate in an audio-taped interview.

Participants contacted the researcher directly by phone to express interest in the study. Each potential participant underwent a brief phone screening (see Appendix II) during which they obtained more information about the study, provided information to determine if they met the BMI and therapy attendance requirements, and agreed to their interview being audiotaped. A small description of each participant is presented in Table 1, and the results note the participant number for all quotes cited in the text.

Procedure

Prior to beginning the study, each participant completed an informed consent form (see Appendix III) and received \$20 cash for participation. Participants then completed a brief demographic form that collected information regarding age; height; current, lowest, and highest adult weights; race/ethnicity; education; income; and several other demographic variables (see Appendix IV). Participants then underwent a semi-structured interview.

Semi-Structured Interview

A semi-structured interview (see Appendix V) gathered information about participants' current and past therapy utilization, general experiences with weight stigma, and experiences of weight stigma in therapy. The interview included adapted versions of Shelton and Delgado-Romero's (2011) interview questions and additional items created for the current study, based on a review of the literature examining obese participants' reports of weight stigma, particularly in healthcare settings (Brown et al., 2006; Furber & McGowan, 2011; Merrill & Grassley, 2008).

The interview began with open-ended questions about participants' experiences in therapy, including whether and how participants perceived weight to influence their therapy sessions. The purpose of this section of the interview was to obtain as many experiences as possible without priming participants with stigma-related words or questions. The next portion of the interview inquired about participants' awareness of stereotypes of obese individuals, whether they have experienced stigma or discrimination in general, and whether they have experienced a number of specific stigmatizing experiences in therapy. In both the open-ended and stigma-focused sections of the interview, when participants described stigmatizing experiences, they were then asked how these experiences affected their experience of therapy and how the clinician could have handled the situation differently for a more positive, helpful interaction. Interviews lasted approximately 60 to 90 minutes. Participants also completed two brief questionnaires after the interview, to prevent questionnaire items from influencing their qualitative responses.

Awareness and Expectation of Weight Stigma

After completing the semi-structured interview, participants completed two questionnaires that gathered quantified, descriptive data about their experiences with weight stigma. First, they completed a modified version of the Stigma Consciousness Questionnaire (SCQ; Pinel, 1999), which measures the extent to which an individual expects to be stigmatized by others. It consists of 10 items that are rated on a Likert-type scale from 1 (*strongly disagree*) to 7 (*strongly agree*), with higher scores indicating more stigma consciousness. The SCQ originally included items assessing for expectations of stigma based on race, sex, and sexual orientation and was developed to be adaptable for

other stigmatized groups (Pinel, 1999). The modified version used here retained the format and wording of the original measure, with the exception of substituting “overweight” for the target population and “average weight people” for the potentially stigmatizing population. Pinel (1999) demonstrated good reliability and validity in distinguishing differences in individuals’ awareness and expectation of stigma in samples of women and racial and sexual minority group members. Previous samples of overweight and obese individuals and individuals presenting to weight management centers also demonstrated good internal consistency, with alphas of .85 and .79, respectively (Concepcion, 2007; Schmalz, 2010). Internal consistency in the current sample was good, with an alpha value of .775. See Appendix VI for the complete questionnaire.

Internalized Weight Bias

The Weight Bias Internalization Scale (WBIS; Durso & Latner, 2008) measures the degree to which an individual believes that negative stereotypes about overweight and obese individuals are true for him- or herself. It consists of 11 items rated on a Likert-type scale from 1 (*strongly disagree*) to 7 (*strongly agree*), with higher scores indicating more internalized weight bias. The WBIS demonstrated high internal consistency and convergent and discriminant validity in samples of overweight and obese individuals (Durso & Latner, 2008; Roberto, Sysko, & Bush, 2012). It also predicts variations on measures of psychopathology, including body dissatisfaction. Internal consistency in the current sample was good, with an alpha value of .887. See Appendix VII for the complete measure.

Data Analysis and Synthesis

To examine the qualitative interview data, members of the research team (one doctoral student in clinical psychology, one master's student in kinesiology, and one undergraduate research assistant) and I transcribed each audiotaped interview. To summarize and evaluate these data, a general inductive approach was used (Thomas, 2006), which provides a systematic way to identify and describe core themes present in participants' responses that are relevant to the research objectives. This approach is inductive because, although the findings are guided by the research objectives, the final themes emerge from the data rather than from a priori expectations or hypotheses about the data. General inductive coding involves several steps, throughout which coders engage in multiple readings of transcripts. First, the coder must identify meaningful units of text for the data to be usable. Each unit is given a brief label to identify the meaning. This step necessarily involves making judgments about which data are more and less important based on the research objectives. At the end of this step of coding, many specific units of text have been identified as pieces of data. Additionally, a significant portion of the text (i.e., 50% or more) may be deemed irrelevant to the study objectives and remain uncoded.

The next step of coding involves grouping similar segments of text together into themes. General themes are often generated from the research objectives. For example, since one of the objectives of the current project was to understand participants' experiences of their therapists' appearance and/or body size, a general theme was "Reaction to Therapist's Body Size." Specific themes are generated from the particular meanings of the participants' responses. For example, specific reactions participants had

(or did not have) to their therapists' body sizes could constitute specific themes. Further, the current study utilized hierarchical coding when appropriate, such that subthemes emerged within some specific themes. The final steps of coding involve reviewing the existing codes and combining or omitting codes to reduce overlap and redundancy, and presenting the data by describing the most important categories. It is also important to note that some segments of text fit into multiple qualitative themes, in which case they were coded into all applicable themes. Therefore, one segment of text could support multiple themes.

After coding was complete, a second graduate level researcher conducted a pile sort to confirm the identified themes. The second coder was provided with each piece of data (i.e., meaningful segments of text identified by the primary coder) associated with each major interview question. The second coder was also provided with the theme labels and theme descriptions for each question. Her task was to sort each segment of text into its associated theme (or themes). An inter-rater reliability analysis using the Cohen's kappa statistic was performed to determine consistency among raters (Cohen, 1960). When disagreements occurred, the second coder and I discussed any discrepancies resulting from this sorting process until agreement was reached about the best way to represent the data. These discussions resulted in clarification of themes and creation of some new themes. Bernard and Ryan (2010) outline this sorting method as a way for several people to independently code data. They note that having more than one independent coder is ideal; however, they also acknowledge instances of limited time or money that necessitate only one primary coder. In these situations, they suggest the use of an additional coder to code sample chunks of text to ensure that the primary coder's

codes are not idiosyncratic. The sorting method described above was used as a reliability check to ensure the same.

In addition to the qualitative data, which constituted the core research questions, I analyzed questionnaire data by calculating scale and item means and standard deviations to provide a description of the sample's levels of awareness and expectation of weight stigma and internalized weight bias.

Since it seemed inevitable that personal experiences, interests, and assumptions would influence data collection and analysis to some extent, I took a *reflexive* stance. Reflexivity is a researcher's attempt to demonstrate to the reader "their historical and geographic situatedness, their personal investments in the research, various biases they bring to the work, [and] their surprises and "undoings" in the process of the research endeavor..." (Gergen & Gergen, 2000; p. 1027). Several aspects of my personal experience seemed relevant throughout the research planning and data collection and analysis. I am an overweight woman, and I am also a doctoral intern with experience working with women with eating and weight problems. As such, I have personal and professional interests in the lived experience of obese women and ways in which mental health providers can provide them with maximally sensitive treatment. On the other hand, I have also lived my entire life in a culture in which obesity is denigrated and, as such, it is reasonable to assume that I, too, hold some stereotypes (conscious or unconscious) about obese individuals (Puhl & Brownell, 2009). My primary assumptions regarding this study are 1) that obese women's accounts of interactions with mental health professionals will include descriptions of weight-based microaggressions and 2) that obese women may be less skilled at labeling microaggressions than other marginalized groups, due to the

relative social appropriateness of weight stigma and to cultural messages that obese individuals are to blame for their marginalized status.

CHAPTER 4

RESULTS

Demographic and Descriptive Information

Individual participant profiles are presented in Table 1, and aggregate descriptive information about participants is presented in Table 2. Participants included 15 women who ranged in age from 27 to 63 years, with a mean age of 49 years. The majority of participants self-identified as European American ($n = 10$), with two participants identifying as multiracial, one as African American, one as Latina, and one as Persian. Although nearly all participants identified as heterosexual ($n = 13$), one identified as a lesbian, and one as bisexual. In terms of marital status, seven participants were divorced, five were single and never married, two were in committed relationships, and one was married.

Participants' Body Mass Index (BMI; weight in kilograms divided by height in meters squared) ranged from 33.51 to 56.96, with an average BMI of 41.52. Although two participants had a BMI below the study cutoff of 35 (BMI = 33.51 and 33.93), they were deemed eligible for the study because 1) they had previously attended therapy at a BMI of 35 or higher and 2) their current BMI was still in the mildly obese range at the time of study participation. Two-thirds of participants ($n = 10$) endorsed having a disability: seven reported a physical disability (including fibromyalgia; multiple sclerosis; spinal stenosis; arthritis; knee, shoulder, and back issues; and respiratory problems); four reported a mental disability (including learning disability and mental illness); and one participant was hearing impaired. Participants' median household income was \$17,000.

Only three participants were currently regularly employed, one participant occasionally engaged in freelance writing for a newspaper, and one was retired.

Participants reported working with their current therapist for between two weeks and 11 years, with an average of 21 months. Although most participants were currently attending individual therapy ($n = 9$), four participants were attending both individual and group therapy and two were attending group therapy alone. Eight participants reported currently taking psychotropic medication, and three others reported a history of psychotropic medication to treat depression, anxiety, and/or bipolar disorder. For two of these participants, it was unclear whether they might still be taking medication for mental health concerns. Participants were currently attending therapy at community mental health clinics ($n = 6$), private practices ($n = 4$), a university counseling center ($n = 2$), and through a faith community ($n = 1$), with two participants' treatment settings unspecified. Participants were currently in therapy with a psychologist ($n = 7$; 3 participants were working with the same psychologist), predoctoral psychology practicum student ($n = 3$), marriage and family therapist ($n = 2$), or psychiatrist ($n = 1$). Two participants did not provide their therapists' credentials.

Participants reported a variety of presenting concerns and/or problems that were the focus of therapy. All but one participant reported more than one concern that was the focus of therapy. The most commonly-occurring presenting problems included depression ($n = 10$); trauma (including childhood sexual abuse, domestic violence, and sexual assault in adulthood; $n = 8$); anxiety (including social anxiety, panic attacks, and obsessive-compulsive symptoms; $n = 4$); acting out/addiction ($n = 4$); low self-esteem ($n = 3$); dissatisfaction with weight and/or disordered eating ($n = 3$); and coping with own or

a parent's medical problems ($n = 2$). Five participants reported having been diagnosed with bipolar disorder, although they tended to identify depression or other concerns as having brought them to therapy. Presenting problems identified by only one participant included grief, sexual identity questioning, recurring interpersonal problems, dissatisfaction at work, dissatisfaction in a romantic relationship, family relationship problems, and concerns related to having an alcohol-abusing parent.

Quantitative Data on Weight Stigma

Quantitative questionnaires completed after the interviews indicated that participants endorsed some awareness and internalization of weight stigma ($n = 14$; one participant was mistakenly not given the questionnaires). Specifically, regarding awareness and expectation of weight stigma (SCQ), participants' mean score of 3.11 indicated that they "slightly" expected to be stereotyped by others based on their weight (See Table 2). Regarding internalization of weight stigma (WBIS), participants' mean score was 4.75, indicating that the average participant was neutral to slightly in agreement that negative attributions about obesity were true about herself.

Qualitative Interview Themes

Inter-rater reliability varied considerably among themes, with kappa ranging from slight agreement to substantial agreement. The kappa statistic (κ) ranges from -1 to +1 and represents the proportion of agreement over and above chance. Statistical significance ($p < .05$) indicates that the kappa value is statistically significantly different from zero. Coding for two of the interview questions yielded substantial inter-rater

agreement³: $\kappa = .750$, $p < .001$ for the question regarding the impact of participants' weight on their presenting problems and $\kappa = .647$, $p < .001$ for the question eliciting advice for therapists working with overweight women. Coding of participants reports of weight stigma in therapy yielded moderate inter-rater agreement, $\kappa = .400$, $p < .001$. There was fair inter-rater agreement for participants' responses regarding how they gained weight, $\kappa = .313$, $p < .001$. Coding of the remainder of the questions yielded slight inter-rater agreement: $\kappa = .186$, $p < .001$ for participants' responses regarding how weight has impacted their presenting problems; $\kappa = .168$, $p < .001$ for their reports of general experiences of weight stigma; $\kappa = .060$, $p = .005$ for their descriptions of unhelpful therapy experiences; $\kappa = .037$, $p = .007$ for their descriptions of relationships with their current therapists; and $\kappa = .000$, *ns* for their descriptions of helpful therapy experiences.

Following the reliability check, the two coders collaboratively discussed each discrepancy until agreement was reached about how to best present the data. An elaboration of the coding process is illustrated in Table 3, which includes each participant response associated with the interview question labeled "Advice for Therapists" and illustrates how these responses were coded into themes and subthemes.

For ease of discussion, themes are organized and discussed in this project according to the interview question(s) with which they correspond (see Table 4). In general, responses within each theme emerged as a reply to the specific question(s) within which they are coded. However, in some cases, participants provided a response

³ Landis and Cohen (1977) offered the following guidelines for the interpretation of Cohen's kappa: <0: Poor agreement; 0.0 – 0.2: Slight Agreement; 0.21 – 0.4: Fair Agreement; 0.41 – 0.6: Moderate Agreement; 0.61 – 0.8: Substantial Agreement; 0.81 – 1.00: Almost Perfect Agreement

that supported a specific question earlier or later in the interview than that question was asked. For example, it was common for participants to discuss their beliefs about why they gained weight and describe instances of being stigmatized for their weight not only in response to questions directly inquiring about these topics but also at other times during the interview.

In response to the 11 interview questions, 47 themes and 39 subthemes emerged. These themes and subthemes are discussed below and are organized by interview question(s). The interview was organized to begin with the least suggestive questions to prompt participants to think about their size and their therapy experiences, building up to examining (in the least suggestive way) how the two intersect and eventually directly inquiring about therapy microaggressions. The results are presented in this order below. When quotes from participants are provided, they are followed by the participant number in parentheses.

Question 1: Cause of Overweight

Participants were asked several questions as precursors to items inquiring about subtle weight bias in therapy. One such question was how participants believed they became overweight or stayed overweight. As shown on Table 4, responses were grouped into six emergent themes and several subthemes. Nearly all participants identified behavioral factors leading to weight gain or maintenance of higher weight ($n = 13$; 87%). Specifically, responses in this category fell into three general subthemes: poor eating habits ($n = 6$; 40%), potentially disordered eating (i.e., binge or emotional eating; $n = 8$; 53%), and lack of physical activity ($n = 7$; 47%). In a response that captures all of the subthemes, one participant stated, “I contribute [*sic*] it to lack of exercise. I contribute

[sic] it to my eating habits...I snack more than I sit and eat a meal. When I do eat a meal, it's not a healthy one. Um, I am an emotional eater, so when I'm stressed, I like potato chips and stuff to crunch on. When I'm sad, I like chocolates and sweets" (P8).

Two-thirds of participants attributed their weight gain or maintenance to life events or environmental factors, including relationship problems and interpersonal violence, childhood abuse, developmental milestones, and life transitions ($n = 10$; 67%). For example, one participant stated, "But then I went through this terrible divorce, marriage didn't last long. It seems like since then I just keep going and going and going [gaining weight]" (P5). Another participant noted, "[Age] 40 to 50, I took care of my parents and they were older...So when I went back there it just turned into a whole food fest" (P3). Most participants also identified physical or mental health problems or their treatment (i.e., medication, attaining sobriety) as resulting in weight gain ($n = 11$; 73%). For example, one participant described her experience with psychotropic medication: "I put on 70 pounds after...I was diagnosed as bipolar. I mean, within six, eight months' time I put on 70 pounds from medication" (P15). Another participant discussed weight gain secondary to depression: "When you're in the darkness...some people don't eat, some people clean their house, I am the other person. I am the one that eats in depression" (P9).

One-third of participants also discussed their understanding of the function of the weight or weight gain ($n = 5$; 33%). For example, one participant understood her weight as a way to avoid conforming to family and cultural expectations: "There are underlining angers and fears that are causing this...my weight issue is definitely caused by emotional things, including fear that I never thought I had...The fear piece is, oh, what if I do lose

the weight and I become exactly what everybody wants me to be, and not what I want to be?” (P8) Others discussed weight as a way to keep others at a distance: “Maybe the weight has been like my protection, my wall of protection” (P4).

Three participants (20%) discussed negative weight-related comments from others as contributing to behaviors that caused weight gain. For example, one participant stated, “Years of growing up, ya know, somebody saying ‘you’re fat, you’re ugly, you’re not attractive, you’re never going to get a man, um, nobody likes you, you’re bad.’... and the more people said things, the more I ate” (P16). Finally, a small portion of participants also attributed their weight gain to genetics and/or their body’s natural predisposition to being bigger ($n = 3$; 20%). A response typical of this theme included, “It was just that’s how I was built...I had three younger brothers, and we, uh, I had a chubby brother, and then two scrawny brothers. And we all had the same, we have the same parents, same food, everything” (P4).

Question 2: How Weight is Related to Presenting Problems

When asked whether and how their weight was related to presenting problems in therapy and whether they were aware of their therapist’s ideas about any connection between the two, participants’ responses fell into four themes. First, two-thirds of participants stated that their presenting concerns or treatment of presenting concerns (i.e., psychotropic medication) either directly caused weight gain or resulted in behaviors that led to weight gain ($n = 10$; 67%). For example, one participant discussed how anger may have led to weight gain: “I was like, angry for 30, 40 years. And that coulda had a lot to do with it...I was angry and I could’ve been doing other things to hurt my body that I didn’t realize I was doin’” (P5). Another noted, “When I get more depressed...I tend to

maybe eat more” (P15). Another participant noted the effect of her psychotropic medication on her weight: “Well, the, the one medication I take, Seroquel, it doesn’t help you lose weight. That’s all that I know... ‘cause I talked to my psychiatrist about it and he said that the Seroquel could be one of the main reasons why it’s hard, hard for me to lose weight” (P12).

Second, over half of participants identified weight and/or their thoughts or feelings about their weight as causing, exacerbating, or maintaining presenting concerns ($n = 8$; 53%). A response typical of this theme included, “On the outside, I have the persona of, my weight is not what’s holding me back. But on the inside I’m incomplete because I’m not at the weight I want and I’m unhappy. And it does make me sad. And I think that it brought me to therapy because that’s also another reason why I feel like my emotional, internal cup has overflowed” (P8). Another participant described how being overweight resulted in a problematic interpersonal pattern that was a focus of therapy, stating, “For many, many years, it was all sorts of, ‘People aren't going to like me because I'm fat.’ So I needed to do other things to make them realize that I'm a great person. And that's where a lot of that pleasing, caregiving and caretaking came in” (P2).

Third, one-third of participants discussed ways in which their weight serves a coping function, often by creating a barrier between self and others and/or protecting from abuse ($n = 5$; 33%). For example, one participant stated, “Like, my weight is something I hide behind...I always hide from other people. I’m constantly hiding from other people because people are scary” (P1). Another noted, “When you’re molested as a child...being heavy protects you from being hurt again. And I haven’t been in a relationship in almost 14 years, and, and I know part of it is afraid of being hurt, and I

know that that's why it's taken me so long to get focused on getting the rest of the weight off" (P7).

Finally, a smaller portion of participants indicated that weight and eating behaviors have been primary foci of therapies ($n = 3$; 20%). As one stated, "Well, I think that one of the reasons I go to therapy is to find out why I'm eating so much. Get to the bottom. They always say in these articles and things you see...until you get to the bottom of why you're overeating, then you're gonna continue with this problem" (P13).

Question 3: Relationship with Current Therapist

To elicit descriptions of weight-based microaggressions (if relevant) in the least suggestive way, early in the interview participants were asked to describe their relationship with their current therapist. Responses to this question were grouped into two emergent themes with several subthemes. First, each participant's response included information about the overall valence of the quality of the therapeutic relationship. Although the vast majority of participants described their relationship with their current therapist in solely positive terms ($n = 12$; 80%), two participants (13%) described having negative or unsatisfactory relationships with their current therapists, and one participant (7%) noted having mixed feelings about her therapist.

The second primary theme included descriptions of positive therapeutic relationships ($n = 12$; 80%). The majority of participants' descriptions ($n = 9$; 60%) included mention of therapist factors, including relationship factors (i.e., feeling comfortable and understood; therapist as trustworthy, present, and non-judgmental) and therapist style in session (i.e., direct, challenging, allowing the process to unfold). A response typical of this theme included, "She's there with you, working with you all the

time. And there'll be times when some parts of my life make your eyebrows kind of curl around, and she's, she's just been right there, ya know, in the trenches with me" (P9).

Another participant stated, "My therapist has just been so fabulous and being able to understand, um, what I need" (P4). Discussing her therapist's style in session, one participant noted, "She's a little more direct than uh, the other two therapists that I had. Um, she's a little more challenging and I find that's what I need at this point" (P13).

Another shared, "She listens and then she kind of lets me work through it, and then she tells me what she thinks...I really enjoy that she gives me time to process it" (P2).

The second subtheme regarding descriptions of positive therapeutic relationships captured responses more focused on the therapist's use of specific interventions or types of interventions (i.e., behavioral suggestions, facilitating increased insight; $n = 3$; 20%). For example, one participant described her therapist being available outside of session to help her with coping skills: "I may be havin' a really bad day...And, and she'll tell me what to do on the phone—now, remember this, remember that. Remember your breathing exercises, relax" (P12). Another participant discussed her therapist facilitating increased insight and self-awareness, stating, "She gives good feedback... it's another layer of myself that I realize, that I would have never realized" (P8).

There were not enough responses describing negative or mixed relationships to code these responses into themes. However, of the two participants who reported having negative relationships with their current therapists, one participant discussed her perception of her therapist as overly emotional in session, which brought up frustration and reenactment of her tendency not to share her experiences with others. She stated, "On our first session or second session, I made her cry. And then on our third session, like I

could see that she was visibly getting angry, which is understandable but I don't want to – I've been through a lot and a lot of times I don't share them because I don't – it feels almost selfish in a way, like I don't want to make someone kind of relive what I lived or go through what I went through” (P1). The other participant who reported a negative therapeutic relationship had more overtly negative feelings about her therapist, reporting feeling uncomfortable with and judged by him: “I feel really uncomfortable around him, I don't like the way that he...and he doesn't judge me, but I take it like he's judging me when he corrects my English...when he corrects me in front of others. I run late and then he uh, ‘Well why are you running late?’ I says, ‘Well I'm an adult, why are you asking?’” (P6). The one participant who described mixed feelings about her current therapist acknowledged that her therapist does what is best for her, which is difficult at times: “I have mixed feelings because, like, she can be hard. Like, tough love. But I'm not used to that... She gets deep. She gets – and mind you, when you're, when you're like an addict and you're running from your problems, you're not used to dealin' with 'em. But they're still there. So she, I see the purpose in it” (P10).

Question 4: Helpful Therapy Experiences

When asked to describe a particularly helpful therapy experience, participants' responses fell into three emergent themes and several subthemes. First, nearly all participants described one or more specific therapeutic interventions ($n = 14$; 93%). Over one-third of participants described interventions aimed at identifying, validating, and/or changing their emotions, including reducing shame and self-blame ($n = 6$; 40%). One response typical of this theme included, “That process of breaking down to the primary feeling and getting to what that primary feeling is, um, was helpful for me. Because a lot

of the time I would use, um, a depressed feeling or an angry feeling when in reality, it was like, hurt or something more meaningful for me to deal with. Um, so that was really helpful” (P3). Within this theme, another group of participants described interventions aimed at increasing assertiveness, boundary-setting, and/or prioritizing of own needs ($n = 4$; 27%). In a response typical of this subtheme, one participant shared, “And my doctor gave me permission to be selfish... sometimes you have to do what’s right for you, even if it’s not right for everyone else. And for me, that was like a light bulb moment... I’m always worried about everyone else and never worried about myself. And so that was one of the first times, where I realized that... in order for me to be happy, I have to figure out what it is I want” (P2).

Nearly half of participants ($n = 6$; 40%) also described additional interventions not fitting into the above subthemes, ranging from increasing mindfulness and challenging negative self-perceptions to initiating hospitalization. One response within this theme included, “Trying to slow down to think enough in the process, instead of afterwards when I’ve already done the damage and then feel bad of doing the damage” (P8). Another participant noted, “One of the things was to go and for the next month and write down... what you are thankful, what happened that day that was good. And it could be the most minuscule thing” (P9).

Another primary theme included therapist or relationship factors ($n = 6$; 40%). Participants described their therapists as non-judgmental, understanding, and supportive and noted the helpfulness of instilling hope. For example, one participant described trusting her current therapist enough to tell him everything: “The one I’m with now I’ve been with for years, um, I got comfortable tellin’ everything, ya know, because that stuff

I had never disclosed to the other one. I always knew it but I couldn't get good enough relationship" (P5). Another participant described her therapist's role in facilitating hopefulness despite her history of childhood abuse: "He basically let me know that...it's an experience that's gonna live with me for the rest of my life, but that I can grow to be a better person and that I'm a strong woman and that, ya know, I would get through this" (P7).

Although the vast majority of the experiences participants described were not related to interactions involving their weight, two participants (13%) described helpful experiences related to their weight or eating behaviors. For example, one participant described the relief she experienced when her therapist explicitly stated that she would not judge her disordered eating behaviors: "Having the therapist say that there was no judgment...and allowing myself to actually say what I've eaten. Because that was the first time I've ever shared with people what I would binge on. And how much I would binge on" (P3). Another participant identified as particularly helpful increasing her insight into her poor self-esteem, particularly related to her appearance: "Understanding that, um, my low self-esteem, um, definitely came from a childhood from parents of the generation where looks were everything, instead of who you are inside" (P4). She also discussed the helpfulness of therapists helping her to rebuild her self-esteem: "I didn't appreciate who I was, and with talking to them I started to get those little buds of, "Oh! I'm not so bad, just because I'm fat!...What she has done is really point out to me, um, my special attributes" (P4).

Question 5: Unhelpful Therapy Experiences

When asked to describe a particularly unhelpful therapy experience, participants' responses were grouped into five themes and several subthemes. Nearly all participants discussed therapist and/or relationship factors ($n = 14$; 93%), and several subthemes emerged within this theme. First, most of these participants described disruptions in the working alliance, including therapist and client having incongruent ideas about the goals or focus of therapy and clients feeling misunderstood or unheard ($n = 11$; 73%). For example, one participant said, "She didn't listen...I just felt that she was never focusing on what I thought the problem was and those are things I needed to talk out...She wanted to focus on, I guess mainly how to get me out of a panic attack...and that's understandable, but I think that everything I have all comes from the same root. Ya know, so if I don't get to that then it's still always gonna be there to a certain degree" (P1). Another noted, "It was almost like the first doctor kind of zeroed in on, 'This is what your problem is.' And that's the only interpretation that she would take of it...And of course, you know, she is a doctor, she may know more, but I was like, but I'm living it, and I'm in it and I don't feel it like you do" (P2). Another described her experience working with therapists who were not understanding of her current level of motivation for change: "I noticed that a lot of those counselors in there were not very understanding with me being in denial" (P12).

Another subtheme related to the therapeutic relationship was that of therapists making specific and overt statements that left participants feeling offended, rejected, or shamed ($n = 7$; 47%). For example, one participant described being "fired" by her therapist: "And she was, said to me something to the fact of, 'Well, if you're not able to

go there and do that [get in touch with an emotion], then I'm not gonna be able to work with you anymore.'...It was devastating" (P16). Another noted, "He told me just to get over it and ya know, you can't be blaming your parents, you're 18 now" (P15). Some participants described unhelpful therapist self-disclosures: "He would, um, just start on a rant about something in his life that was bothering him that day or something. And I would just sorta sit there" (P4). Another participant shared that her therapist disclosed his own history of cocaine use (P3).

Participants also discussed negative mental health interactions related to medication ($n = 4$; 27%). For example, some participants reported experiences of being overmedicated: "When I was 15 when I came here, um, they medicated me heavily. And I just slept all the time. And I didn't think that was helpful at all, just to medicate me" (P13). Another participant described being immediately offered medication when she was hoping for more collaborative discussion with her psychiatrist: "Well the first time I saw him, the first things, the first words out of his mouth was, 'What do you want?' Meaning what prescription can he write me to help me, and so that was like...it made me think that was all he was there for, was to prescribe medication and that was it" (P7).

Finally, two participants (13%) described culturally unhelpful interventions. One participant was hearing impaired and noted that she is therefore unable to fully participate in some group therapy activities (P9). Another participant described advice about boundary-setting that is not a good fit with family and cultural values: "So the advice was, I usually do...date night with my dad on Wednesdays...Um, but that becomes an abusive time for me. Um, where I get abused verbally and stuff. So the advice was just to not go...The unhelpful piece is, I wish we, we were working on steps to correct it,

because obviously this is my dad, and this relationship will never just end. Especially with my culture being so family-driven...it's causing a little strain in my family connection" (P8).

Nearly half of participants also specified the impact of these unhelpful therapy experiences ($n = 7$; 47%). One-third of participants reported that they quit working with their therapist as a direct result of the experience they described ($n = 5$; 33%). As one participant said, "And I felt like I was keeping more from her than I was sharing with her. Then I'm like, what am I paying for? What am I wasting my time for?" (P2). Two additional participants (13%) noted that although they stayed in therapy, the therapeutic relationship suffered and the therapy became less effective. For example, one participant noted that therapy became "less helpful and annoying. I really just I didn't even want to look at her" (P1).

Similar to participants' descriptions of helpful therapy experiences, only two of the unhelpful experiences described (13%) were weight-related. One participant identified as unhelpful a therapist's attempt to help her move toward more intuitive eating: "She usually said, 'Don't, don't deprive yourself of something if you want it.' Um, and that was not helpful for me. Because for me, it's a very slippery slope when it comes to food, and what I eat, and what I don't eat. You know, so somebody that says to me, 'Don't deprive yourself of something. Have what you wanna eat' is like, a free license" (P3). Another participant noted feeling that a previous therapist behaved more like a friend than a therapist, including mentioning her own need to lose weight: "She would say that a couple times, 'Girl, I need to lose some weight,' you know. And that's what I

mean gettin' too friendly. I don't care, I ain't here to talk about you, I'm here to talk about me!" (P5).

Question 6: How Weight Impacts Therapy Sessions

Participants were also asked whether and how weight has impacted their current or past experiences in therapy, and their responses fit into three emerging themes. First, four participants (27%) reported that their weight has not impacted their therapy experiences or that they were not sure of the impact. Two additional participants either were not asked this question or provided a tangential response. All other participants indicated awareness of some way in which weight has played a role in their therapy sessions ($n = 9$; 60%). The primary theme was that participants' weight (and often associated shame or self-consciousness related to weight) resulted in them being less forthcoming, more evasive, or more avoidant in session ($n = 6$; 40%). In a response typical of this theme, one participant stated, "I would say that I may have been more evasive. Because I didn't want to admit why I wouldn't do something. Because it, it's one thing to say I don't wanna go to a party because I feel social anxiety...but it's more private to say I don't wanna go because I'm embarrassed because I'm fat" (P13). Another similarly shared, "I think definitely that my weight is still that protector...Like, you can't see everything about me. You might see that I eat, and I binge eat, but you can't see anything else beyond that, unless I share it with you...I think it made things delayed. Because I think it stopped me from getting to emotions and feelings" (P3).

Two participants (13%) also identified weight as a reason for missing therapy sessions. For example, one participant shared that she has skipped her group therapy due to embarrassment about having no appropriately-fitting clothing: "There's times where I

just don't want to go because you can't fit in anything. I really have to force myself to go and sometimes I don't go, and I'll call and say I've fell on my head and it's really because I'm a big, fat pig and I'm staying on the couch" (P9). Another described weight-related social anxiety, stating, "Well, there have been times that I just didn't wanna go out of the house to a session because of my weight" (P13).⁴

Question 7: Stereotypes about Overweight Individuals

Responses to a question inquiring about societal stereotypes of overweight individuals fit into six primary themes. First, over two-thirds of participants described negative social and environmental consequences of being overweight, including being socially undesirable or unworthy and having fewer appealing clothing options ($n = 12$; 80%). A comment that fit this theme was, "And I think that in society, people don't gravitate towards fat people. We really have to have something special about us or do something extra to get people to see past the weight. And see who you are as an individual" (P8). Another noted, "You're kinda hidden, you know... You're not part of the 'in' crowd, I guess, is the way to look at it" (P3). Over two-thirds of participants also identified negative personality characteristics associated with overweight individuals, including laziness, lack of intelligence, and apathy ($n = 11$; 73%). A typical response in this category included, "They're lazy. They're not as motivated. They're not as successful. Um, they are uncaring people, selfish people" (P8).

Additionally, more than one-third of participants' responses referred to the cultural thin ideal, including media messages around body size and cultural valuing of

⁴ In response to this question, two participants also described interactions with their therapists that were coded as microaggressions; these incidents are included in the section below outlining participants' descriptions of weight-related microaggressions in therapy.

thin bodies over larger ones ($n = 6$; 40%). As one participant stated, “The culture doesn’t really afford us to be fat and smiling, they prefer us to be skinny and smiling” (P9).

Another participant discussed the lack of media representation of larger bodies and the disproportionate negative consequences of being overweight for women as compared to men: “Just the Hollywood thing, you gotta be slim to get good parts—for women. And this is a women’s study. They don’t treat men the same” (P5). Participants also noted that overweight people are associated with physical characteristics that are devalued in dominant culture, including being unattractive and appearing older ($n = 6$; 40%). For example, one participant noted, “They look at a woman that’s overweight and think she’s not attractive because she got, has weight on her...Or they think she’s older than she is because she’s heavy, which has nothin’ to do with her age” (P5).

Another emerging theme was around negative assumptions about overweight individuals’ behaviors and their health status, including that all overweight individuals have poor eating habits, are inactive and unhealthy, and lack self-control ($n = 4$; 27%). In one participant’s words, “That we all drive those little scooters. That all we do is eat all the time. And sit around, and we never eat anything healthy for us. We always eat cupcakes and, and chicken wings” (P2). Another spoke about her own insecurities based on her perception of this stereotype: “I don’t want these people to think that because of my blubber that I’m just scarfing down food [pig noise]...Ohhh, it looks like a fat person porking out” (P9). Finally, two participants noted the seemingly positive stereotype that overweight people are good-natured or jolly (13%). One participant simply noted this perception without much commentary (P6), and the other seemed to feel constrained by

this stereotype: “We always have to be happy, ya know, they’re the good natured, happy fat people. I’m like, no, there are days where I have a bad day!” (P2).

Question 8: General Experiences with Weight Stigma

As a way to prompt participants to think about experiences of weight-related stigma before inquiring about potential microaggressions in therapy, they were asked to reflect on the stereotypes they provided and discuss any instances of perceived weight-based stigma or discrimination. Four primary types of stigmatizing experiences emerged, with some subthemes. First, nearly all participants reported having experienced overtly rude, mean, or demeaning weight-related comments ($n = 14$; 93%). The majority of these participants reported current or past comments from family members ($n = 8$; 53%). For example, one participant described interactions with her mother: “She said, ‘You need to face the fact that you’re not one of those naturally pretty girls. You need to wear makeup every day. I see you slop that shit on in the car and you just need to wake up earlier and make sure that you do that and don’t try and tell me otherwise because I see you’” (P1). Another participant described demeaning comments from her father: “My dad always, he’s like, ‘You’ve become as fat as a cow,’ um, ‘You’ve become disgusting. We don’t want our friends to even see you because it’s an embarrassment. Everybody else’s kid is healthy, getting married, skinny, and all you do is eat and make yourself disgusting.’” (P8).

Participants also reported explicitly rude or demeaning comments from strangers ($n = 7$; 47%), bullying or teasing by peers in childhood ($n = 5$; 33%), and comments from current or ex partners ($n = 3$; 20%). Describing childhood weight-related bullying, one participant stated, “I used to get called orca and big mama...kids can be very, very cruel.

So, and I remember that, I remember getting made fun of. I do. And it sucked and it hurt” (P7). Another participant described being harassed by strangers at a bar, stating, “Some of the drunk guys made comments, but I was like 25 and it was devastating because I wasn’t trying to hit on anybody or date anybody. I was just sitting there having a beer minding my own business and they just had some comments to make” (P2). Finally, describing an interaction with her ex-husband, one participant stated, “When I stopped with the drugs I was gaining a lot of weight. He would hurt my feelings a lot and say, ya know, ‘You’re just really fat now.’” (P12).

In addition to rude or demeaning comments, participants discussed others’ unwanted expressions of concern about their weight ($n = 9$; 60%). Comments falling within this category included explicit or implied concern about how participants’ weight impacts their physical or mental health, often accompanied by suggestions to try to lose weight. Within this category, many of the comments came from medical professionals ($n = 6$; 40%). For example, one participant noted, “After I had my son, and this overweight gynecologist, obstetrician said to me, ‘You know, you, you really need to lose weight.’” (P4). Another stated, “See, once a month I see [name], the nurse. She weighs you...And lately she’s been weighing me and stuff like that, and she says, ‘Boy, you’re gaining a lot of weight’...And that, that, and it kinda, you get disgusted” (P12). Participants also discussed concern expressed by family members, friends, and strangers ($n = 6$; 40%). For example, one participant described interactions with immediate and extended family members: “The first thing is, ‘Oh, you’ve gained more weight.’ But you’re, and it’s always a false positive. Because it’s always, ‘Oh, but you’re so pretty! We just want you to get healthy!’ And it’s like, ya know, leave me alone!” (P8). Another discussed

suggestions from friends and strangers that she try to lose weight: “And I mean (sighs), and the big question everybody always asks is, ‘Have you ever tried to lose weight?’ No, I’ve never thought of that. Of course, I’ve tried!” (P2).

Another emerging theme was of participants feeling ignored or invisible due to their weight ($n = 5$; 33%). For example, one participant contrasted her social interactions when she was thinner to her current social treatment at a higher weight: “Well of course the guys are more flirtatious and wanting your number, you know. More sociable. Like, people wanna interact with me more. And then I notice being overweight, people just, like, shun me” (P10). Participants also noted invisibility in terms of fewer and/or less appealing clothing options for overweight women. In addition to sharing their experiences of stigma, one-third of participants noted that their perceptions of stigma could be distorted due to their own insecurity or sensitivity to perceived judgments ($n = 5$; 33%). For example, after sharing experiences she attributed to weight stigma, one participant provided the caveat, “Granted, some of it might just have been because I was so overly, you know, sensitive of those things” (P4). Another similarly stated, “I think I probably magnified those things in my own head because my own dysmorphia about what I looked like” (P9).

Finally, many participants discussed the impact of weight stigma ($n = 12$; 80%). Two-thirds of participants reported more empowered reactions or feelings, including anger, a sense of injustice, or developing a “thick skin” when faced with weight stigma ($n = 10$; 67%). For example, one participant discussed her reaction to a coworker saying he felt sorry for overweight people: “Well why? Why do you feel sorry for them? Who told you that your weight and look is the right way?” (P5). Another talked about how her

reaction to rude comments has changed over time, stating, “At this point in the game, 40 years into this, I usually consider the source now of who’s saying whatever they’re saying. And if it’s some drunk guy at a bar or some frat guy or whatever, okay, again, thanks for your opinion, awesome, go away, ya know” (P2).

One-third of participants discussed feeling sad, hurt, or ashamed during or after stigmatizing experiences ($n = 5$; 33%). For example, one participant described how she felt after being called fat by her boyfriend: “I thought to myself, you know, that’s, that’s humiliation...it’s hurting my feelings” (P12). Another participant shared the impact of not being hired because of her weight: “It just hurt for a really long time. I, I was shocked at that kind of discrimination” (P4).

Participants also noted the direct negative impact of stigmatizing experiences on their body image and health-related behaviors ($n = 6$; 40%). For example, participants frequently attributed their poor body image to years of demeaning comments from parents. One participant stated, “No matter what I looked like, my mother would always put me down. Always. So I think that I had such a distorted view of my weight all my life” (P9). Another participant described her pattern of restriction and bingeing as originating from her father’s critical weight-related comments: “He came in and he was angry, and he said, ‘Why can’t you just push yourself away from that table?’... from then on, it’s been starting starvation for the day, as long as I could take it without eating. Then I would binge at night” (P3). Another participant noted one potential negative outcome of unwanted comments about weight from medical providers: “And matter of fact, I missed an appointment last month because I didn’t wanna hear it from [nurse’s name]” (P12). Finally, three participants (20%) described social avoidance due to previous experiences

or expectations of stigmatizing weight-related experiences. As one participant noted, “And, um, then when I became a young mother, I was afraid to go out, um, because it just seemed like...you were fair game for, um, people saying mean things to me” (P4).

Question 9: Weight Stigma in Mental Health Settings

Near the end of the interview, participants were asked whether they had ever felt uncomfortable, insulted, or disrespected by therapist comments or behaviors that seemed to imply something negative about their weight. Responses to this question were grouped into five emerging themes. First, the vast majority of participants denied having experienced any weight-related stigma in session ($n = 12$; 80%). Only three participants (20%) explicitly endorsed stigmatizing experiences in therapy. One participant reported believing that her current group therapist discriminates against overweight group members: “I sometimes feel that there’s...thin people in the group, okay, and they tend to talk to them only...and there’s other people in the group that are heavysset and we lock eyes, you know, why be there, you know. It’s supposed to be a group meeting, you know, everybody gets to talk okay, not just Miss Thin over here, or you know Mister Thin...it’s very obvious, well to me it’s very obvious. But then I think, well am I seeing this because I’m heavy or because she needs the help? And um, no, I end up saying, no, it’s because I’m heavy” (P6). Earlier in the interview, this participant had discussed being in the process of trying to find a new therapist.

Another participant discussed previous mental health professionals who focused on her weight rather than important mental health concerns: “But back then I would have an attitude toward my doctors... I’d say I didn’t like them... Just because the comments that they would make, you know, ‘You need to lose some weight [name], you just need to

lose some weight. You'd feel much better about yourself.' And that was the whole topic of our discussion, was that I needed to lose some weight and then I'd feel better about myself, instead of looking at what really was the problem" (P7). This participant also discussed the negative impact of these interactions, stating, "It made me feel terrible...they just made me feel worse about myself than I already did." Finally, a third participant shared her perception that therapists have been less interested in her at times because of her weight: "Um, sometimes I sense that maybe people don't wanna, even maybe my counselors...I don't want them to feel like they're wasting their time... 'cause I can tell if someone's interested in interacting, engaging in conversation...And I don't like sittin' there, again, there, I think is because I'm overweight. 'Cause ya know, when I was skinny, people wouldn't act like that with me, ya know. I can't say that's what it is, but that thought crosses my mind. That, how I'm treated because of my weight" (P10).

Comprising another emerging theme, two participants (13%) described experiences with therapists that sounded potentially stigmatizing, although they did not identify these instances as stigmatizing. One participant discussed her therapist's assumption that she has poor eating habits: "We were talkin' about weight and he said, um, he did ask me kinda how I was eating... 'cause he said, 'I've got one client...she sits in the bed all day and eats, uh, candy and, ya know, just junk food, and she can't figure out why she's gettin' big.' I'm like, 'Well, I don't do that.' I can't, couldn't even afford at that time to buy junk food like that, cause junk food can be expensive...it really kinda took the emotional weight off of me, ya know. 'Cause like, ya know, she's tellin' him that this is what she's eatin' and can't figure out how she's gainin' weight and I'm tellin' him what I'm eatin' and I can't figure out how I'm gainin', so it was comical, ya know"

(P5). Another participant stated that her therapist has initiated conversations about weight loss due to concern about the participant's health: "Well, I think, you know, in terms of once in a while that I think [current therapist] does [initiates conversations about weight loss], in terms of my health... You know, I don't have a problem with her talking about weight loss" (P16).

As a way to further assess for potential therapy microaggressions, participants were also asked whether they encountered physical barriers in the therapy environment (i.e., therapy room, waiting room). A few participants had complaints about their therapist's waiting room, primarily related to the furniture and their awareness of how much space they occupy there ($n = 4$; 27%). For example, one participant noted that many waiting room chairs are too small for her to sit comfortably: "When you walk in there [the waiting room], they have chairs and couches. The couches push down, so I'm always having a difficult time getting off the couch. And the chairs, um, have handles. So sometimes I don't fit in the chairs. That's the same way I feel when I'm on planes or airlines. I am always hanging over. And that bothers me" (P8). Another described awareness of the amount of space she took up in a crowded waiting room: "When I go to [name of clinic] over there, I have to... have a seat in between. I don't ever wanna be in a, in a chair right now where I'm like right next to somebody. I want a chair in between... That's because of my size" (P16).

Finally, two participants (13%) suspected that therapists are careful with how they approach the topic of weight in session, although they had slightly different reactions to this approach. The first participant appreciated it, stating, "I suspect that they may have carefully addressed things. Like if I were to bring up my weight, kind of go off of what

I'm saying and not be necessarily more free with whatever they may want to ask... I think they may have done that. But just by listening and taking cues from what I'm saying and how I'm saying it... I think it's a good idea. I think it's a good thing and I think it's definitely a more respectful approach" (P1). A similar approach in session made the second participant question her therapist's motives: "I think maybe sometimes that the way things are approached, maybe more careful, more gentle might be the right word... Like, the few times that I even remember it being brought up, it was very sort of back door. We finally got there after 20, 30 minutes of our other conversation... that first doctor I felt like sometimes she—I felt she maybe wanted to bring it up more but then after she saw, kind of, my, two or three times the reaction was to fight it and to resist it—I don't know if she just gave up and just was like, 'Screw it, it's your money, do whatever you want,' or if it was like, 'Okay maybe there are deeper issues that are at work here that we need to consider'" (P2).

Question 10: Reactions to Therapist Appearance

To understand another aspect of therapy that may be especially salient to clients living with eating, body image, or weight-related issues, participants were asked to discuss any reactions to their current or past therapists' appearance, weight, or body size. Four primary themes and several subthemes emerged. First, most participants described a current and/or past therapist's physique ($n = 12$; 80%). Participants most frequently described therapists as thin or slender, or in ways that suggested they viewed the therapist as fit or healthy—essentially as not overweight ($n = 10$; 67%). For example, one participant stated, "She's not somebody I would describe as thin, but I wouldn't describe her as overweight, she just seems like a healthy person" (P1). Another noted, "Well I

think the last two have been, they've got nice shapes" (P15). Three participants (20%) described a current or past therapist as overweight.

Most participants described having some reaction to at least one current or previous therapist's appearance or body size ($n = 9$; 60%). The most frequently occurring reaction was of participants making appearance-based comparisons between self and therapist ($n = 8$; 53%). For example, one participant simply described how her clothing compares unfavorably to her therapists': "That they could, look at their clothes and know that, you know, I'm wearing these moo-moo things! And baggy, elastic" (P4). Most responses within this theme reflected participants' desire to be more like their therapist regarding appearance or weight. For example, one participant stated, "I guess because I'm envious of that? You know, somebody that has a weight and that maintains that weight. It doesn't fluctuate...I would say stability would be...what she has that I don't have, that I wish I had...control over my body" (P3). Another noted, "I just wished I could look more like that, in terms of the body. Not facial appearance, cause I thought I was more attractive, but (laughs) um, body weight. She was nice full breast and you couldn't tell if she had any issues, you couldn't see it, you know" (P5). She also noted that the comparison felt particularly salient because she and her therapist were similar regarding race and educational achievement: "I just felt like I had a lot of the same qualities she did. And we're livin' in the same world. But I guess this is what she has that I don't" (P5).

A significant portion of participants also described explicitly negative reactions to their therapist's appearance or body size ($n = 6$; 40%). These reactions were primarily to therapists described as thin or average weight and included participants feeling intimidated, envious, and as if the therapist could not possibly understand her lived

experience. Most of these participants noted that their negative reaction dissipated as therapy progressed. One participant stated, “I can remember thinking stuff like, ‘How would she really understand, she's never been through it’...Oh my, I don't think that now, but I used to think that way a lot” (P4). Another other shared, “And so when I walked into the doctor’s office and she’s cute and she’s, ya know, obviously smart, I was like, oh yeah I can’t do this, I can’t come in here and tell her I feel ugly...And then I’m like, I’ll just try it out until that’s done, and then by that time, I was like, oh she’s so cool, I’m like, she’s so laidback and she, like I said, I feel very comfortable with her and now I trust her implicitly” (P2). One participant discussed the hypocrisy of an overweight therapist encouraging her to lose weight: “I mean, why are you focusing on my fat and not on your own? So that really, ya know, to me, do as you say, say as you do. And you can talk the talk, but can you walk the walk? And that’s kind of how I think now, back then I would just look at them like what a, what is that word I’m looking for, hypocrite that you are” (P7).

Two participants (13%) also reported making positive attributions about thin or average weight therapists’ personal characteristics and life experiences. For example, one participant described her therapist as strong: “Because to me, those people are like beyond strong...I always gave them so many more kudos, because, you know, for me being overweight was such an obstacle. For them, they obviously didn't have that obstacle” (P4). The other assumed that her therapist had experienced a life that was free of problems: “If you grew up and you were kind of a big girl, you grow up thinking that thin girls don’t have any problems and that’s not true, as we know...she’s cute, she’s tiny and she’s, ya know, she’s dressed very nice, she has nice shoes and I’m like, so

immediately that means she's...never had to want for anything, she's never had to worry about never getting asked out on a date" (P2).

Finally, two participants (13%) discussed explicitly positive reactions related to their therapists' body size. The first was the only participant who reported initiating a discussion in session about her therapist's body. She noted that while working with a "thin" therapist, she mentioned that she used to look more like her therapist, when she (the participant) was thinner. This reportedly led to a conversation about her perception of her therapist's body, in which her therapist "said she was kind of naturally thin. That she, ya know, worked out when she could but that, ya know, she wasn't um, naturally prone to be overweight" (P13). The participant indicated that knowing this about her therapist resulted in her experiencing less shame in session around weight-related issues: "It was a positive conversation for me...that she was naturally skinny. Like, she didn't have to fight the battle like I did. So it wasn't that she was doing this humongous effort, ya know, to diet and exercise and stuff to be that thin. That she could be naturally thin and that she didn't have to work so hard to get it" (P13).

The other participant who described solely positive reactions to her therapist's body size reported working with an "overweight" therapist with whom she had a unique dual relationship within which the therapist disclosed a lot about her own eating habits and weight (e.g., the participant knew the therapist's pant size). She described having lunch with her therapist weekly, although she noted that "during lunch, she [the therapist] eats...and I don't. I don't eat in front of people...I'm watching her eat" (P16). The participant noted that her therapist eats "very healthy," and was aware of the particulars of her therapist's diet, including eating gluten-free, raw, and moving toward

vegetarianism. This participant was pleased about the way her eating habits were impacted by her therapist's modeling: "Ya know, I've picked up a lot of her eating habits, ya know, she's gluten free, um, I've eaten less carbs. Um, when I'm not bingeing, I eat less sugar. Um, ya know, I'm thinking about goin', ya know, eating raw. She's introduced me to some raw foods. When I'm taking care of myself, I cook." She also discussed feeling inspired by her therapist's self-compassion despite her weight: "She's okay even though she's fat...She's a fine person. She's upstanding, she's smart, she's intelligent. She has a place, you know, in the world...And she walks around with her head up, she has no shame. She doesn't have some of the issues that I carry...and I relate to her, so I feel like I can have those qualities too" (P16).

Including the client-initiated discussion and the therapist-initiated self-disclosures discussed above, a total of seven participants (47%) described in-session comments about or disclosures of information related to the therapist's weight or weight-related behaviors. The majority of these participants described instances in which therapists themselves mentioned something about their weight, eating, or exercise habits ($n = 4$; 27%). For example, one participant described inspiring a previous therapist to lose weight: "And we were both kinda chubby at the time...and during that time I saw her is when I started losing all my weight...it was interesting that as soon as I lost all my weight, she lost all her weight too and got back to normal body size. And she told me that I inspired her to lose weight" (P16). Another participant noted that a previous psychiatrist disclosed that she was a body builder. She described the psychiatrist's body as "perfect," but she found the disclosure strange. When asked how she knew her psychiatrist was a body builder,

she stated “She told me. She just told me one day! It was just kinda really odd. That was kinda odd. It was just odd” (P12).

In the last subtheme, two participants (13%) mentioned commenting on their therapist’s clothing. When asked whether she had shared her reaction to her therapist’s appearance in session, one participant said, “No. No. Just, just her outfits and her shoes...I love her shoes. She's got so many colorful, different shoes” (P3). Another stated, “Like, she’ll have cute shoes or whatever, ‘cause I never wear heels...and so I’m always intrigued by people’s heels. I’m like, those are so cute, and she wears those really tall ones too, and I’ll be like, ‘I love your shoes,’ like all the time, I’m like, ‘Your shoes are so cute’” (P2). Notably, both participants reported having had initial negative reactions to their therapist’s body size and neither had shared this reaction with the therapist.

Finally, nearly half of participants denied reactions to at least one therapist’s appearance or body size ($n = 7$; 47%; some of these same participants did have reactions to another therapist’s appearance or body size). Some participants simply discussed not thinking about their therapist in terms of appearance. For example, one stated, “No, no, no, no, no, no, no. I don’t think of [therapist’s name] that way.” (12) Another said, “No! No, I’m more involved in their brain” (P9). Others specified that their relationship with their therapist allows them to feel comfortable despite noticeable differences in body size. One noted, “Um, they look nice. I mean, but it’s not like I feel inadequate or, I don’t feel like they, like they make me feel like, um, I wanna say like, inferior or, you know because I’m overweight. They don’t, I don’t feel that they’re judgmental, I guess, in any way” (P10). Another said, “When I’m in therapy, it’s more like I’m sitting talking to a mom, a

cousin, or something. And it's a very neutral, unjudgmental. And it's more of me being able to get things off my chest and let her into my secret world, than to, than the outside world" (P8).

Question 11: Advice to Therapists Working with Overweight Women

Finally, participants provided advice to therapists working with overweight women. Participants' responses to this question were grouped into five themes and several subthemes. A primary emerging theme in response to this question was around the importance of remembering that clients' problems are not really—or not only—about weight ($n = 9$; 60%). Responses in this theme emphasized working on the whole person (not just her weight), focusing on underlying or core issues, and the belief that resolving emotional problems could result in weight loss. One participant provided a memorable response that is typical of the sentiment captured by this theme: "It's not about the blubber, it's about the brain, it's about the soul, it's about the heart, it's about the ability to get up every day and be something, do something. That's where we have to function, that's where we have to focus our therapy...Brain is where we're supposed to be working, our emotions. At least that's my theory" (P9). Emphasizing the importance of returning to underlying issues, one participant noted, "I'm not sayin' don't spend too much time on their weight, but I mean, get down to the core reasons why" (P15). Another provided the opinion that "I think that it's always good to constantly reiterate that there's underlying issues that need to be worked on to be able to fix the big problem" (P8).

Participants also recommended specific interventions therapists should use when working with overweight women ($n = 9$; 60%). Within this theme, some participants suggested interventions specifically aimed at helping clients meet weight-related goals (n

= 3; 20%). For example, one participant advised therapists to provide guidance about eating that fits with a client's lifestyle: "Trying to relate it more to what your client's daily life is. And trying to make it, give examples or work on things that are more realistic...Like, if you know your client, for example, travels a lot, okay. Telling them to make homemade meals and take this and do this is not going to help it...And come up with little tricks or solutions so that eventually when a situation happens where they wanna grab for food, something clicks...Even some little thing to maybe you don't stop eating the food, but you don't eat as much. Or helps you stop and maybe think about something else in a different way" (P8). Another participant advised against "overfocus[ing] on diets. They don't work" (P16). She emphasized supporting clients in their weight loss efforts and suggested telling clients about the statistical failure of diets as encouragement to adopt healthy lifestyle changes instead: "It's just, get 'em not to give up...Not to give up losing weight. And knowing the statistics that, that losing weight, most of the people that lose weight don't keep it off...So keep, ya know, that's why you have to have a healthy eating plan" (P16). She also suggested helping clients set small, realistic weight loss goals. Relatedly, participants also suggested providing referrals to Overeaters Anonymous or to a clinic specializing in weight loss.

The majority of participants who made recommendations about interventions suggested providing clients with support and positive feedback, being non-judgmental, and/or building up self-esteem ($n = 7$; 47%). For example, one participant mentioned the importance of acknowledging hard work and growth in therapy: "I think it's always good to give positive feedback at the end of the session, so you leave feeling good...Like, we did a good job, like, it was a hard session, however, we, we went through it and we're

moving, and it's a good growth" (P8). Another shared that, "Compliments help. Ya know, like, just little things like, you're doing a good job. Or you're on the right path. Or, I notice when I shared my recovery experience, people, they literally applauded me! So, and that's uplifting, and it makes me wanna keep on going. Ya know, so...it's always good to give, um, words of encouragement, I guess. Yeah, that helps" (P10). One participant described a particularly useful technique she learned in therapy: "Every reflection I went to, I told myself, 'I love me' or, 'You're a beautiful woman.' Yes, every reflection. It's like, growing up and being told you're a piece of shit, you believe it, so every mirror, every reflection I saw, I didn't care how fast I said it, I thought it. And that's how I became, that's how I came to terms with loving me" (P7). Participants also emphasized the importance of common factors such as empathy and non-judgment.

Another emerging theme captured participants' advice about when and how to broach the topic of weight in therapy ($n = 6$; 40%). Most participants who provided an opinion encouraged therapists to allow clients to be the first to bring up weight and allow them to direct conversations about weight ($n = 4$; 27%). One participant used her own experience in therapy as an example: "Well like I said, I feel the fact that it was me who brought it up made a huge difference in my willingness to talk about it...because I may not need to talk about that today, and there are days when the weight is the biggest issue" (P2). Yet another participant warned against the negative consequences of broaching this topic without the client having addressed it first, stating, "And then I would only bring up the weight if it was a really, if it was an issue with the patient at that time...if you focus on somebody being heavy, then you're just going to make them feel worse than they already do" (P7). Finally, one participant's response pointed to the importance of

following clients' leads regarding the words used to describe their weight: "Like, I know I'm overweight, I know. I know I'm technically obese but I don't like that word and it feels like, like you can't come back from it, ya know. Like, that word feels hopeless to me so I wouldn't like if we went to that level" (P1). On the other hand, two participants (13%) recommended therapists bring up the topic of weight if they have noticed weight gain and/or have concerns about client health. For example, one noted, "Oh, I would maybe have maybe them bring it up [weight] just a little bit more...It's not, that's a tough one. I guess so, yeah...I think they should bring it up just a little bit more...for your health...to not hurt you, but to help you" (P12).

Participants also urged therapists not to make assumptions about how weight impacts clients and their presenting problems or about the cause of clients' weight gain ($n = 5$; 33%). For example, one participant noted, "Don't assume that you know how it affects them...I know I am more confident now than I've ever been at this weight, but I know that...there are times when I was at a like, a quote unquote healthier weight and I felt completely like my body image was completely disjointed. Like, I looked in the mirror and I saw somebody that was 500 pounds, ya know. So I think that's the main thing, is don't assume that when you see somebody that's maybe 30 pounds overweight that it's probably not a big deal for them, because it's probably the hugest deal for them" (P1). Another participant warned against assuming what a client needs from therapy: "I guess, not to assume that they're coming to you for a weight issue. You know, they might, it might be a symptom of something else so um, don't assume that that's what they want help with" (P3).

Somewhat in contrast, some participants identified “truths” about overweight women ($n = 5$; 33%). For example, participants noted that all overweight women are emotionally affected by their weight and that weight impacts self-esteem: “And so, I think it would be good, as far as weight goes, to maybe ask someone, how do you feel about yourself? You know, because of course if there is a weight problem, issue – that affects their self-esteem” (P10). One participant noted that overweight women lead “double lives” that can be “self-destructive” (P8), and another described overweight women as coping with being overweight in one of two ways: “It is something that’s, we can’t hide it, it’s not like, ya know, with other women you can hide your flaws or whatever. We can’t hide it, so one of two things happens: either you just don’t care about it—I’ve met women who are just like, ‘Whatever, I’m me and you gotta love it, ya know, I don’t care.’ They don’t dress appropriately or whatever. Or it’s more like I am, where you kind of build a wall around it, ya know, like no, don’t talk to me” (P2).

CHAPTER 5

DISCUSSION

Results of the current qualitative study yield important information about weight-related stigma and microaggressions experienced by obese women in general and in therapy. Before summarizing and discussing the findings, it is important to note some core demographic variables of the current sample. Participants included 15 obese, middle-aged women (mean age of 49) with a mean BMI of about 42. They self-identified primarily as White and heterosexual, were currently attending therapy with a mental health provider, and reported a number of presenting concerns for current and previous therapy attendance, with depression and trauma the most common. Most participants reported having a physical and/or mental disability and most were unemployed, which yielded a small median household income of \$17,000.

Keeping these demographic characteristics in mind, the current study offers key information relevant to treatment, supervision, and training. In particular, these data offer information about awareness, internalization, and experiences of weight bias; weight-based microaggressions in therapy; common reactions to therapist appearance; and recommendations for therapists working with obese women. These results and their implications for clinical work and research are discussed individually below.

Awareness, Internalization, and Experiences of Weight Bias and Stigma

The current sample's levels of awareness and internalization of weight bias were generally consistent with previous samples of overweight/obese individuals based on quantitative and qualitative data (Concepcion, 2007; Durso et al., 2013). For example, the current sample demonstrated only slightly higher awareness of weight bias than

overweight and obese men and women sampled in an unpublished dissertation ($m = 3.11$ and 3.28 , respectively; Concepcion, 2007). Regarding internalization of weight bias, findings from the current sample were identical to the mean score obtained by a sample of obese patients with binge eating disorder (WBIS $m = 4.75$ in both samples; Durso et al., 2013). Additionally, during the interview, participants identified stereotypes of overweight individuals consistent with existing literature, including that overweight individuals are seen as lazy, unintelligent, and unattractive and as engaging in unhealthy behaviors (Puhl et al., 2008; Puhl, Moss-Racusin, & Schwartz, 2007). The current sample described experiences of stigma that were generally consistent with previous qualitative and quantitative self-reports (Lewis et al., 2011; Puhl & Brownell, 2006).

Also consistent with previous research (Puhl et al., 2008), most participants reported feeling hurt and embarrassed during or after instances of weight-related stigma or discrimination. Notably, however, the current sample most frequently identified anger or development of a “thick skin” in reaction to weight stigma. Overall, it seems reasonable to assume that emotional and behavioral reactions to stigma will vary depending on the source of the stigma, the setting, and other factors (Puhl & Brownell, 2006). Close to half of participants in the current sample described stigmatizing experiences as directly and negatively impacting their body image and/or health behaviors (i.e., resulting in emotional eating) and/or as a factor in causing or maintaining their weight gain. This is also consistent with previous research demonstrating that cultural weight stigma has dangerous implications for obese individuals’ emotional and physical well-being (Friedman et al., 2005; Puhl & Heuer, 2010).

Clinically, this information suggests that therapists should acknowledge that overweight and obese clients may experience stigma in day-to-day life, and help clients identify ways to cope with weight stigma. Existing research highlights the variety of ways in which obese individuals effectively cope with stigmatizing and discriminatory experiences, including utilizing positive self-talk, obtaining social support, ignoring the situation, practicing self-acceptance, and participating in fat acceptance online communities (Dickins, Thomas, King, Lewis, & Holland, 2011; Puhl & Brownell, 2006).

Weight-Based Microaggressions in Therapy

Contrary to predictions, participants in the current sample reported experiencing very little weight-based stigma in mental health settings. Only three participants reported weight-based stigma from therapists and, as predicted, these incidents are best understood as microaggressions. Specifically, two participants described the general sense that their therapist was less interested in them because of their weight, and a third described mental health professionals inaccurately or excessively attributing her problems to weight and touting weight loss as the solution to complex emotional and environmental problems. This latter microaggression mirrors a theme described in the literature by lesbian, gay, and bisexual therapy clients, in which presenting problems were inappropriately attributed to sexual identity (Shelton & Delgado-Romero, 2011).

The fact that only one-fifth of participants reported weight-based microaggressions in therapy was somewhat unexpected, given the frequency of therapy microaggressions described by other oppressed groups (Constantine, 2007; Owen et al., 2010; Shelton & Delgado-Romero, 2011) and the frequency with which obese individuals in the current and other samples endorsed stigmatizing experiences committed by other

healthcare professionals (i.e., Myers & Rosen, 1999; Puhl & Brownell, 2006; Rand & McGregor, 1990). Although additional research is necessary to truly understand this phenomenon, I offer here some possible explanations.

First, these data suggest that mental health providers (at least those whose clients were represented in the current sample) interact with their obese patients in a way that is infrequently experienced as stigmatizing. Although this finding was unexpected, it is encouraging and certainly seems plausible, as sensitivity to individual and cultural factors are increasingly valued in mental health fields (APA, 2002). The low endorsement of weight-based stigma also seems consistent with participants' reports of generally positive relationships with their current therapists, an important finding, as the client's perception of the therapeutic alliance is a robust predictor of therapy outcome (Crits-Cristoph, Connolly Gibbons, & Muherjee, 2013). In a move that could further enhance mental health providers' competence working with obese clients, the American Psychological Association recently formed a panel tasked with developing treatment guidelines for obesity (APA, 2014). Given existing practice guidelines (APA, 2012), it seems likely that attention will be given to the possibility of negative physical and mental health outcomes associated with weight stigma, and to the importance of therapists providing sensitive treatment to this already stigmatized population.

Given existing research demonstrating the presence of weight bias in mental health providers (i.e., Hassel et al., 2001), it is also necessary to consider alternate explanations for these findings. For example, perhaps both mental health providers and their clients may be motivated to avoid conversations about weight in session, which may reduce the potential for identifiable microaggressions. For example, when asked how

their weight impacts therapy sessions, over one-third of participants reported being evasive or less forthcoming in session due to their weight. They specified several reasons for avoiding discussions around weight: weight loss seemed unattainable, they were uncertain about their readiness for change, they did not want therapy to become solely about weight, and they had high levels of shame associated with their weight status. It also certainly seems possible that clients may not consider therapy the best arena in which to discuss weight concerns, as weight may be deemed a medical issue and mental health providers may be presumed untrained to address issues around weight. Providers themselves may also be motivated to avoid weight as a focus of therapy. Although samples of clinicians and trainees endorse feeling competent and prepared to treat obese clients, they also consistently rate obese clients as lacking motivation and noncompliant with treatment recommendations, and they have low confidence in obese clients' ability to maintain achieved weight loss (i.e., Puhl, Latner, et al., 2014; Puhl, Luedicke, et al., 2014). These beliefs could certainly result in therapists avoiding weight as a topic in session, particularly given the current public health climate in which weight loss is seen as the primary way for obese individuals to achieve improved health (Bacon & Aphramor, 2011).

Another potential explanation for very low endorsement of weight-related microaggressions in therapy is that such instances of stigma may be infrequently labeled as stigma or oppression by obese clients. In fact, two participants in the current study described therapy interactions that the coders identified as potential microaggressions: one participant's therapist assumed she ate junk food all day, and another's therapist initiated unsolicited conversations about weight loss. However, the participants denied

experiencing these events as stigmatizing. Similar to members of other oppressed groups, obese individuals receive strong, negative explicit and implicit cultural messages about their stigmatized status (Dickins et al., 2011) and internalize these negative messages, which results in increased vulnerability to the harmful impact of stigma (Puhl et al., 2007). Despite internalized stigma, research demonstrates that members of racial minority groups tend to express favorable opinions about their in-group (Crocker, Luhtanen, Baline, & Broadnax, 1994; Rudman, Feinberg, & Fairchild, 2002). Obese individuals, on the other hand, consistently exhibit explicit and implicit weight bias (Puhl, Masheb, White, & Grilo, 2010; Schwartz et al., 2006; Wang et al., 2004). Thus, it is possible that obese individuals are not primed to label or understand a weight-related microaggression as such, but may be more likely to accept it as truth or as further evidence that they should be doing something to improve their stigmatized status. This may be especially true in the therapy arena, in which there is a power differential, clients are in a vulnerable position, and the relationship between therapist and client is a particularly important part of the work.

Advice for Therapists

Participants offered important advice to mental health providers regarding working with overweight women. Notably, although they tended not to report experiencing weight-related stigma in their own therapies, much of their advice essentially warned against committing weight-related microaggressions. The most frequently-endorsed theme emphasized that weight is often not the real or “only” problem. Participants particularly discussed the importance of identifying and working on underlying issues. This finding suggests that the current sample saw increasing insight

into weight-related issues and working through related emotions as a crucial part of treatment. Within this theme, participants also discussed the importance of focusing on the whole person rather than solely on weight. This latter piece of advice is consistent with microaggression research with lesbian, gay, and bisexual clients, demonstrating that it may be important not to overfocus on the stigmatized aspect of the client's identity while also not ignoring it or denying the social impact (Shelton & Delgado-Romero, 2011).

Participants also advised therapists to allow clients to initiate and direct conversations about weight and warned them against making assumptions about causes of weight gain and how weight impacts clients' lives. They also suggested beneficial interventions for working with overweight women. Although a few participants suggested interventions directly aimed at changing weight-related behaviors, the vast majority suggested more generally being supportive and non-judgmental and helping clients build self-esteem.

Reactions to Therapist Body Size and Appearance

Over half of participants reported some reaction to their therapist's body or appearance. Of these participants, nearly all discussed making appearance-based comparisons to thin or average weight therapists that placed the participant in the inferior position. Most of them also reported explicitly negative reactions, such as beliefs that a thin therapist could not possibly understand their concerns. Participants also described negative reactions to overweight therapists, noting that it felt hypocritical for an overweight therapist to suggest weight loss. Finally, one participant reacted positively to a therapist's overweight body, as her experience of her therapist as self-assured and self-

compassionate challenged weight biases she held against herself. Despite a number of in-session reactions to therapists' bodies, only one participant reported initiating a conversation in session about her therapist's body, with positive results. Overall, this data suggests that clients experience a number of reactions to therapists' bodies but are unlikely to volunteer these feelings in session unprompted.

These data are consistent with a small body of empirical and theoretical literature in the eating disorders field that addresses how the therapist's body can impact treatment and how therapists may work effectively with client reactions (Daly, 2014; Jacobs & Nye, 2010; Lowell & Meader, 2005; Rance, Clarke, & Moller, 2014; Warren, Crowley, Olivardia, & Schoen, 2009). For example, Rance and colleagues (2014) interviewed 11 women who had been treated for anorexia nervosa regarding their experience of their therapists' bodies. Participants' responses indicated that they had noticed and observed therapist bodies and made a number of assumptions based on therapist body size. Participants reported making conclusions about therapists' relationships with food and about their ability to help clients with eating disorders, attributing unhealthy eating behaviors and lack of competency to therapists perceived as both thin and fat. These authors and others (i.e., Jacobs & Nye, 2010) highlight how common it is for clients to have fantasies about the therapist's life based on her body size, and encourage therapists to turn this into fuel for therapeutic exploration and growth.

Although obese clients who do not have eating disorders are unlikely to observe and react to therapists' bodies to the same degree as clients with anorexia nervosa, exploring client reactions to the therapist's body (both positive and negative) could prove a fruitful endeavor from a variety of theoretical perspectives. For example, a therapist

operating from a psychodynamic perspective would likely find it important to analyze the transference to enhance insight and self-awareness (McWilliams, 2004). From an interpersonal perspective (i.e., Teyber & McClure, 2011), clients' reactions to the therapist may represent typical ways of responding to others in their lives, and working on these patterns in the here-and-now of therapy may translate to greater connectedness and support in the client's life. From a cognitive-behavioral perspective (i.e., Beck, Shaw, Rush, & Emery, 1979), exploring assumptions about the therapist's life or her ability to empathize based on her body size may serve as a jumping off point for challenging maladaptive thoughts. Finally, operating from a feminist and/or multicultural approach (i.e., Brown, 2009; Sue, Ivey, & Pederson, 1996), a therapist may be interested in exploring with the client cultural messages about women's bodies and roles, perhaps even utilizing transparency to demonstrate that therapists too receive and are impacted by these toxic messages.

Notably, plenty of obese clients may not have strong reactions to therapists' bodies, and participants in the current study made it clear that they did not always want their therapy to revolve around issues of weight. Thus, it may be useful to notice markers for potential reactions and attend to them as appropriate. For example, several participants who reported explicitly negative reactions to their therapist's appearance mentioned that although they never disclosed their reactions, they admired and commented on their therapist's shoes in session. Such indirect commentary on the therapist's appearance may serve as a marker for further exploration about potential comparisons, beliefs, assumptions, or feelings about the therapist's body or appearance.

A larger-scale study examining obese clients' reactions to their therapists' bodies and whether and how these reactions impacted the work is also warranted. Most participants in the current sample described therapists as thin or average weight, but it would be valuable to learn more about obese clients' responses to overweight therapists' bodies as well. Finally, future research elucidating whether and how therapists bring their own bodies into the here-and-now of obese clients' therapy work and the impact of these discussions would be relevant.

Limitations

These results must be considered in light of some specific limitations. Given the small sample size, it is certainly not possible to suggest that the current findings are generalizable. Further, the inter-rater reliability between the two coders was overall quite low during the first coding phase. In hindsight, the second coder needed clearer descriptions of each code and/or some sample data within each code. Although reliability was initially low, the two coders discussed each discrepancy until agreement was reached about the themes. In some cases, this involved creation of new themes or elimination or combination of existing themes. Nonetheless, future research should certainly aim to utilize two independent coders throughout the coding process to ensure the validity of findings.

Finally, some specific demographic characteristics of the current sample may have impacted the findings regarding weight-related therapy microaggressions. The majority of the current sample reported a physical and/or mental disability and most were unemployed, resulting in a very low median income. This trend seems due to sampling bias that may have emerged due to the monetary incentive in exchange for participation,

which likely impacted motivation on the part of both participants and of therapists who advertised the study. During the recruitment phase of the research, I spoke with many local therapists to request that they advertise the study in whatever way they felt comfortable. These conversations indicated that therapists tended to feel uncomfortable directly referring clients to the study, given the BMI criterion and concern about what referring to the study would communicate about their perception of clients' sizes. The therapists who reported an intention to speak directly to clients about the study fell into two categories: 1) therapists working with clients with whom weight was a regular topic in therapy and 2) therapists working in community mental health clinics with low-income clients. The latter was by far the larger of the two groups, and these therapists' awareness of clients' financial needs seemed to outweigh any potential discomfort related to the study's BMI criterion.

Additionally, three participants were working with the same therapist, which may have skewed results somewhat, although no discernible patterns separated these participants' experiences from those working with other therapists. In addition to impacting whether and how therapists chose to advertise the study, it is certainly reasonable to assume that the monetary incentive disproportionately attracted lower-income participants. It is possible that recruitment of a sample that was lower-income and fairly functionally impaired could have impacted findings in several ways. For example, these participants may have been less likely to discuss weight in session, as it may have been a lower priority compared to other concerns, which could have impacted the presence of weight-related microaggressions. On the other hand, given the negative association between obesity and socioeconomic status (McLaren, 2007), therapists

working in community mental health clinics may encounter a higher proportion of obese clients. It could be that working directly with more obese clients results in less weight stigma (Schwartz et al., 2003), although there is not a lot of existing evidence to support this claim.

Clinical Implications and Future Directions

Despite these limitations, these findings have important implications for future research and clinical practice. First, although participants reported very few therapy microaggressions, it is important to take note of the types of microaggressions they did report. Participants described therapists overly focusing on weight as the cause of presenting concerns and weight loss as the solution, and perceived therapists as less interested in them because of their weight. These descriptions point to the importance of therapists attending to clients' personal attributions regarding their presenting concerns and their ideas about how to resolve them, therapeutic skills that are crucial for a strong working alliance with all client populations (Crits-Cristoph et al., 2013). Further, it is important for therapists to monitor personal reactions to clients in the moment to understand whether their feelings toward the client or choice of interventions are influenced by weight bias. It seems crucial for therapists to notice and repair these therapeutic missteps, as two of the three participants in this study who reported therapy microaggressions described very poor overall relationships with the therapists who committed them.

A small portion of the current sample also expressed some dissatisfaction with waiting room seating options, consistent with literature demonstrating that obese individuals frequently encounter physical barriers or unaccommodating spaces due to

their body size (Friedman et al., 2005; Merrill & Grassley, 2008; Puhl & Brownell, 2006). This topic warrants attention from providers, who presumably do not intend for the physical environment of therapy to be anxiety- or shame-provoking. Based on anecdotal clinical experience and data from this study, this population appears to have two unique needs. First, sufficient space is necessary for clients to physically fit in the available seating without feeling as though they are encroaching on others' space. Second, obese clients may be concerned with the sturdiness of seating options, as several participants in this study discussed feeling self-conscious when trying to stand up from a couch or chair that sinks in. To meet these needs, therapists may consider a well-reinforced couch or wide chair, or one without arms. Although not discussed by the current sample, it would also make sense to provide publications in waiting areas that showcase body size diversity and that do not promote thin-ideal images, which are consistently shown to negatively impact women's body image (Groesz, Levine, & Murnen, 2002).

When the current sample provided their impressions of helpful therapy interventions (i.e., when their accounts of helpful therapy experiences and advice to therapists working with overweight women included mention of specific interventions), they tended to focus predominantly on therapist/common factors and emotion-focused interventions rather than interventions targeting weight-related behaviors. This makes sense given their reported presenting concerns, very few of which were weight-related. Overall, they reported positive relationships with their therapists and few instances of weight-related microaggressions and generally seemed very pleased with their current therapies. Thus, it would seem that when working with obese women, it is typically

effective for therapists to conduct business as usual, employing strong empathy and non-judgment and interventions consistent with their typical theoretical approach, particularly when eating- and weight-related issues are not at the forefront. This extrapolation from the current findings likely does not come as a surprise and is surely how most therapists think about their work with obese clients.

That said, a couple of key findings point to some potentially unique and important factors for consideration when conducting therapy with obese women. First, a large proportion of the current sample noted that their weight status has resulted in their being less forthcoming in session. This finding indicates that obese clients may be avoiding the topic of weight in session, even when it may be a relevant and important issue to explore. This is unfortunate, as mental health providers have specific expertise that could be used to provide support, identify strategies for coping with stigma, facilitate increased self-awareness and insight, and assist with behavior change. In fact, many participants discussed the importance of exploring emotions and experiences underlying weight-related behaviors, suggesting that they do value working on these issues in therapy. Given the stigma attached to being obese, the likelihood that obese clients have experienced previous weight loss failures that can impact motivation and create ambivalence about weight management (Mann et al., 2007), and a lack of visible alternatives to a weight loss focus for obese women (Dickins et al., 2011), it should not be surprising that clients are motivated to avoid this topic in session. It seems important for clinicians to be aware that obese clients may be avoiding discussions around weight in session, perhaps for the reasons offered by the current sample (i.e., shame, low readiness for change, concern that weight will become the primary focus of session).

Shame about discussing weight and eating and ambivalence for change are also present in work with clients with eating disorders, and normalizing and working with ambivalence is frequently part of treatment (i.e., Costin & Grabb, 2011). Given the current findings, it appears important for clinicians working with obese clients to watch for markers of weight or body size as potentially important therapeutic foci and broach the topic if appropriate. Given the current participants' concerns, it may be beneficial to "predict" client concerns about discussing weight in session (i.e., "For some people, discussing dissatisfaction with weight brings up a lot of 'shoulds' about pursuing weight loss," or "Some clients worry that discussing weight here means that it will become the main focus of our work together.").

Many clients may have immediate weight loss goals or body dissatisfaction that creates an ever-present sense that they "should" be working on weight management and will begin behavioral change at some undetermined future date (Neumark-Sztainer et al., 2000; Schwartz & Brownell, 2004). Although it is true that changing health-related behaviors may be necessary for some clients' health and well-being, societal stigma and shame can interfere with initiating these changes (Lewis et al., 2011; Myers & Rosen, 1999). Further, the predominant paradigm for improving health in obese individuals, dieting with the goal of weight loss, has quite low long-term success rates (Mann et al., 2007). Thus, it may be useful to introduce clients to alternate approaches that challenge the predominant weight-loss paradigm for obese individuals. For example, Health at Every Size (HAES, which has marked similarities to approaches labeled "non-diet" or "intuitive eating") is a trans-disciplinary movement aimed at supporting improved health behaviors for people of all sizes, without using weight as a marker of health or weight-

loss as a health goal; weight loss may or may not be a side effect of healthier behaviors (Bacon & Aphramor, 2011). HAES is empirically supported to improve physiological measures (i.e., blood pressure), health behaviors (i.e., eating and physical activity), and psychosocial outcomes (i.e., mood, self-esteem, body image). It also has a high retention rate as compared to control conditions, which is particularly important given the documented high dropout rates in weight loss programs (Bacon & Aphramor, 2011).

HAES has been accepted as standard practice in the eating disorders field and weight-related civil rights organizations (Bacon & Aphramor, 2011) but may be relatively unknown outside eating disorder and obesity clinicians and researchers. Given that obesity is one factor associated with increased risk for many diseases (Malnick & Knobler, 2006), clinicians may experience a dilemma when working with obese clients: the desire to attend holistically to client health while remaining affirming and non-pathologizing of larger bodies. Increasing awareness of and comfort and competence facilitating non-diet approaches to eating and health could be a way for clinicians to resolve this tension.

There is also a growing, grassroots fat acceptance movement that emerged in the 1960s as a response to weight bias and stigma (Cooper, 2010). The key tenet of fat acceptance is that all bodies are acceptable, whether or not they conform to the societal thin ideal; many proponents also subscribe to HAES principles (Dickins et al., 2011). This movement has a strong online presence and participation in this community may be a positive coping mechanism for obese clients who receive stigmatizing sociocultural messages about body size. Overall, more research is needed examining 1) how mental health providers intervene with obese clients when issues around weight dissatisfaction

and coping with weight stigma emerge in session, 2) how confident they feel working with these topics, and 3) awareness of resources, such as HAES that may help clinicians approach these topics in more affirming ways.

Although participants in the present study reported low frequencies of weight-related microaggressions in therapy, the fact remains that previous research has demonstrated the presence of weight bias in mental health professionals (i.e., Agell & Rothblum, 1991; Hassel et al., 2001; Puhl, Latner, et al., 2014; Young & Powell, 1985). Given that the current sample overall did not describe therapy interactions as stigmatizing, it seems important for researchers to continue exploring whether and how mental health providers' weight-biased attitudes impact their work. Overall, more research examining therapist and client factors that result in more or less therapist weight stigma would be useful. One interesting line of research may be to conduct a similar study utilizing a sample of obese men, as gender differences have generally been found in men and women's experiences of weight-based stigma (Fikkan & Rothblum, 2011).

Finally, it remains crucial for providers to examine their own attitudes toward and beliefs about overweight and obese individuals and to seek education, consultation, and/or supervision as necessary to reduce the negative impact of these biases on their work. Puhl, Luedicke, et al. (2014) outline several suggestions for weight bias reduction in training programs for future healthcare professionals, including education regarding the complex etiology of obesity and the complexity of weight control and documented difficulty most people have in maintaining significant weight losses. More research is needed to understand the effectiveness of these strategies, but in the meantime they could generally be adapted for self-implementation among practicing professionals.

APPENDIX I
RECRUITMENT FLIER



SEEKING WOMEN FOR RESEARCH

“Women’s Experiences in Therapy,” is a research study conducted through the Psychology Department at **UNLV**.

Purpose: To understand overweight women’s experiences of counseling/therapy.

Eligibility: Women with a Body Mass Index (BMI) of 35 or higher who have attended therapy/counseling within the past 6 months. (I will help you calculate your BMI over the phone—please call if you think you MIGHT qualify.)

Process: A one-hour interview and 3 brief questionnaires.

Compensation: \$20

Call Kerri at **(702) 483-8737** for further information or to make an appointment.

Principal Investigator: Dr. Cortney S. Warren (702) 895-0109

APPENDIX II

PHONE SCREENER

“Thank you for expressing interest in our study. I have some questions to ensure that you are eligible for the study, but first I want to tell you more about myself and the study. This will only take a few minutes. My name is Kerri Schafer and I am a student in the clinical psychology doctoral program at UNLV. For my dissertation, I am conducting a study called “Women’s Experiences in Therapy,” under the supervision of my advisor, Dr. Cortney Warren. The purpose of the study is to understand overweight women’s experiences in therapy, including whether and how issues around weight might come up in session. In order to be eligible for this study, you must be a woman who has attended at least 1 therapy session within the last 6 months. You must also have a body mass index of 35 or higher. If you are eligible, I will ask that you schedule a time to come to UNLV to participate in an hour-long interview and complete 3 brief questionnaires, and you will be paid \$20 for participation. Do you have any questions based on what I’ve just told you?” (*Answer questions, if any.*) “Do I have your permission to move forward with a few questions to determine your eligibility?”

- Do you identify as female?
- How old are you?
- Are you currently attending counseling or therapy with a mental health professional?
 - a. (If no): Have you attended a counseling or therapy session with a mental health professional within the past 6 months?

Body Mass Index, or BMI, is an estimate of body fat that is calculated by dividing your weight in kilograms by your height in meters squared. I will ask you for your height and weight and then calculate your BMI. It is your choice whether or not I share your BMI with you. Knowing your BMI may be distressing if it is higher than you would like. Would you like me to tell you your BMI when I calculate it?

- How tall are you?
- How much do you weigh?”

If caller does not meet all eligibility criteria: “I’m sorry, but you are not eligible for this study. Thank you so much for calling, though. We appreciate your willingness to help.”

If caller meets all eligibility criteria: “You are eligible to participate in the study! If you are interested, you will need to schedule a time when you can come to the UNLV campus for an interview with me. You’ll want to plan for about an hour and a half. In the interview, I’ll be asking you about your experiences in therapy and your experiences related to your weight. You would also fill out 3 very brief questionnaires. You’ll receive \$20 cash at the beginning of the study. Are you still interested in participating?”

If yes, schedule an interview and provide driving and parking directions. Answer participant’s questions, if any.

APPENDIX III

INFORMED CONSENT



INFORMED CONSENT

Department of Psychology

TITLE OF STUDY: Women's Experiences in Therapy

INVESTIGATOR(S): Cortney S. Warren, Ph.D. (PI), Kerri J. Schafer, M.S. (SI)

For questions or concerns about the study, you may contact Kerri Schafer at **702-483-8737**.

For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted, contact **the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 877-895-2794 or via email at IRB@unlv.edu**.

Purpose of the Study

You are invited to participate in a research study. The purpose of this study is to understand overweight women's experiences in psychotherapy.

Participants

You are being asked to participate in the study because you fit this criteria: You are a woman age 18 or older, with a Body Mass Index of 35 or higher, who is currently participating in psychotherapy or has had one therapy session with a mental health professional within the past 6 months.

Procedures

If you volunteer to participate in this study, you will be asked to do the following: Participate in an audio-taped semi-structured interview designed to elicit your experiences in therapy, particularly how your weight may or may not impact your therapy experiences. You will also be asked to complete a brief demographic form and two brief questionnaires inquiring about weight-related variables. You are free to decline to answer any question and can withdraw from the study at any time.

Benefits of Participation

There may be direct benefits to you as a participant in this study. It is possible that discussing your therapy experiences and general experiences as an overweight woman

will enhance self-awareness and/or provide a sense of relief. Even if there is not a direct benefit to you, your participation will help us learn about overweight women's experiences in therapy and to make recommendations to mental health providers about working effectively and sensitively with other overweight clients.

Risks of Participation

There are risks involved in all research studies. This study may include only minimal risks. For example, you may become uncomfortable answering some questions about your experience in therapy or what concerns brought you to therapy. However, I expect that any discomfort will be minimal, and if you are not currently in therapy and would like counseling referrals they will be provided to you.

Cost /Compensation

There may not be financial cost to you to participate in this study. The study will take approximately one hour of your time. You will be compensated for your time. If you are participating through the psychology subject pool, you will be assigned research credits commensurate with the time you spend on the study (no less than 1 credit for full participation). If you are not part of the psychology subject pool, you will be compensated \$20 for participation.

Confidentiality

All information gathered in this study will be kept as confidential as possible. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for at least 5 years after completion of the study. After the storage time the information gathered will be shredded (paper files) or deleted (electronic files).

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with UNLV. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Participant Consent:

I have read the above information and agree to participate in this study. I have been able to ask questions about the research study. I am at least 18 years of age. A copy of this form has been given to me.

Signature of Participant

Date

Participant Name (Please Print)

Audio Taping:

I agree to be audio taped for the purpose of this research study.

Signature of Participant

Date

Participant Name (Please Print)

APPENDIX IV
DEMOGRAPHIC FORM

Age: _____

Height: _____ Weight: _____

How would you describe your current weight?

- Extremely underweight
- Underweight
- Slightly underweight
- Average/normal weight
- Slightly overweight
- Overweight
- Extremely overweight

Lowest adult weight: _____ At what age were you this weight? _____

Highest adult weight (when not pregnant): _____ Age? _____

Do you have a disability? No Yes If yes, what? _____

What is your relationship status? (Circle one)

- Married/Domestic Partnership
- In a committed relationship
- Separated
- Divorced
- Widowed
- Single, Never Married
- Other (please explain): _____

What is your sexual orientation? _____

How many children do you have? _____

How do you identify racially and/or ethnically? _____

Is English your first language? Yes No

If no, what is your first language? _____

Generational Status: Circle the one that best applies to you.

First generation: You were born in another country but live in the USA

Second generation: You were born in the USA but *at least one* parent was born in another country

Third generation: You and *both* your parents were born in the USA and *all* grandparents were born in another country

Fourth generation: You and your parents were born in the USA and *at least one* grandparent was born in another country, with the remainder born in the USA

Fifth or greater generation: You, your parents, and *all* grandparents were born in the USA

What is the highest level of education you have completed? (Circle one)

Did not complete high school

Did not graduate from high school but obtained a GED

High school diploma

Some college (at least 1 year)

Degree from a 2-year college

Degree from a 4-year college

Some graduate school (at least 1 year)

Graduate degree

What is the highest level of education completed by your parent? (Circle one)

Did not complete high school

Did not graduate from high school but obtained a GED

High school diploma

Some college (at least 1 year)

Degree from a 2-year college

Degree from a 4-year college

Some graduate school (at least 1 year)

Graduate degree

What is the highest level of education completed by your other parent? (Circle one)

Did not complete high school

Did not graduate from high school but obtained a GED

High school diploma

Some college (at least 1 year)

Degree from a 2-year college

Degree from a 4-year college

Some graduate school (at least 1 year)

Graduate degree

Are you employed? Yes No If yes, what is your occupation? _____

What is *your* approximate yearly income? _____

What is your *household* approximate yearly income? _____

What are/were the occupations of your parents?

Parent 1: _____

Parent 2: _____

APPENDIX V

SEMI-STRUCTURED INTERVIEW

I am going to ask you some questions about your current and past experiences in therapy *and* your experience being an overweight woman. Please take your time and give me as much detail as you want. If I ask any questions that seem vague or that you don't quite understand, please ask me to clarify. I might also ask you additional questions so I can really understand what you're saying. There are no right or wrong answers to these questions—everyone's experiences are different and I just want to understand yours.

Information about participants' current and previous utilization of therapy:

- How many sessions have you had with your current or most recent therapist?
 - When did you start seeing your current or most recent therapist?
 - Why did you start seeing him/her? (What was bothering you enough to get you to therapy at that time?)
- How many different therapists have you had in your lifetime?
 - How old were you when you first went to therapy?
 - Approximately how many total therapy sessions in lifetime?
- Describe one therapy situation (with current or previous therapist) that was particularly helpful.
- Describe one therapy situation (with current or previous therapist) that was particularly unhelpful.

Impact of Weight on Therapy Sessions:

- What words would you use to describe your weight/body shape? (Note: if participant uses language that is clearly derogatory, we will attempt to find a more neutral word to continue using throughout the interview.)
- What effect, if any, do you think your weight has on your current (or past) experience in therapy?
- What effect, if any, do you think your weight has on the current (or past) issue that is bringing you to therapy?
- What did your therapist understand about the impact of your weight on the concerns that brought you to therapy?
 - How did you know this? (Did he/she tell you? Did you infer his/her understanding?)
 - Was his/her understanding similar to yours?

(If any negative/stigmatizing experiences emerge from the previous question):

- You mentioned (briefly summarize any negative/stigmatizing experiences the participant described). How did these experiences make you feel?
 - About yourself?
 - About your therapist?

- What are some of the ways that you dealt with these experiences?
 - Did you ever call attention to the situation in session or tell your therapist how you felt? If so, tell me about it.

- How did these experiences impact the overall quality of your therapy experience?

- How would you have preferred this was handled in therapy? What could your therapist have said or done differently that would have made this interaction more positive or helpful?

Specific Questions about Weight Stigma:

- Tell me some of the stereotypes that you're aware of that exist about (use weight language used by participant) people.

- Tell me about a couple of experiences in which someone seemed to think these stereotypes about you. These experiences could be direct (like mean comments) or indirect (you felt that someone thought something negative about you because of your weight, even if they didn't come out and say it).

(For the following questions, some participants may have already identified experiences about which I am inquiring. In these cases, I will briefly summarize what they have already told me and ask whether other similar experiences come to mind).

- As you've experienced (if patient endorsed weight-based discrimination), (use weight language used by participant) individuals often have experiences in which they are directly or subtly discriminated against, made to feel uncomfortable, or "put down" because of their weight or body size. In thinking about your therapy experiences, do any situations come to mind in which you felt uncomfortable, insulted, or disrespected by a comment made by your therapist that seemed to imply something negative about your weight? Please tell me about them.

- Have you ever suspected that your therapist treated you differently because of your weight? What happened that made you feel this way?

- Did you ever feel that your therapist focused too much on your weight or thought your weight influenced your problems more than you did? Tell me about that.
 - Did your therapist ever suggest weight loss without you bringing it up?
 - Did they explain *why* they brought this up?
 - How did you feel about it?

- Did you ever talk to your therapist about wanting to lose weight?
 - If so, did this become a therapy goal? How was this goal to be accomplished? Did you make progress? What was this process like for you?
 - Did your therapist encourage acceptance of your current weight? How did you feel about that?
- Why do you think you became (use weight language used by participant) and/or stayed (language of participant)?
 - Did your therapist ever say (or imply) why he/she thought you became (use weight language used by participant) and/or stayed (language of participant)?
- Remember the instances you described earlier, in which people directly or indirectly put you down because of your weight? Have you ever discussed situations like that with your therapist? How did that discussion go?
- Has the physical environment of therapy ever been unaccommodating to your weight/body size? Tell me more about that.

Effect of weight stigma in therapy (if participant describes any weight stigma expressed by therapists, beyond what they described in the open-ended portion of the interview):

- (Briefly summarize stigmatizing incidents described by participant). How did these experiences make you feel?
 - About yourself?
 - About your therapist?
- What are some of the ways that you dealt with these experiences?
 - Did you ever call attention to the situation in session or tell your therapist how you felt? If so, tell me about it.
- How did these experiences impact the overall quality of your therapy experience?
 - Did it affect what you discussed in session? How?
 - Did it affect your therapy attendance or decisions about when to end your therapy?
- How would you have preferred this was handled in therapy? What could your therapist have said or done differently that would have made this interaction more positive or helpful?

APPENDIX VI

STIGMA CONSCIOUSNESS QUESTIONNAIRE

Directions: Please indicate the extent to which you **agree** with each statement by circling the number associated with your response.

1. Stereotypes about overweight people have not affected me personally.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

2. I never worry that my behaviors will be viewed as stereotypical of overweight people.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

3. When interacting with average weight people, I feel like they interpret all my behaviors in terms of the fact that I am overweight.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

4. Most average weight people do not judge overweight people on the basis of their weight.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

5. My being overweight does not influence how average weight individuals act with me.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

6. I almost never think about the fact that I am overweight when I interact with average weight people.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

7. My being overweight does not influence how people act with me.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

8. Most average weight people have a lot more negative thoughts about overweight people than they actually express.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

9. I often think that average weight people are unfairly accused of having negative attitudes about overweight people.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

10. Most average weight people have a problem with viewing overweight people as equals.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

APPENDIX VII

WEIGHT BIAS INTERNALIZATION SCALE

Directions: Please indicate the extent to which you **agree** with each statement by circling the number associated with your response.

1. As an overweight person, I feel that I am just as competent as anyone.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

2. I am less attractive than most other people because of my weight.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

3. I feel anxious about being overweight because of what people might think of me.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

4. I wish I could drastically change my weight.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

5. Whenever I think a lot about being overweight, I feel depressed.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

6. I hate myself for being overweight.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

7. My weight is a major way that I judge my value as a person.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

8. I don't feel that I deserve to have a really fulfilling social life as long as I'm overweight.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

9. I am OK being the weight that I am.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

10. Because I'm overweight, I don't feel like my true self.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

11. Because of my weight, I don't understand how anyone attractive would want to date me.

1	2	3	4	5	6	7
strongly disagree	somewhat disagree	slightly disagree	neither agree nor disagree	slightly agree	somewhat agree	strongly agree

APPENDIX VIII

TABLES

Table 1

Participant Profiles

Participant #1 (P1)

P1 was a 27-year-old woman who self-identified as second-generation Mexican American and heterosexual. She was single (never married), reported a disability (multiple sclerosis), and her BMI was 42.97. She was a university student and reported a household income of \$5,000. She was attending individual therapy at a university counseling center with a pre-doctoral practicum student with whom she had worked for one month. She reported having participated in a little over a year of therapy in her lifetime, working with four different therapists. Her current and previous presenting concerns included anxiety, depression, self-injury, and dealing with her medical diagnosis.

Participant #2 (P2)

P2 was a 44-year-old woman who self-identified as White and heterosexual. She was single (never married), did not have a disability (emotional or physical), and her BMI was 56.96. She held a graduate degree, worked as a teacher, and reported a household income of \$52,000. She was attending individual therapy in private practice with a psychologist with whom she had worked for two years and five months. She reported having participated in almost four years of therapy in her lifetime, working with two different therapists. Her current and previous presenting concerns included depression, relationship problems, work-related problems, and grief.

Participant #3 (P3)

P3 was a 46-year-old woman who self-identified as Caucasian and lesbian. She was single (never married), did not report any disability, and her BMI was 46.36. She was a graduate student working as a substance abuse counselor with a reported household income of \$25,000. She was attending individual therapy at a university counseling center with a pre-doctoral practicum student with whom she had worked for four months. She reported having participated in three years and seven months of therapy in her lifetime, working with six different therapists. Her current and previous presenting concerns included depression, dealing with childhood and adult sexual trauma, sexual identity questioning, and disordered eating.

Participant #4 (P4)

P4 was a 59-year-old woman who self-identified as White and heterosexual. She was married, did not report any disability, and her BMI was 33.51. She had completed some college, was not employed, and reported a household income of \$160,000. She was attending individual therapy at a private practice with a psychologist with whom she had worked for six months. She reported having participated in five and a half years of therapy in her lifetime, working with five different therapists. Her current and previous presenting concerns included depression, low self-esteem, anxiety, alcohol abuse, and pursuing weight loss.

Participant #5 (P5)

P5 was a 54-year-old woman who self-identified African American and straight. She was engaged, reported a disability (arthritis), and her BMI was 38.73. She held a bachelor's degree, was retired, and reported a household income of \$26,000. She was attending individual telecounseling with a psychiatrist with whom she had been working for 11 years. She reported having participated in 18 ½ years of therapy in her lifetime, working with three different therapists. Her current and previous presenting concerns included depression and interpersonal problems at work.

Participant #6 (P6)

P6 was a 63-year-old woman who self-identified as multiracial (Pakistani/Mexican) and heterosexual. She was divorced, reported a disability (knee problems), and her BMI was 42.91. She had obtained a GED, was unemployed, and reported a household income of \$10,900. She was attending group therapy at a community mental health clinic with a psychologist with whom she had worked for a little over a year. She reported having participated in at least seven years of therapy in her lifetime, working with five different therapists. Her current and previous presenting concerns included bipolar disorder, anxiety, and dealing with her own and her child's sexual abuse.

Participant #7 (P7)

P7 was a 49-year-old woman who self-identified as White and heterosexual. She was divorced, reported a disability (11% disabled on right shoulder), and her BMI was 33.93. She had graduated from high school, was unemployed, and reported a household income of \$17,000. She was attending individual and group therapy. She did not report her therapy setting or therapist's credentials but reported having worked with her therapist for one year. She reported having participated in 30 years of therapy in her lifetime, working with 10 or more different therapists. Her current and previous presenting concerns included substance use/acting out in adolescence, depression, and post-traumatic stress due to childhood sexual trauma.

Participant #8 (P8)

P8 was a 33-year-old woman who self-identified as first-generation Persian and bisexual. She was in a committed relationship with a man, did not report any disability, and her BMI was 40.35. She held a bachelor's degree, worked in sales, and reported a household income of \$85,000 plus commission. She was attending individual therapy in private practice with a psychologist with whom she had worked for eight months. This was her first therapy experience, and her presenting concern was emotional dysregulation related to dealing with a parent's medical diagnosis.

Participant #9 (P9)

P9 was a 57-year-old woman who self-identified as White and heterosexual. She was single (never married), reported a disability (hearing impaired), and had a BMI of 39.67. She held an associate's degree, worked (irregularly) as an independent contractor for a newspaper, and reported a household income that included a yearly pension of \$1,782 and \$200 each time she published an article. She was attending group therapy at a community mental health clinic with a psychologist with whom she had worked for one year and three months. She reported having participated in one and a half years of therapy in her lifetime, working with two different therapists. Her current and previous presenting concerns included depression, bipolar disorder, domestic violence, and the death of her dog.

Participant #10 (P10)

P10 was a 41-year-old woman who self-identified as multiracial (Caucasian/Hispanic) and heterosexual. She was divorced, did not report any disability, and her BMI was 37.44. She had attended some college, was unemployed, and reported no household income. She was attending individual therapy through her faith community with a marriage and family therapist with whom she had worked for one year. She reported having participated in one year and eight months of therapy in her lifetime, working with three different therapists. Her current and previous presenting concerns included depression, bipolar disorder, domestic violence, and problem gambling.

Participant #12 (P12)

P12 was a 45-year-old woman who self-identified as White and heterosexual. She was divorced, reported a disability (bipolar disorder), and her BMI was 46.17. She had attended some college, was unemployed, and reported no household income. She was attending individual and group therapy at a community mental health clinic with a psychologist. She was unable to estimate how long she had worked with her current or past therapists but reported having worked with four different therapists over her lifetime. Her current and previous presenting concerns included bipolar disorder and relationship problems.

Participant #13 (P13)

P13 was a 56-year-old woman who self-identified as Caucasian and heterosexual. She was divorced, reported a disability (fibromyalgia), and her BMI was 38.89. She had attended some college, was unemployed, and reported a household income of \$35,000. She was attending individual therapy at a community mental health clinic with a pre-doctoral practicum student with whom she had worked for two weeks. She reported having participated in six and a half years of therapy in her lifetime, working with eight different therapists. Her current and previous presenting concerns included anxiety, histories of childhood sexual abuse and domestic violence, and dealing with her children's behavioral problems.

Participant #15 (P15)

P15 was a 53-year-old woman who self-identified as White and heterosexual. She was divorced, reported a disability (bipolar disorder) and her BMI was 34.94. She held a bachelor's degree, was unemployed, and reported a household income of \$18,000. She was attending individual therapy at a community mental health clinic with a pre-doctoral practicum student with whom she had worked for five months. She reported having participated in almost three years of therapy in her lifetime, working with six different therapists. Her current and previous presenting concerns included depression, bipolar disorder, and low self-esteem.

Participant #16 (P16)

P16 was a 56-year-old woman who self-identified as White and heterosexual. She was divorced, reported a disability (bipolar disorder, respiratory problems, and lower back problems), and her BMI was 38.73. She held a bachelor's degree, was unemployed, and reported a household income of \$13,000. She was attending individual therapy in private practice with a marriage and family therapist with whom she had worked for five years. She reported having participated in 25 years of therapy in her lifetime, working with seven different therapists. Her current and previous presenting concerns included dissatisfaction with her weight and issues related to having grown up with an alcoholic parent.

Participant #17 (P17)

P17 was a 55-year-old woman who self-identified as White and heterosexual. She was single (never married), reported a disability (severe spinal stenosis), and her BMI was 51.21. She had attended some college, was unemployed, and reported no household income. She was attending individual and group therapy at a community mental health clinic with a psychologist with whom she had worked for one month. She reported having participated in two months of therapy in her lifetime, working with three different therapists. Her presenting concerns included depression, low self-esteem, and having experienced childhood sexual abuse.

Table 2

Aggregate Participant Characteristics and Descriptive Information

Question Responses	Summary of responses (%)
Age	$M = 49.2$ years, $SD = 9.96$, range = 27 – 63
Race/Ethnicity	
White/European American	$n = 10$ (67%)
Multiracial	$n = 2$ (13%)
African American	$n = 1$ (7%)
Latina	$n = 1$ (7%)
Persian	$n = 1$ (7%)
Sexual Orientation	
Heterosexual	$n = 13$ (87%)
Lesbian	$n = 1$ (7%)
Bisexual	$n = 1$ (7%)
Relationship Status	
Divorced	$n = 7$ (47%)
Single, never married	$n = 5$ (33%)
Committed relationship	$n = 2$ (13%)
Married	$n = 1$ (7%)
Children	
Yes	$n = 8$ (53%)
No	$n = 7$ (47%)
Body Mass Index (BMI)	$M = 41.52$, $SD = 6.49$, range = 33.51 – 56.96
Disability	
Physical	$n = 8$ (53%)
Mental	$n = 4$ (27%)
None	$n = 5$ (33%)
Employment	
Unemployed	$n = 10$ (67%)
Employed	$n = 4$ (27%)
Retired	$n = 1$ (7%)
Household Income	$M = \$41,712$; $SD = 59,822$; median = \$17,000
Stigma Consciousness Questionnaire (SCQ)	$M = 3.11$, $SD = 0.96$, range = 1.90 – 5.20
Weight Bias Internalization Scale (WBIS)	$M = 4.75$, $SD = 1.38$, range = 2.82– 6.45

Time with Current Therapist	$M = 29.31$ months, $SD = 32.45$ range = 2 months – 11 years
Mode of Current Therapy	
Individual therapy alone	$n = 9$ (60%)
Group therapy alone	$n = 2$ (13%)
Individual and group therapy	$n = 4$ (27%)
Current Therapy Site	
Community mental health clinic	$n = 6$ (40%)
Private practice	$n = 4$ (27%)
University counseling center	$n = 2$ (13%)
Faith community	$n = 1$ (7%)
Did not report	$n = 2$ (13%)
Type of Therapist	
Psychologist	$n = 7$ (47%)
Predoctoral practicum student	$n = 3$ (20%)
Marriage and family therapist	$n = 2$ (13%)
Psychiatrist	$n = 1$ (7%)
Did not report	$n = 2$ (13%)
Presenting Problems (current and past)	
Depression	$n = 10$ (67%)
Trauma	$n = 8$ (53%)
Anxiety	$n = 4$ (27%)
Weight/eating-related	$n = 4$ (27%)
Acting out/drug use	$n = 4$ (27%)
Low self-esteem	$n = 3$ (20%)
Medical issues (own or other's)	$n = 2$ (13%)

SCQ = Stigma Consciousness Questionnaire; response options range from 1 to 7, with higher scores indicating more stigma consciousness. WBIS = Weight Bias Internalization Scale; response options range from 1 to 7, with higher scores indicating more internalized weight bias.

Table 3

Elaboration of Data, Themes, and Subthemes: Advice for Therapists

Theme Subtheme	Data Unit
Weight is not real (or only) problem	<p>“It's not about the weight. It's about what's going on in your head. Because if I had no legs, no arms, no anything, I'm right here. And that's one of the, the things that, um, has totally helped me at this point of growth, is, um, it's always been a struggle up here. It has had nothing to do with this. Um. It's what was said to me [in childhood], and how I related to it. I could have been a drug addict. Instead, I chose food.” (P4)</p> <p>“We're not dealing with the body as much as were dealing with the mind, correct? The body um, isn't as important as the soul, the person, the person itself, sometimes.” (P6)</p> <p>“The advice that I would give is to focus on the whole person and not just the weight, because I truly believe that if you take care of the psyche and you work on the psyche that the body will come to terms with how a person feels... It makes a person feel like you're not attacking them as a person and the way they look, because you're in therapy and therapy shouldn't focus on that outer part of the body. Therapy is supposed to focus on a person's psyche and how they feel, because they all combine, they all come together. I mean that's how I feel.” (P7)</p> <p>“I think that it's always good to constantly reiterate that there's underlying issues that need to be worked to be able to fix the big problem.” (P8)</p> <p>“It's not about the blubber it's about the brain, it's about the soul, it's about the heart, it's about the ability to get up every day and be something, do something. That's where we have to function, that's where we have to focus our therapy, and I think that's – if somebody were to focus their therapy on my blubber and you're not my doctor or you're not, ya know, I already solicited the lap-band or some other something like that, it would be out of place because there's a place and time for everything. Brain is where we're supposed to be working, our</p>

	<p>emotions. At least that's my theory." (P9)</p> <p>"To get to the bottom of it before they make any determinations in their mind of why this person is overweight." (P13)</p> <p>"Not to focus too much on it [weight], and be um, just be like a cheerleader for 'em." (P15)</p> <p>"I'm not sayin' don't spend too much time on their weight, but I mean, get down to the core reasons why." (P15)</p> <p>"And find out what's eating them. Ya know, what, what is really eating them, the reason why you're eating." (P16)</p> <p>"There's some root ties from the parents and the aunts that feed into an individual's life, and the wordplay on a person, like my mom always called me her fat little Dutch girl." (P17)</p>
<p>Specific Interventions</p> <p>i. Weight/Eating-related</p>	<p>"Trying to relate it more to what your client's daily life is. And trying to make it – give examples or work on things that are more realistic than unrealistic. Like, if you know your client, for example, travels a lot, okay. Telling them to make homemade meals and take this and do this is not going to help it. To discuss real, uh, situations in their life, so that they can connect to and work on. And come up with little tricks or solutions so that eventually when a situation happens where they wanna grab for food, something clicks in mentally of the therapy sessions. Even some little thing to maybe you don't stop eating the food, but you don't eat as much. Or helps you stop and maybe think about something else in a different way." (P8)</p> <p>"Maybe some, maybe some help. Maybe like, uh, maybe, 'This doctor's really good at that.' Maybe a referral to a, some type of clinic that can help overweight women lose weight." (P12)</p> <p>"One, don't overfocus on diets. They don't work." (P16)</p>

<p>ii. Support, common factors</p>	<p>“Ya know I really think OA works! I recommend OA highly.” (P16)</p> <p>“That’s another thing, another thing on losing weight is to focus on ten at a time, or ten percent of your body weight at a time.” (P16)</p> <p>“It’s important to have eye contact, and lean forward when you’re talking to somebody. Don’t lean back, because when you lean back it’s, you’re making distance between you and, and when people read you differently, but when you lean forward and you make that eye contact you know and uh, that really that’s a lot of help.” (P5)</p> <p>“I mean if you start looking at my body and the different colors I have on, well then I start covering up... Yeah, so don’t, yeah, it’s better to just keep eye contact.” (P5)</p> <p>“One thing I’ve learned in therapy is that every reflection I went to, I told myself, ‘I love me’, or, ‘You’re a beautiful woman, you’re a beautiful woman.’ Yes, every reflection. It’s like growing up and being told you’re a piece of shit, you believe it, so every mirror, every reflection I saw, I didn’t care how fast I said it, I thought it. And that’s how I became, that’s how I came to terms with loving me.” (P7)</p> <p>“I think it’s always good to give positive feedback at the end of the session, so you leave feeling good... Like, ‘We did a good job, like, it was a hard session, however, we, we went through it and we’re moving, and it’s a good growth, uh, for you.’” (P8)</p> <p>“And so, I think it would be good, as far as weight goes, to maybe ask someone, ‘how do you feel about yourself?’ You know, because of course if there is a weight problem, issue, that affects their self-esteem.” (P10)</p> <p>“And compliments help. Ya know, like, just little things like, ‘You’re doing a good job.’ Or, ‘You’re on the right path.’ Or I notice when I share my recovery experience, people – they</p>
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	<p>literally applauded me! So, and that's uplifting, and it makes me wanna keep on going. Ya know, so whether it's a therapist or just anybody. You know, it's always good to give, um, words of encouragement, I guess. Yeah, that helps." (P10)</p> <p>"Be sensitive to their—what's the word—insecurities. Well, I think, I've known quite a few overweight people myself. We tend to gravitate together, and the one issue that all of us is important to us is that people be sensitive to our issues. That, not be judgmental. That's all I can think of." (P13)</p> <p>"I look up to my therapist as, ya know, not like a god or a guru or anything, but I mean I look to them to help me...Just realize that what you say can really impact their thinking about themselves." (P15)</p> <p>"So I want somebody empathetic and, and not judgmental and—and I, I would fire somebody if, I mean I wouldn't stick around if that ever became an issue." (P15)</p> <p>"Not to focus too much on it [weight], and be um, just be like a cheerleader for 'em." (P15)</p> <p>"Um, and building self-esteem I think is, is, is, is a great uh, it's a great tool to use." (P16)</p> <p>"It's just, get 'em not to give up. Not to give up losing weight. And knowing the statistics that, that losing weight, most of the people that lose weight don't keep it off. So keep, ya know, that's why you have to have a healthy eating plan." (P16)</p> <p>"The lightbulb will eventually go on. Just lead 'em to the light switch, just don't turn on the light switch." (P17)</p>
<p>Discussing weight in therapy</p> <p>i. Allow client to direct conversations</p>	<p>"It's okay to kind of steer around an issue to see if they want to talk about it or see what they want to discuss and letting them to a certain extent before you meet to really steer it a certain way be very open because if they are the more they talk, you'll figure out exactly what they</p>

<p>ii. Bring up weight if worried</p>	<p>want to talk about... I guess it's okay for the first two sessions to be mainly them talking and you taking notes, that's okay because you'll see the main issues they want to discuss may come out that way." (P1)</p> <p>"Well like I said, I feel the fact that it was me who brought it up made a huge difference in my willingness to talk about it... because I may not need to talk about that [my weight] today and there are days when the weight is the biggest issue." (P2)</p> <p>"Let the client go there. Um... and listen carefully how they go there. Whether it's something they say in passing, or whether it's the crux of the sentence that they speak. Um, for example, 'My eating is out of control.'" (P3)</p> <p>"If you focus on somebody being heavy, then you're just going to make them feel worse than they already do... And then I would only bring up the weight if it was a really, if it was an issue with the patient at that time." (P7)</p> <p>"I, I think if you see, um, a situation getting outta control that they're not bringing up, and if that's their weight, ya know, it's their weight. Maybe you should bring it up, unlike my therapist, he waits for me to say what I wanna talk about... Because it, I, and I don't, oh I hate to feel like this, but I will agree that at some point it's, it's out of control. Like if you, like some of the people you see on TV, 600 pounds, you know, that kind of stuff. That's out of control." (P5)</p> <p>"Oh, I would maybe have, maybe them bring it up just a little bit more [the topic of weight in therapy]. Um, because my health is deteriorating. I'm gonna say mentally, though. See that's the problem. It's not, that's a tough one. I guess so, yeah. I, I, I think, I think, I think they should bring it up just a little bit more. For, for your, for your health, for your health, for, for your, for, for, to not hurt you, but to help you." (P12)</p>
<p>Don't make assumptions</p>	<p>"Don't assume that you know how it affects them... I know I am more confident now than I've</p>

	<p>ever been at this weight but I know that, not even at this weight, in life, there are times when I was at a like a quote unquote healthier weight and I felt completely like my body image was completely disjointed like I looked in the mirror and I saw somebody that was 500 pounds ya know so I think that's the main thing is don't assume that you see somebody that's maybe 30 pounds overweight is probably not a big deal for them because it's probably the hugest deal for them." (P1)</p> <p>"To say, 'What impact has your weight had on your life?' – there's an assumption made there. As opposed to, 'Do you think there has been a weight...' and, ya know, and there's a huge – to me those are two different questions, and a therapist who asks me the first question, I would be immediately not wanting to answer. I'd be like, 'You don't know me.' I would be much less willing to speak to somebody who just make assumptions that every single problem that I have is weight-related. (P2)</p> <p>"I guess not to assume that they're coming to you for a weight issue. You know, they might, it might be a symptom of something else so, um, don't assume that that's what they want help with." (P3)</p> <p>"Well just cause I gained weight doesn't mean I'm unhappy about anything. And that's where a lot of 'em try to take it. So, um, try to find out why they're gaining weight without insulting them on something's wrong. That doesn't, only thing that might be wrong with you is you like to eat! Food is good, you know." (P5)</p> <p>"Not assume that this person just has no self-control. Or this person, um, is using food as a crutch, or whatever. To get to the bottom of it before they make any determinations in their mind of why this person is overweight." (P13)</p>
<p>"Truths" about overweight women</p>	<p>"I think weight does affect a lot. And to not be, don't be blind to that, that it does and it affects everybody." (P1)</p> <p>"We can't hide it [weight], so one of two things happens. Either you just don't care about it – I've met women who are just like, 'Whatever, I'm me and you gotta love it, ya know, I don't</p>

	<p>care.’ They don’t dress appropriately or whatever. Or it’s more like I am, where you kind of build a wall around it, ya know, like no, don’t talk to me.” (P2)</p> <p>“The things that come to mind is definitely, cause overweight people, I think, are always looking for the quick fix.” (P8)</p> <p>“I think as overweight people, we tend to live double lives. And sometimes, depending on how long it’s gone on, we are being self-destructive and don’t know it.” (P8)</p> <p>“And so, I think it would be good, as far as weight goes, to maybe ask someone, ‘how do you feel about yourself?’ You know, because of course if there is a weight problem, issue, that affects their self-esteem.” (P10)</p> <p>“Be sensitive to their—what’s the word—insecurities. Well, I think, I’ve known quite a few overweight people myself. We tend to gravitate together, and the one issue that all of us is important to us is that people be sensitive to our issues. That, not be judgmental. That’s all I can think of.” (P13)</p>
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Table 4

Final Qualitative Interview Themes

Question	<i>n</i> of responses (%)
Emergent Themes	
1. Why do you think you became overweight or stayed overweight?	
a. Behavioral factors	<i>n</i> = 13 (87%)
i. Poor eating habits	<i>n</i> = 6 (40%)
ii. Potentially disordered eating	<i>n</i> = 8 (53%)
iii. Lack of physical activity	<i>n</i> = 7 (47%)
b. Life events/environmental factors	<i>n</i> = 10 (67%)
c. Mental/physical health issues	<i>n</i> = 11 (73%)
d. Function of weight	<i>n</i> = 5 (33%)
e. Weight stigma	<i>n</i> = 3 (20%)
f. Genetics	<i>n</i> = 3 (20%)
2. What effect, if any, do you think your weight has on the current (or past) issue that is bringing you to therapy?	
a. Presenting problems caused weight gain	<i>n</i> = 10 (67%)
b. Weight caused presenting problems	<i>n</i> = 8 (53%)
c. Coping function of weight	<i>n</i> = 5 (33%)
d. Weight/eating as presenting problem	<i>n</i> = 3 (20%)
3. How do you feel about your relationship with your current therapist?	
a. Valence of relationship	
i. Positive	<i>n</i> = 12 (80%)
ii. Negative	<i>n</i> = 2 (13%)
iii. Mixed	<i>n</i> = 1 (7%)
b. Descriptions of positive relationships	<i>n</i> = 12 (80%)
i. Therapist factors	<i>n</i> = 9 (60%)
ii. Interventions	<i>n</i> = 3 (20%)
4. Describe one experience with your current or a previous therapist that stands out as particularly helpful.	
a. Specific interventions	<i>n</i> = 14 (93%)
i. Emotion-focused interventions	<i>n</i> = 6 (40%)
ii. Assertiveness interventions	<i>n</i> = 4 (27%)
iii. Other interventions	<i>n</i> = 6 (40%)
b. Therapist/relationship factors	<i>n</i> = 6 (40%)
c. Weight/eating related	<i>n</i> = 2 (13%)

5. Describe one experience with your current or a previous therapist that stands out as particularly unhelpful.

- | | |
|---------------------------------------|---------------------|
| a. Therapist/relationship factors | <i>n</i> = 14 (93%) |
| i. Working alliance disruptions | <i>n</i> = 11 (73%) |
| ii. Offensive comments | <i>n</i> = 7 (47%) |
| b. Medication-related | <i>n</i> = 4 (27%) |
| c. Weight/eating related | <i>n</i> = 2 (13%) |
| d. Culturally-unhelpful interventions | <i>n</i> = 2 (13%) |
| e. Impact of unhelpful experiences | <i>n</i> = 7 (47%) |
| i. Quit therapy | <i>n</i> = 5 (33%) |
| ii. Negative impact on relationship | <i>n</i> = 2 (13%) |

6. What effect, if any, do you think your weight has on your current (or past) experience in therapy?

- | | |
|--------------------------------|--------------------|
| a. Less forthcoming in session | <i>n</i> = 6 (40%) |
| b. Missed sessions | <i>n</i> = 2 (13%) |
| c. No impact/unsure of impact | <i>n</i> = 4 (27%) |

7. We live in a culture that has clear messages about weight and physical appearance. What stereotypes do you see from our culture (e.g., media, relationships) about overweight people?

- | | |
|---------------------------------------|---------------------|
| a. Social/environmental consequences | <i>n</i> = 12 (80%) |
| b. Negative personality traits | <i>n</i> = 11 (73%) |
| c. Cultural thin ideal | <i>n</i> = 6 (40%) |
| d. Devalued physical characteristics | <i>n</i> = 6 (40%) |
| e. Assumptions about behaviors/health | <i>n</i> = 4 (27%) |
| f. Positive personality traits | <i>n</i> = 2 (13%) |

8. Are there any times that you have experienced someone thinking stereotypes about you or treating you differently because of your weight? These experiences could be direct (like mean comments) or indirect (you felt that someone thought something negative about you because of your weight, even if they didn't come out and say it).

- | | |
|---|---------------------|
| a. Overtly demeaning comments | <i>n</i> = 14 (93%) |
| i. Family members | <i>n</i> = 8 (53%) |
| ii. Strangers | <i>n</i> = 7 (47%) |
| iii. Childhood peers | <i>n</i> = 5 (33%) |
| iv. Current/previous partners | <i>n</i> = 3 (20%) |
| b. Unwanted expressions of concern | <i>n</i> = 9 (60%) |
| i. From medical professionals | <i>n</i> = 6 (40%) |
| ii. From others | <i>n</i> = 6 (40%) |
| c. Ignored/invisible | <i>n</i> = 5 (33%) |
| d. Reactions to Stigma | <i>n</i> = 12 (80%) |
| i. Anger, "thick skin" | <i>n</i> = 10 (67%) |
| ii. Neg impact on body image/health bxs | <i>n</i> = 6 (40%) |
| iii. Possibility of misinterpretation | <i>n</i> = 5 (33%) |
| iv. Hurt, sad, embarrassed | <i>n</i> = 5 (33%) |

v. Social avoidance

n = 3 (20%)

9. Overweight individuals often have experiences in which they are directly or subtly discriminated against, made to feel uncomfortable, or “put down” because of their weight or body size. In thinking about your therapy experiences, do any situations come to mind in which you felt uncomfortable, insulted, or disrespected by a comment made by your therapist that seemed to imply something negative about your weight? Please tell me about them.

- | | |
|--|---------------------|
| a. Denied stigmatizing experiences | <i>n</i> = 12 (80%) |
| b. Complaints about waiting room | <i>n</i> = 4 (27%) |
| c. Endorsed stigma from therapist | <i>n</i> = 3 (20%) |
| d. Therapist careful with topic of weight | <i>n</i> = 2 (13%) |
| e. Potential microaggression that did not bother her | <i>n</i> = 2 (13%) |

10. What effect, if any, does/did your therapist’s weight or physical appearance have on your therapy experience?

- | | |
|---|---------------------|
| a. Description of therapist’s body | <i>n</i> = 12 (80%) |
| i. Thin/average | <i>n</i> = 10 (67%) |
| ii. Overweight | <i>n</i> = 3 (20%) |
| b. Reactions | <i>n</i> = 9 (60%) |
| i. Appearance comparisons | <i>n</i> = 8 (53%) |
| ii. Explicitly negative reactions | <i>n</i> = 6 (40%) |
| iii. Positive attributions about therapist | <i>n</i> = 2 (13%) |
| iv. Explicitly positive reactions | <i>n</i> = 2 (13%) |
| c. In-session discussions/disclosures | <i>n</i> = 7 (47%) |
| i. Therapist disclosures | <i>n</i> = 4 (27%) |
| ii. Client comment about therapist clothes | <i>n</i> = 2 (13%) |
| iii. Client-initiated discussion re: therapist weight | <i>n</i> = 1 (7%) |
| d. No reaction | <i>n</i> = 7 (47%) |

11. What advice do you have for therapists who work with overweight women?

- | | |
|---|--------------------|
| a. Weight is not real (or only) problem | <i>n</i> = 9 (60%) |
| b. Specific interventions | <i>n</i> = 9 (60%) |
| i. Support, common factors | <i>n</i> = 7 (47%) |
| ii. Weight/eating-related | <i>n</i> = 3 (20%) |
| c. Discussing weight in therapy | <i>n</i> = 6 (40%) |
| i. Allow client to direct conversation | <i>n</i> = 4 (27%) |
| ii. Bring up weight if worried | <i>n</i> = 2 (13%) |
| d. Don’t make assumptions | <i>n</i> = 5 (33%) |
| e. “Truths” about overweight women | <i>n</i> = 5 (33%) |

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EDUCATION

- August 2008-
present Doctor of Philosophy – Clinical Psychology
University of Nevada, Las Vegas
Dissertation Title: Weight-based microaggressions experienced by
obese women in psychotherapy
Date of Expected Graduation: August 2014
Major Advisor: Cortney S. Warren, Ph.D.
- May 2008 Master of Science – Clinical Psychology
Missouri State University, Springfield, MO
Thesis Title: Effect of a pant size manipulation on women's body
image, self-esteem, and mood
Major Advisor: Brooke L. Whisenhunt, Ph.D.
- May 2005 Bachelor of Arts (Cum Laude)
Southwest Missouri State University, Springfield, MO
Major: Psychology

GRADUATE AWARDS AND HONORS

- 2012 Outstanding Research Presentation Award, Second Place, Graduate and
Professional Student Research Forum, UNLV
- 2011 Book Scholarship, Graduate and Professional Student Association, UNLV
- 2011 Travel Award, Graduate and Professional Student Association, UNLV.
\$850
- 2011 Patricia Sastaunak Scholarship, Graduate College, UNLV
- 2011 College of Liberal Arts Dean's Graduate Student Stipend Award, UNLV
- 2011 Student Research Award, First Place, Nevada Psychological Association
Annual Convention
- 2010 Travel Award, Graduate and Professional Student Association, UNLV.
\$530
- 2010 Summer Session Scholarship, Graduate College, UNLV

- 2009 Student Travel Award, Association for Psychological Science. \$200
 2008 Clinical Psychology of Women Student Research Award, Second Place, APA Division 12
 2007 Student Travel Award, Psychology Department, Missouri State University. \$250
 2007 Student Travel Award, Graduate College, Missouri State University. \$150

PEER-REVIEWED PUBLICATIONS

Warren, C. S., **Schafer, K. J.**, Crowley, M. E., & Olivardia, R. (2013). Demographic and work-related correlates of job burnout in professional eating disorder treatment providers. *Psychotherapy, 50*, 553-564.

Warren, C. S., **Schafer, K. J.**, Crowley, M. E., & Olivardia, R. (2013). Eating disorder treatment providers with a history of eating pathology: A qualitative examination of common experiences. *Eating Disorders, 21*, 1-15.

Warren, C. S., **Schafer, K. J.**, Crowley, M. E., & Olivardia, R. (2012). A qualitative analysis of job burnout in eating disorder treatment providers. *Eating Disorders, 20*, 1-20.

Warren, C. S., Schoen, A., & **Schafer, K. J.** (2010). Media internalization and social comparison as predictors of eating pathology among Latino adolescents: The moderating effect of gender and generational status. *Sex Roles: A Journal of Research*. Special issue: *Fiction, Fashion, and Function: Gendered Experiences of Women's and Men's Body Image*, 712-724.

PROFESSIONAL PRESENTATIONS (Selected)

Schafer, K. J., Whisenhunt, B. L., Drab-Hudson, D. L., & Warren, C. S. (2011, September). *Effect of a pant size manipulation on women's body image, self-esteem, and mood*. Paper presented at the Association for Behavioral and Cognitive Therapies annual convention, Toronto.

Warren, C. S., Schoen, A., & **Schafer, K. J.** (2011, September). *Sex differences in media internalization and social comparison as predictors of eating pathology among Latino adolescents*. Paper presented at the Association for Behavioral and Cognitive Therapies annual convention, Toronto.

Schafer, K. J., & Warren, C. S. (2011, April). *Eating disorder treatment providers with a history of eating pathology: Common experiences and recommendations*. Poster presented at the Nevada Psychological Association Annual Conference, Las Vegas, NV.

Lindsay, A., Warren, C. S., Velasquez, S., & **Schafer, K. J.** (2010, November). *Healthy Steps to Freedom (HSF): Evaluation of a health and body image curriculum for women in substance abuse treatment*. Poster presented at the Association for Behavioral and Cognitive Therapies annual convention, San Francisco, CA.

Schafer, K. J., Warren, C. S., Crowley, M. E., Olivardia, R., & Allec, A. (2010, August). *Burnout in therapists with a history of eating disorders*. Poster presented at the American Psychological Association annual meeting, San Diego, CA.

Schafer, K. J., Warren, C. S., Ashley, L. L., Kitterin, M., Pitts, L. E., & Prpich, M. (2010, August). *Are exotic dancers at risk for psychopathology?* Poster presented at the American Psychological Association annual meeting, San Diego, CA.

Warren, C. S., **Schafer, K. J.**, Crowley, M. J., & Olivardia, R. (2010, June). *Treating patients with eating disorders: An examination of therapist burnout*. Paper presented at the Academy of Eating Disorders annual meeting, Salzburg, Austria.

Schafer, K. J., & Warren, C. S. (2010, June). *Anti-fat attitudes and fear of fatness: Does ethnic identity matter?* Poster presented at the Academy of Eating Disorders annual meeting, Salzburg, Austria.

Schafer, K. J., Warren, C. S., & LaRosa, J. L. (2009, May). *Stronger ethnic identity related to fewer anti-fat attitudes in ethnically-diverse women*. Poster presented at the Association for Psychological Science annual convention, San Francisco, CA.

Schafer, K. J., Whisenhunt, B.L., Drab-Hudson, D.L., & Patel, S.M. (2007, November). *Effect of pant size on women's body image, self-esteem, and mood*. Poster presented at the Association for Behavioral and Cognitive Therapies annual convention, Philadelphia, PA.

Patel, S., Whisenhunt, B.L., Drab-Hudson, D.L., **Schafer, K. J.**, Skeens, K. L., & Toellner, B. R. (2005, November). *The illusive size 8: The arbitrary nature of women's clothing sizes and its implications for cognitive and behavioral practice*. Poster presented at the Association for the Advancement of Behavior Therapy annual convention, Washington, DC.

RESEARCH EXPERIENCE

Doctoral Dissertation

In progress

Title: *Weight-based Microaggressions Experienced by Obese Women in Psychotherapy*

Committee Chair: Cortney S. Warren, Ph.D.

Dissertation Proposal: Approved Sept 2012

Dissertation Defense: Scheduled July 2014

Utilizing qualitative methodology to examine the experiences of obese women currently in psychotherapy. Conducted one-on-one interviews to elicit participants' weight-related experiences in therapy, particularly focusing on whether they experienced weight-based microaggressions (i.e., subtle, often unintentional expressions of bias) conveyed by their therapists. Used a general inductive approach to identify common themes in participants' responses and provide recommendations to therapists regarding how to engage in helpful, sensitive therapeutic relationships with this population.

Graduate Research Assistant

May 2009-June 2010

Treating Patients with Eating Disorders: An Examination of Therapist Burnout

University of Nevada, Las Vegas

Principal Investigator: Cortney S. Warren, Ph.D.

Graduate research assistant for a grant titled “Treating Patients with Eating Disorders: An Examination of Therapist Burnout,” funded (\$10,000) by the National Eating Disorder Association (NEDA). Recruited participants, supervised an undergraduate research assistant, managed the dataset, coded data using an inductive approach, and assisted in preparing manuscripts.

Graduate Research Assistant/Lab Manager

Aug 2008-May 2010

Eating Disorders, Body Image, and Multiculturalism Lab

University of Nevada, Las Vegas

Advisor: Cortney S. Warren, Ph.D.

Involved in on a number of research studies, including examining body image, eating behaviors, and cultural factors in female undergraduates; substance use, trauma, and eating behaviors in exotic dancers; media awareness in high school students; eating behaviors in college athletes; and substance use as a means of weight management in women undergoing substance abuse treatment. Created online studies, managed datasets, supervised undergraduate research assistants, analyzed data, assisted in manuscript preparation, and presented data at national conferences. Collaborated with my supervisor on article reviews for a number of peer-reviewed journals.

Master’s Thesis

Aug 2006-May 2008

Title: *Effect of a Pant Size Manipulation on Women’s Body Image, Self-Esteem, and Mood*

Missouri State University

Committee Chair: Brooke Whisenhunt, Ph.D

Examined the effect of a pant size manipulation on women’s self-reported body image, self-esteem, and mood. Participants tried on pants that were either two sizes smaller, two sizes larger, or the same size as their self-reported size that was shown on the label. After trying on the pants, participants completed state measures of body image, self-esteem, and mood.

Undergraduate Research Project

Aug 2004-Dec 2005

Title: *Effect of Major and Minor Triads on Perception of Word Valence*

Southwest Missouri State University

Supervisor: Frank Raggozine, Ph.D.

Examined the effect of emotional consistency of word valence and musical stimuli on reaction time and errors. Designed the study, collected and analyzed data, and presented results at a regional conference.

Research Assistant

Jan 2004-May 2005

Body Image and Eating Disorders Lab

Southwest Missouri State University

Supervisors: Brooke Whisenhunt, Ph.D. and Danae Hudson, Ph.D.

Recruited participants, participated in human subjects data collection, entered and analyzed data, conducted reviews of the literature, created poster presentations and presented at national regional and national conferences, planned and implemented events for National Eating Disorders Awareness Week, attended weekly lab meetings.

CLINICAL TRAINING

Doctoral Internship – APA-Accredited**University of Missouri Counseling Center**

Aug 2013-present

Columbia, MO

Primary Supervisors: Kim Daniels, Ph.D.

Raeona Nichols, Ph.D.

Provide brief, individual therapy to college students with a variety of presenting problems. Co-facilitate two general interpersonal process groups, including a multiple co-leader group. Conduct crisis and initial intake assessments. Provide outreach programming and consultation services to students, parents, and campus organizations. Provide weekly primary supervision to a master's-level practicum student (one per semester). Participate in eating disorders focus area, including individual caseload of clients with eating concerns, co-facilitating the Eating Issues therapy group (Spring 2014 semester), attending meetings of the campus-wide, multidisciplinary Eating Disorders Treatment Team, and planning and implementing events for National Eating Disorders Awareness Week. Carry crisis pager and provide crisis interventions. Participate in professional issues, multicultural, and topical seminars. Participate in weekly disposition meetings. Provide appropriate campus and community referrals to students. Attend monthly meetings of the Transgender Health Network, a local consultation group for trans-friendly healthcare providers.

Pre-doctoral Practicum Training**Creative Health Solutions**

June 2012-May 2013

Private Practice Eating Disorder Treatment

Supervisor: Lindsey Ricciardi, Ph.D.

Las Vegas, NV

Provided individual and group therapy to adult and adolescent clients with a variety of eating disorder diagnoses. Co-facilitated two 20-week Dialectical Behavior Therapy (DBT) skills groups, including 24/7 availability for phone coaching. Co-facilitated a 6-week body image group and a 10-week group for women struggling with weight management. Consulted with multidisciplinary team including psychologists, physicians, and a dietitian. Conducted psychological evaluations for bariatric surgery candidates and

facilitated a monthly post-surgery emotional support group. Participated in weekly individual supervision.

Psychological Assessment and Testing Clinic, UNLV

May 2009-May 2013

Psychology Department Assessment Clinic
Las Vegas, NV

Supervisor: Michelle G. Paul, Ph.D.

Conducted comprehensive psychoeducational assessments, most commonly for attention and hyperactivity problems, learning disorders, and memory problems. Conducted clinical interviews, administered and scored tests, wrote integrated reports, and provided feedback. Mentored 1st-year graduate students through an assessment case (explained assessment procedures and test battery selection, taught scoring, and modeled conducting a clinical interview, administering assessments, and providing useful feedback).

Proficient in the administration, scoring, and interpretation of the following assessments: Delis-Kaplan Executive Function System, Millon Clinical Multiaxial Inventory, Minnesota Multiphasic Personality Inventory, Personality Assessment Inventory, Wechsler Adult Intelligence Scale – IV, Wechsler Intelligence Scales for Children – IV, Wechsler Memory Scales – IV, Woodcock Johnson Tests of Achievement – III, and Woodcock Johnson Tests of Cognitive Abilities – III.

The PRACTICE: A UNLV Mental Health Clinic

Aug 2012-Dec 2012

Psychology Department Mental Health Clinic
Clinical Graduate Assistant
Las Vegas, NV

Supervisor: Michelle G. Paul, Ph.D.

Provided individual therapy and conducted initial intake interviews with adults. Provided consultation to 2nd-year doctoral student therapists. Carried out administrative duties and attended weekly staff meetings. Participated in weekly individual supervision.

Counseling and Psychological Services, UNLV

Aug 2010-Aug 2012

University Counseling Center
Clinical Graduate Assistant
Las Vegas, NV

Supervisors: Vicky Genia, Psy.D.
Emily Slife, Ph.D.
Shauna Landis, Psy.D.

Provided brief, individual psychotherapy and conducted initial intake interviews. Clients were college students who were diverse regarding race, ethnicity, age, sexual orientation, and presenting concerns. Co-facilitated 8-week Building Social Confidence and Mindfulness and Yoga for Well-Being groups. Provided outreach programming, including developing and delivering a stress management presentation to a student organization and involvement in Love Your Body Day and National Eating Disorders Awareness Week. Participated in a reading group focused on conceptualization and treatment of eating disorders. Participated in weekly individual and group supervision, which included case discussions, videotape review, and providing peer feedback. Participated in weekly staff disposition and case consultation meetings.

Center for Individual, Couple, and Family Counseling, UNLV Aug 2009-Aug 2010
Psychology Department Mental Health Clinic Supervisor: Marta Meana, Ph.D.
Las Vegas, NV

Conducted initial intakes and provided individual long-term psychotherapy to adults with various Axis I and II diagnoses. Participated in weekly individual and group supervision, which involved case discussions, videotape review, and providing peer feedback.

Pre-master's Practicum Training

Learning Diagnostic Clinic, Missouri State University Aug 2006-May 2008
Psychology Department Assessment Clinic Supervisor: Steve Capps, Ph.D.
Clinical Graduate Assistant
Springfield, MO

Conducted comprehensive psychoeducational assessments for adults, adolescents, and children, most commonly for learning disorders and attention problems. Conducted clinical interviews, administered and scored tests, wrote integrated reports, and provided feedback to clients.

Springfield Public School District May 2007-May 2008
School Psychology Practicum Supervisor: Lorri Sheets, Psy.D.
Springfield, MO

Conducted social-emotional evaluations of preschool through high school students to determine eligibility for special education. Assessments included student and parent interviews, classroom observations, behavior rating scales, and records reviews. Wrote psychological reports and attended team meetings.

SUPERVISION EXPERIENCE

Primary Supervisor Aug 2013-present
University of Missouri Counseling Center

Provide primary, weekly therapy supervision to a master's level practicum student. Supervision included discussion of client and professional growth issues, videotape review, and progress note review. Participated in group "sup of sup," which included presenting videotape of supervision sessions and providing peer feedback.

Psychotherapy Supervisor in Training May 2012-Aug 2012
Center for Individual, Couples, and Family Counseling, UNLV
Supervisor: Michelle G. Paul, Ph.D.

In tandem with a course, Introduction to Clinical Supervision (PSY 762), provided primary, weekly therapy supervision to a second-year clinical psychology doctoral student. Supervision included discussion of client and professional growth issues, videotape review, and progress note review. Conducted two co-therapy sessions at the

home of a client who presented with hoarding. Participated in both individual and group “sup of sup,” including videotape review of supervision sessions.

TEACHING EXPERIENCE

Basic Principles of Psychotherapy (PSY 451)

Fall 2012 & Spring 2013

Course Instructor

University of Nevada, Las Vegas

This course was designed to acquaint advanced psychology majors with some of the most prominent theoretical models underlying the process and practice of psychotherapy. Specific course objectives included 1) promoting increased self-exploration and self-awareness, 2) increasing awareness about ethical and professional issues in psychotherapy, 3) providing basic information about prominent theoretical orientations, 4) clarifying what the process of therapy “looks like” and addressing common misperceptions, and 5) providing some information about possible career paths in psychology. Course evaluation scores for the three sections taught over two semesters averaged 3.9 (out of 4).

Introductory Psychology (PSY 101)

Fall 2010 & Spring 2011

Course Instructor

University of Nevada, Las Vegas

This course was designed to acquaint undergraduate students with basic topics, terms, and concepts in psychology. Specific course objectives included 1) developing an understanding of the discipline of psychology, 2) developing scientific values and skills, 3) fostering personal growth, and 4) enhancing general writing and research skills. Course evaluation scores for the four sections taught over two semesters averaged 3.82 (out of 4).

PROFESSIONAL DEVELOPMENT (Selected)

2012-2013	<u>Comprehensive Training in Dialectical Behavior Therapy</u> 8-day, 3-part training seminar presented by Dr. Alan Fruzzetti. Included training in conceptualization, group and individual therapy, skills coaching, and forming a consultation team.
2012	<u>Treatment Planning for the Eating Disorder Patient</u> 1-day seminar presented by Jennifer Lombardi, MFT
2010	<u>Introduction to Acceptance and Commitment Therapy (ACT)</u> 1-day seminar presented by Dr. Victoria Follette
2009	<u>Advanced Treatment for Eating Disorders</u> 4-day seminar, Summit for Clinical Excellence, Las Vegas, NV

PROFESSIONAL SERVICE ACTIVITIES

2011-2013	Campus Representative, Advocacy Coordinating Team, American Psychological Association of Graduate Students (APAGS)
2011-2013	Campus Representative, Nevada Psychological Association Southern Region

- 2010-2013 Member, Diversity Committee, Nevada Psychological Association
 2010-2013 Student Reviewer, *Psychology of Women Quarterly*
 2009-2013 Mentor, Outreach Undergraduate Mentoring Program, Psychology Department, UNLV
 2009-2012 Incoming Graduate Student Mentor, Psychology Department, UNLV
 2009-2012 Community Services Coordinator, Diversity Committee, Psychology Department, UNLV
 Fall 2011 Psychology Department Representative, Graduate and Professional Student Association, UNLV
 2010-2011 Co-chair, Clinical Student Committee, Psychology Department, UNLV
 2009-2010 Cohort Representative, Clinical Student Committee, Psychology Department, UNLV

PROFESSIONAL AFFILIATIONS

- Missouri Psychological Association, Student Member
 Academy for Eating Disorders, Student Member
 American Psychological Association, Student Member
 Division 12, Society for the Teaching of Psychology
 Division 35, Psychology of Women
 Division 44, Society for the Psychological Study of LGBT Issues
 Nevada Psychological Association, Student Member
 The Obesity Society, Student Member

REFERENCES

Cortney Warren, Ph.D.

Dissertation Chair

Assistant Professor

Department of Psychology

University of Nevada, Las Vegas

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Jenny Lybeck-Brown, Ph.D.

Internship Training Director

Associate Director—Training

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Kim Daniels, Ph.D.

Current Clinical Supervisor

Staff Psychologist

Counseling Center

University of Missouri-Columbia

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Columbia, MO 65211

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Phone: (573) 882-6601

Michelle G. Paul, Ph.D.

Previous Clinical Supervisor/Instructor

Clinical Director

The PRACTICE: A UNLV Community Mental Health Clinic

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