

2013

Do Psychologists Demonstrate Bias Based on Female Client Weight and Ethnicity? ;An Analogue Study

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DO PSYCHOLOGISTS DEMONSTRATE BIAS BASED ON FEMALE CLIENT
WEIGHT AND ETHNICITY? AN ANALOGUE STUDY.

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DOCTOR OF PHILOSOPHY IN URBAN EDUCATION, SPECIALIZATION IN
COUNSELING PSYCHOLOGY
at the
CLEVELAND STATE UNIVERSITY
APRIL 2013

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ACKNOWLEDGEMENTS

Many, many thanks to Dr. Welfel for inspiring me to choose CSU's program, advising me as I moved through it, helping me feel confident in my clinical and academic work, and assisting me with my entire dissertation process. Also, thank you to Dr. Harper for your help, flexibility, and support as my methodologist. I appreciate my committee members, Dr. Toman, Dr. Schultheiss, and Dr. Hollinger, for providing thoughtful feedback. Thank you to my family, friends, and Dr. Curran; without you I could never have written this dissertation. Finally, I need to acknowledge Dr. Irvin Yalom and his willingness to openly share his reactions to a fat client; his writing was the inspiration for this study.

DO PSYCHOLOGISTS DEMONSTRATE BIAS BASED ON FEMALE CLIENT
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LINDSAY C. VARKULA

ABSTRACT

Although anti-fat bias and discrimination have been widely documented (see Puhl, Andreyeva, & Brownell, 2008), few studies have examined whether psychologists exhibit biases toward clients who are fat. Only one study (Locker, 2011) examined whether client characteristics of ethnicity and weight influenced therapists' bias; no studies have exclusively examined psychologists. This analogue study investigated psychologists' biases toward a hypothetical client (vignette adapted from Zadroga, 2009) when the client characteristics of weight (average/obese) and ethnicity (African American/European American) were manipulated. Participants in this study included a national sample of 194 licensed, currently practicing psychologists. A 2 (client weight) x 2 (client ethnicity) randomized experimental design was utilized. Participants' biases were determined by Global Assessment of Functioning scores, prognosis scores, and scores from an adapted version of the Working Alliance Inventory (see Burkard, 1997) Therapist form (WAI-T-A; Horvath & Greenberg, 1989). A 2 x 2 factorial MANOVA indicated no statistically significant differences according to vignette client weight [$F(1, 192) = 1.46, p = 0.23$], vignette client ethnicity [$F(1, 192) = 0.77, p = 0.51$], or weight by ethnicity interaction [$F(1, 192) = 0.28, p = 0.85$]. Results, implications, and limitations were discussed, along with suggestions for further research.

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CHAPTER I

INTRODUCTION

In the United States, most people believe that when individuals make bad choices they get what they deserve. For example, most people believe that those who choose to smoke deserve the health problems that they tend to acquire. Research shows that these attitudes are fairly accurate regarding tobacco use; according to the Centers for Disease Control (CDC) in America smoking is directly responsible for one in five deaths each year (CDC, 2008). Weight status, however, works differently. Research shows that the overwhelming majority of people in the United States believe that “choosing to be fat” is bad and that fat people are at fault for their own weight status and health problems (Saguy & Riley, 2005). High body weight is seen as the result of the “risky behavior” of unhealthy lifestyle choices (Saguy & Riley, 2005). From this perspective the use of dieting and other weight loss aids should therefore be encouraged because expunging obesity should be a priority (Saguy & Riley, 2005). In reality, having a high Body Mass Index (BMI) only accounts for about 9% of the variance in health outcomes (Gaesser, 2002). People have far less control over weight status than is commonly perceived and having a higher weight does not necessarily mean that a person is unhealthy (Rothblum & Solovay, 2009).

Many physicians, health care professionals, and the United States government are committed to “fighting” obesity (Abakoui & Simmons, 2010; Saguy & Riley, 2005). In accordance with CDC reports, they state that obesity is a dangerous, growing epidemic in the United States (CDC, 2010). Currently, an estimated 33.8% of adults in the United States are “obese,” defined as having a body mass index (BMI) of 30 or higher (Flegal, Carroll, Ogden, & Curtin, 2010). More specifically, about 32.2% of men and 35.5% of women are obese (Flegal, et al 2010). Combined rates of “overweight” (defined as having a BMI of 25 to 29.9) and “obesity” show that about 68% of adults in the United States fall into one of these groups (Flegal, et al, 2010). Obesity has been linked to increased likelihood of significant health problems, including increased risk of diseases such as heart disease, type II diabetes, cancer, hypertension, shortened life-span, and stroke, and psychological problems including depression, body image problems, and low self-esteem (Cash & Pruzinsky, 2002; Fairburn & Brownell, 2002; Irwin, 2004; Schwimmer, Burwinkle & Varni, 2003). Studies (e.g., McGinnis & Foege, 1993) have linked obesity to over 300,000 deaths.

Other researchers, however, have highlighted several methodological problems with research on obesity. According to Flegal, Graubard, Williamson, and Gail (2005), BMI is not an accurate measure of health; other measures including body composition, body type, level of physical fitness/muscularity, location of excess adipose tissue, dietary intake, and other lifestyle choices (e.g., smoking) provide better estimates of health status. Studies that linked obesity with high death rates (e.g., McGinnis & Foege, 1993) greatly inflated original estimates of the morbidity and mortality associated with obesity; in reality, obesity-related deaths tend to only occur when people have a BMI over 35

(Flegal et al., 2005). In addition, Flegal et al. (2005) found that people categorized as “overweight” actually tend to be healthier than those with lower weights. In other words, fatness does not necessarily equal disease and thinness does not necessarily equal health (Cogan & Ernsberger, 1999, p. 191).

Because “obesity” has been correlated with many health problems, people may have inaccurately or selectively concluded that a correlation implies causation: that obesity actually causes poorer health (Boero, 2007; Cogan & Ernsberger, 1999). Media coverage, in particular, has likely exacerbated the situation by oversimplifying research results (Boero, 2007; Connors & Melcher, 1993; Muennig, 2008). Muennig (2008) stated that “there is no direct evidence that expanded adipose cells themselves actually secrete sufficient quantities of biochemical mediators to explain the additional burden of disease suffered by obese persons” (p. 129). Most obesity-related problems, including cardiovascular and metabolic problems, can be solved with better fitness levels and without any weight loss (Gaesser, 2002, 2003). The only negative health condition that is known to definitely be *caused* by obesity is sleep apnea (Muennig, 2008). Muennig, Jia, and Lubetkin (2008) found that the degree to which people are dissatisfied with their own body weight is a much stronger predictor of morbidity than BMI.

Furthermore, many health problems associated with fatness may be caused by chronic stress, which can result from society’s prejudice and oppression of fat people (Muennig, 2008). Many people who have experienced chronic stress (e.g., Post Traumatic Stress Disorder (PTSD), racism) have the same physical and mental health problems for which obesity is being blamed (Muennig, 2008), including hypertension, heart disease, high cortisol levels, type II diabetes, and high cholesterol (Muennig et al.,

2008). Research (e.g., Muennig, 2008; Muennig et al., 2008) has indicated that the chronic stress caused by society's fat stigmatization and discrimination negatively impacts health. The fact that these conditions are disproportionately frequent in the groups that are the most stigmatized because of their weight (younger people, women, and Whites) may indicate that stigma leads to the morbidity and mortality, not BMI (Muennig, 2008).

In the United States, obesity rates are the highest in individuals of low SES (Ernsberger, 2009). Minority individuals (especially African Americans and Hispanic Americans), and marginalized individuals (especially women) have the highest rates of poverty in the United States. Correlations between fat people and poor health are likely influenced by poverty and health disparities. Poor people tend to receive poorer health care and poorer education, and they tend to lack affordable healthy food and safe places to exercise (Ernsberger, 2009; Robert & Reither, 2004; Schnittker & McLeod, 2005). Poverty has been shown to cause chronic stress (Munnig, 2008) and lead to poorer health (for reviews, see Lamont, 2009; and Schnittker and McLeod, 2005). Puhl and Brownell (2003a) argued that people who are fat often "face several layers of bias" (p. 214), in that people may be forced to manage the chronic stress of both weight-related discrimination and discrimination based on their low SES. Feelings of lack of control, lack of autonomy, inability to participate fully in society, and inferior social status likely contribute to this stress (Marmot, 2004; Wilkinson, 2005). Some researchers (e.g., Ernsberger, 2009; Stunkard & Sorensen, 1993) believe that being fat can actually lead to poverty. For example, lower family incomes are correlated with higher weight (Averett & Korenman, 1996), and overweight women tend to finish fewer years of education, are less likely to

be married, and have a lower average household income (Gortmaker, Must, Perrin, Sobol, & Dietz, 1993).

Researchers (e.g., Gaesser, 2002; Hainer et al., 2001; Munnig, 2008) have found that weight is largely genetically determined and that factors such as lifestyle choice have limited influence on BMI. Both Bouchard et al. (1996) and Hainer et al. (2001) have found that there is a “strong genetic contribution” to weight, body fat, and metabolic efficiency. Allison et al., (1996) have estimated that genetics account for 50% to 70% of a person’s weight status.

There are no randomized control trials supporting the notion that losing weight improves health or lengthens lives (Ernsberger, 2009; Ernsberger & Koletsky, 1999). Weight loss, however, is typically recommended to people who are obese. Many professionals, including physicians, have endorsed diet programs and endorsed or prescribed drugs that have led to unhealthy eating habits, harmful weight cycling, illness, and death (Lyons, 2009). In addition, the weight-loss industry makes almost \$60 billion dollars per year and members of the medical field and pharmaceutical companies are making money off of programs, products, and drugs (Lyons, 2009; Wann, 2009).

Researchers have highlighted several problems with dieting (Lyons, 2009; Saguy & Riley, 2005). Between 75% and 95% of people who have taken part in commercial diet programs have re-gained any weight that was lost within one to three years (e.g., Garner & Wooley, 1991; Miller, 1999). Gaining and losing weight multiple times, known as weight cycling or “yo-yo dieting,” is harmful (Lyons, 2009; Wann, 2009). As a result of weight cycling, people have a higher risk of illnesses including cancer, high blood pressure, heart disease, and kidney disease, and have an increased likelihood of future

weight increases (Ernsberger & Koletsky, 1999; Gaesser, 2002; Gaesser, 2003). Some researchers (e.g., Blaine, DiBlasi, & Connor, 2002) believe that many of the health problems that are usually attributed to obesity are actually caused by weight cycling.

Numerous researchers (e.g., Berg, 1994; Levitsky, 1997; Lyons, 2009; Yang, Roth, Schoenfield, & Marks, 1992) have described the dangers associated with diet pills (both prescription and over-the-counter), diets/weight-loss programs (both physician-run and commercial), smoking for weight loss, bariatric surgery, and other weight loss strategies including eating disordered behaviors (use of purging, vomiting, fasting, etc.). Myriad documented risks of these methods include cardiac/circulatory problems, psychological problems, neurological problems, gastro-intestinal problems, organ damage/malfunction, loss of muscle tissue, reduced resistance to infection, loss of bone mass, and death (Berg, 1999; Lyons, 2009). Many people who have recently lost weight are at a higher risk of death (Berg, 1999; Cogan & Ernsberger, 1999). People using weight-loss aids have significantly lower levels of health-related quality of life than those who are not using weight-loss aids (Kolotkin, Crosby, & Williams, 2002). At or before five year follow-ups, over 95% of people using these methods re-gain weight, often ending up at higher weights than when they started (Berg, 1999).

Other methods have outperformed weight loss aids at improving health status. Bacon, Stern, Van Loan, and Keim (2005) conducted a randomized controlled trial comparing a six-month Health at Every Size (HAES) program to a six-month traditional diet/weight loss program. The HAES program taught people to respond to their bodies and attend to their body signals. The HAES approach significantly improved health status, resulting in lower blood pressure, lower blood lipid levels, fewer eating disordered

behaviors, higher self-esteem, lower rates of depression, and better body image.

Improvements were sustained at a two year follow-up. The participants in the traditional diet/weight loss program did not have these positive outcomes, had lower self-esteem than when they started, and any initial weight lost was quickly regained. While this study supported a HAES intervention, additional research is needed to fully assess its efficacy.

As research continues to emerge regarding fatness, health, and the societal mechanisms that influence it, several researchers, sometimes known as fat/size acceptance and Health At Every Size researchers, have been promoting a paradigm shift (Abakoui & Simmons, 2010; Bacon, 2008). They believe that “framing fatness as a sign of body diversity suggests that diversity training, greater social tolerance, and less discrimination on the basis of size is needed” (Saguy & Riley, 2005, p. 873). From this viewpoint, all people should be encouraged to maintain a healthy lifestyle, and public instruction about healthy behaviors should not be exclusively directed at fat people (Burgard, 2009).

In addition, the monetarily powerful food industry impacts social conditions by perpetuating unhealthy lifestyles (Brownell, 2012). As the food industry profits from the sale of processed, non-nutritious, and high calorie foods, these foods continue to be visible and inexpensive, interfering with efforts to maintain healthy lifestyles. In order to increase profit, the food industry has engaged in extensive marketing of foods (including snack foods, fast food, and sugary beverages) to vulnerable populations, including children (Brownell, 2012). While the “anti-obesity” campaign has attempted to work with the food industry to create change, more support is needed for large-scale policy changes including “limits on marketing, taxes on products such as sugared beverages, and

regulation of nutritional labeling” in order to enact change (Brownell, 2012, e1001254).

Therefore, the reality of the problem is that society combines the anti-fat bias with social conditions that make it extremely difficult to eat healthy, appreciate body diversity, and work toward health at every size.

Definition of Terms

Because several terms will be used to facilitate discussion of anti-fat attitudes, it is useful to define these terms. *Stigma* is defined as “a social construction that involves at least two fundamental components: (1) the recognition of difference based on some distinguishing characteristic, or ‘mark’; and (2) a consequent devaluation of the person” (Dovidio, Major, & Crocker, 2000, p. 3). Stigma is also “a shared characteristic of a category of people that becomes consensually regarded as a basis for disassociating from (that is, avoiding, excluding, ostracizing, or otherwise minimizing interaction with) individuals who are perceived to be members of that category” (Leary & Schreindorfer, 1998, p. 15). *Bias* is defined as “the inclination to form unreasoned judgments” (Brownell, 2005, p. 10). Attitude is defined as “a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor...inferred by psychologists from observable responses” (Eagly & Chaiken, 1998, p. 269). Attitudes appear to be composed of emotions and cognitions, which interact with each other (Tropp & Pettigrew, 2005). A *stereotype* is a widely-held belief about a group (Danielsdottir, O’Brien, & Ciao, 2010). *Prejudice* is defined as negative and/or hostile attitudes directed toward individuals (Puhl, Andreyeva, & Brownell, 2008). *Discrimination* is actual negative behavior directed toward an individual based on prejudice (Danielsdottir, O’Brien, & Ciao, 2010). *Oppression* is defined as

“discrimination against and/or the systematic denial of resources to members of groups who are identified as different, inferior, or less deserving than others;” *privilege* is the opposite of oppression (American Psychological Association (APA), 2007).

There is a general problem of inconsistency in choosing words/terms to describe large-sized people, likely because of the meanings and connotations associated with the various words used to describe them (Smith, Schmoll, Konik, & Oberlander, 2007).

Obesity is a medical term defined as a BMI of 30 or more (Roehling, 1999). *Overweight* is also a medical term, indicating that a person has a BMI of 25 to 29. Some researchers (e.g., Crandall & Biernat, 1990) have stated that they avoid the terms *obese* and *overweight* because they imply that the person has a medical condition. Feminist authors (e.g., Wann, 2009; Rothblum & Solovay, 2009) add to the argument against using *obese* and *overweight* because they imply that there is a medical condition that needs to be cured, and because they encourage the belief that all individuals are meant to be the same size and shape. Also, *overweight* implies that people should be working toward some goal of “normalcy” because their current weight is inherently incorrect (Fikkan & Rothblum, 2011).

Feminists often strive to change language and word connotations that have been detrimental to women; these transformations allow women to reclaim personal and political power (Ahern & Tally, 2009). Many believe that it is important to reclaim the word *fat* as a neutral descriptor of weight status and to attempt to remove the taboo (Wann, 2009). In literature reviews (e.g., Fikkan & Rothblum, 2011), several authors prefer to use the term *fat* as a weight descriptor in their original writing, but will sometimes use the reviewed article’s original language because of the different potential

meanings of the terms. In summarizing the work of other researchers, this document will generally use the weight descriptors that were used by the original researchers (these terms vary, but are often words like *obese*, *overweight*, *heavy*, or *large-sized*). In the rest of the document, however, the word *fat* will be used as part of an ongoing effort to destigmatize the word and establish it as a neutral body descriptor.

Societal Oppression and Stigma

When people are members of a stigmatized group, one with less social power, they are likely to experience discrimination (Crocker, Major, & Steele, 1998). Since the 1970s, feminists and other researchers have focused on studying and advocating for groups that have faced discrimination, and have devoted study to the hierarchical differences in power status as a result of gender, ethnicity, sexual orientation, and other areas of human variation.

Women.

Since the 1970s, feminists, researchers, and advocacy groups have worked toward ending the oppression of women. Still, women remain lower than men in the societal power hierarchy in the United States (including economic, political, and social power), and are considered to be a marginalized group (APA, 2007; Fassinger, 2002).

Discriminatory experiences as a result of marginalization may contribute to chronic stress reactions in women (Kessler, Mickelson, & Williams, 1999; Puhl & Heuer, 2010).

Research (e.g., Reel, SooHoo, Summerhays, & Gill, 2008) has shown that women are often seen as sexual objects and are disproportionately influenced by the “culture of thinness,” often exacerbated by the media. Minority women, including African American women, face the compound risks of racial and gender discrimination, sometimes called

“double jeopardy” (Robinson & Howard-Hamilton, 2000). Women often possess multiple identities (including ethnicity, age, ability, SES, etc.) which interact in a complex manner (Stewart & McDermott, 2004); when women are able to appreciate these unique identities and become aware of the oppression they receive in society, they tend to be happier and healthier (APA, 2007).

African Americans.

African Americans exist in a lower position on the social hierarchy in the United States, making them a marginalized and disenfranchised group (APA, 2002). European Americans tend to have prejudicial attitudes toward African Americans (Baron & Banaji, 2006; Nosek et al., 2007), and may engage in racial microaggressions or other discriminatory behaviors (Sue et al., 2007). Symbolic racism, the belief that African Americans do not conform to an important White American Protestant symbols/values, may lead to bias (Crandall, 1994; Kinder, 1986).

Ongoing experiences of racism and systematic social inequities can negatively impact African Americans (APA, 2002; Krieger, 2003; Lamont, 2009). African Americans tend to be less healthy and have shorter life expectancies (Schnittker & McLeod, 2005). They utilize healthcare less frequently and have poorer outcomes than White Americans (Smedley, Stith, & Nelson, 2003). Discriminatory racial experiences have been linked to significant chronic stress and other chronic health conditions in African Americans (Kessler, Mickelson, & Williams, 1999; Puhl & Heuer, 2010), which increase a person’s risk for obesity (Chambers et al., 2004; Hunte & Williams, 2009; Tull et al., 1999). In addition, more African Americans may have to manage the chronic stress

of poverty, often leading to poorer health (Puhl & Heuer, 2010; Schnittker & McLeod, 2005).

Though obesity rates are fairly consistent among men of different racial groups, Black women are 61% more likely to be obese than White women (Burke & Heiland, 2008; Denny, Krueger, Rogers, & Boardman, 2004; Hill & Melanson, 1999; Robert & Reither, 2004). While obesity becomes more prevalent as SES decreases, there is still a statistically significant difference between White and Black women when SES is controlled (Robert & Reither, 2004). Having perceived experiences with racism raises the probability of obesity in African American women (Thomas, 2008), and about 24% of African American women and about 13% of African American men experience weight-related discrimination (Andreyeva, Puhl, & Brownell, 2008). Researchers (e.g., Bodenlos, Lemon, Schneider, August, & Pagoto, in press; Gavin, Rue, & Takeuchi, 2010) have found racial/ethnic differences in the presence of psychopathology comorbid with obesity (Bodenlos et al., 2011; Gavin, Rue, & Takeuchi, 2010).

Fat in America

Feminists and other researchers have focused on studying body image, weight status, and eating disorders, particularly in women (Chrisler, 2012; Fikkan & Rothblum, 2011). They seek to expose how emotional and psychological pressure to be thin can often result in negative body image and eating disordered behaviors. Melcher and Bostwick (2001) stated that many of these potential psychological and psychosocial issues may occur because of the pressures of being fat in a society that highly values thinness.

Body image.

Grogan (1999) defined body image as “a person’s perceptions, thoughts and feelings about his or her body” (p. 1). The prevalence of “the fear of fat” may explain the fact that almost 60% of U.S. women are currently dieting (Neumark-Sztainer et al., 2000). Compared to men and boys, women and girls are almost nine times more likely to have body image disturbance and eating disorders (Stice, Burton, & Shaw, 2004).

Many people, particularly women, tend to evaluate their self-worth in terms of their appearance (Sabik, Cole, & Ward, 2010). Body dissatisfaction tends to be the most pronounced in heterosexual White/European women and homosexual men (Cash & Pruzinsky, 2002; Gettelman & Thompson, 1993; Wildes, Emery, & Simons, 2001). Women are more likely than men to perceive themselves as overweight (Paeratakul, White, Williamson, Ryan, & Bray, 2002). About half of the women in the United States are unhappy with their bodies (Cash & Henry, 1995) and about one-third of women are trying to lose weight (Serdula, Williamson, Anda, & Levy, 1994). White women are more likely to believe that they are overweight than Black women (Paeratakul et al., 2002). A person’s SES may also correlate with his/her attitudes about fat. For females, as SES increases, women’s attitudes toward obese individuals become more negative; higher SES individuals are more likely to view themselves as overweight (Allison, Basile, & Yunker, 1991; Paeratakul et al., 2002).

Women tend to internalize societal messages which strongly encourage being thin, while men tend to feel better about their own weight status and have external anti-fat attitudes toward women (Aruguete, Yates, & Edman, 2006). Objectification Theory (Fredrickson & Roberts, 1997) suggests that people are influenced by social forces and

the media which cause them to see themselves “from a critical, external perspective, and then compare their own bodies to an unrealistic ideal that is reflective of social norms and stigmas” (Reel et al., 2008, p. 323). That is, women begin to see themselves as objects, compare themselves to other objects, and often feel shame and anxiety. The more a woman internalizes a thin ideal and identifies with the other “objects,” the more shame and body image disturbance she will experience. Oehlhof (2012) found evidence of self-objectification in both overweight and obese women.

Studies (e.g., Bergstrom & Neighbors, 2006; Cash & Pruzinsky, 2002) emphasize the importance of socio-cultural pressures to be thin and their corresponding psychological issues. Specifically, body dissatisfaction can lead to a variety of problems with body image disturbance and related psychosocial issues including eating disorders (Bergstrom & Neighbors, 2006; Cash & Pruzinsky, 2002). In addition, people who have more deeply internalized negative stereotypes about fat or have been “stigmatized” by it may binge eat more often (Durso et al., 2012; Puhl, Moss-Racusin, & Schwartz, 2007). The portrayal of women in the media may greatly contribute to body image problems (Fouts & Burggraf, 1999; Fouts & Burggraf, 2000; Greenberg & Worrell, 2005).

Fatness and body image.

Research (e.g., Schwartz et al., 2006) has suggested that many people would go to extreme lengths to avoid fatness; in fact many reported that they would actually be willing to give up one year of their life or to be divorced to avoid being “obese.” Schwartz and Brownell (2002), however, described the wide range of potential body image perceptions held by people who are obese. Not all fat individuals have poor body image. Becoming fat at a young age, suffering stigmatization and discrimination, having

a history of weight-related teasing and criticism, having a history of weight cycling, having a high degree of obesity, having a strong investment in physical appearance, and being a woman are all risk factors for higher levels of body image dissatisfaction, body image disturbance, and associated psychological and behavioral problems (Schwartz & Brownell, 2002). Body image dissatisfaction correlates with depression in obese, middle-aged women (Gavin, Simon, & Ludman, 2010) and has been linked to an increase in binge eating symptoms (Barker & Galambos, 2007; Cash & Pruzinsky, 2002).

Feminists state that evaluations of body size are culturally bound and created by culture; negative attitudes toward people who are obese are the “norm” (Bordo, 1993). Women, a historically marginalized group, suffer more through the pervasive bias against “fat” body types. For example, when overweight women were rejected by an attractive male, they tended to blame the rejection on their weight (Crocker, Cornwell, & Major, 1993). They did not consider the man prejudicial and blame him; they tended to blame themselves. Furthermore, fat women are less likely to engage in routine medical care, even screening for serious illness (Amy, Aalborg, Lyons, & Keranen, 2006; Rothblum & Solovay, 2009).

Fikkan and Rothblum (2011) asserted that the media is likely playing a prominent role in fat women’s stigmatization. Specifically, media shows consistent tendencies to make fat women underrepresented/invisible (by focusing on underweight and non-fat characters) and to focus on fat women’s weight as a plot line, as a reason for sympathy, or as something comical (Fouts & Burggraf, 1999; Fouts & Burggraf, 2000; Greenberg, Eastin, Hofschire, Lachlan, & Brownell, 2003; Himes & Thompson, 2007; Hussin, Frazier, & Thompson, 2011). Researchers (e.g., Fouts & Burggraf, 1999) have claimed

that this tendency in the media may serve as a model for people in real life, leading people to comment positively on thin women and to comment negatively on larger-sized women.

African American women, body image, and fatness.

Celio, Zabinski, and Wilfley (2002) stated that “there appears to be a more flexible standard of attractiveness and a wider range of acceptable weights and shapes among blacks as compared to whites” (p. 234). While White women tend to aspire to a very thin body shape and prefer one in others, Black women tend to believe that moderate and larger body sizes are attractive and “sexy” (Celio et al., 2002; Flynn & Fitzgibbon, 1996; Jackson & McGill, 1996). Black women tend to diet less frequently, be more satisfied with their current weight, feel less appearance-related shame, and have a more positive body image than European, Asian, and Hispanic American women (Breitkopf, Littleton, & Berenson, 2007; Gluck & Geliebter, 2002; Guilford-Davenport, Kumanyika, & Wilson, 1993; Paeratakul et al., 2002; Striegel-Moore et al., 2000; Wildes, Emery, & Simons, 2001). Unlike White women, Black women do not tend to view higher weight status as indicative of personality flaws (Hebl & Heatherton, 1998). Black women tend to believe that Black men also desire moderate and larger body sizes, and research on Black men has supported this belief (Jackson & McGill, 1996). In fact, Black people in general have lower levels of automatic/implicit pro-slim biases than all other racial groups (Nosek et al., 2007).

A difference in cultural norms and social pressures may explain research findings that African American women tend to feel better about their bodies (Cash & Henry, 1995). Black women may not internalize the mainstream pressures to be thin and may

instead focus on personality, attitude, and uniqueness (Breitkopf et al., 2007; Jefferson & Stake, 2009). They may reject White cultural influences and have different cultural ideals for body image, protecting them from negative body image (Hebl & Heatherton, 1998; Jefferson & Stake, 2009). Differences may also stem from that fact that there are fewer ultra-slim African American female images in the media, and Black women may reject White images because they do not relate to them (Jefferson & Stake, 2009). African American individuals may adhere less strongly to the conservative and Protestant value systems that are more generally held by White Americans, which might make larger body size more acceptable in their culture (Hebl & Heatherton, 1998). Larger-sized bodies may also be more acceptable because they were signs of health and wealth in their African ancestors' cultures (Ofosu, Lafreniere, & Senn, 1998).

Hebl, King, and Perkins (2009) found preliminary research support for the Disidentification Theory (Steele, 1997) as a way to describe differences between Black and White people's body image evaluations and weight expectations. According to this theory, "when stigmatized individuals experience threat in a domain, they begin to disengage from and ultimately disidentify from valuing the domain" (Hebl et al., 2009). Black people may tend to disengage from the White value of thinness because they believe that "their group is falling short of a standard that is evaluative of their self-worth" (Hebl et al., 2009, p. 1170-1171).

A more salient ethnic identity may also contribute to positive body image in African American women, regardless of weight status (Celio, Zabinski, & Wilfley, 2002). When African American women scored in the pre-encounter stage of the Racial Identity Model (Helms, 1990), meaning that they primarily identify with White culture, they

tended to have poorer body image and more eating disordered symptoms (Abrams, Allen, & Grey, 1993). African American women may be buffered from negative body image in later identity development stages if they identify with their own group (Sabik, Cole, & Ward, 2010). Granberg, Simons, and Simons (2009) found that Black teenage girls who received more racial socialization at home, in that their family taught them to take pride in their ethnicity, culture, and history, tended to have a more positive self-image. Young African American women may also experience a protective “social context” effect (Root, 1990; Rosenberg & Simmons, 1971) because they tend compare themselves only to others within their own group and because the group members tend to focus on the positive aspects of one another. By comparing themselves only within their group, young African American women tend to feel more positive about their appearance and tend to give/receive less negative feedback (Root, 1990). African American women may be able to cope with fat discrimination by shifting to a more salient African American identity over an identity as female (Lamont, 2009; Mossakowski, 2003). This shift may protect them from the pressures to be thin, leading to better psychological outcomes.

Several feminist authors (e.g., Beauboeuf-LaFontant, 2003; Lovejoy, 2001; Root, 1990; West, 1995) have described the way in which historical images of Black women and systems of oppression have influenced current African American women’s body image. The historical Black Southern slave figure of “Mammy” is associated with maternal, nurturing, self-sacrificing, and family-oriented traits in Black women, and is usually pictured as obese, dark-skinned, and poor (West, 1995). While this traditional image may influence the way women picture their own bodies, authors (e.g., Root, 1990) have suggested that others may wish to create distance between themselves and this

image. Recurring experiences of oppression, an over-identification with the notion of being a strong Black woman, and an unwillingness to openly express personal pain and suffering may lead to comfort-related over-eating and binge eating by African American women (Beauboeuf-LaFontant, 2003; Walcott-McQuigg, Sullivan, Dan, & Logan, 1995). Beauboeuf-LaFontant (2003) expressed that the acceptance of a large, strong Black woman lifestyle could also indicate a passive acceptance of the lower hierarchical status and double-jeopardy of being an African American woman.

While Black culture may tend to emphasize self-acceptance regardless of weight status, African American women also describe private personal desires to manage weight (Baturka, Hurnsby, & Schorling, 2000; Lovejoy, 2001; Reel et al., 2008). Pro-thin influences from majority White culture may still lead to body image problems in some Black women (Striegel-Moore & Smolak, 1996; Root, 1990). According to Grant et al. (1999), many low-SES, African American adolescents do have poor body image and report that they would like to lose weight.

Feminists and fat.

Early publications by feminists (Orbach, 1978; Wooley, Wooley, & Dyrenforth, 1979) helped to launch awareness of the problems faced by fat people. Additional pro-fat advocates, members of a Fat Acceptance movement which began in the late 1960s, were part of organizations such as the Fat Underground (Wann, 2009). Today, many pro-fat organizations including the National Association to Advance Fat Acceptance (NAAFA), the International Size Acceptance Association (ISAA), the Council on Size and Weight Discrimination, the National Organization of Lesbians of Size (NOLOSE), and the Chubsters exist and welcome members regardless of body size, gender, race, and other

categories of human diversity (Fikkan & Rothblum, 2011; Saguy & Ward, 2011). Writers and researchers (e.g., Wann, 1999) have just recently begun larger-scale efforts to direct more attention to the experiences of people (particularly women) who are fat (Fikkan & Rothblum, 2011). The recent feminist-led, multidisciplinary field of Fat Studies is dedicated to researching, advocating, and teaching about the hardships faced by fat people (Rothblum & Solovay, 2009). These hardships include society's prevalent anti-fat attitudes, avoidance, and discrimination toward people who are fat, the discriminatory attitudes of the health care field and the harmfulness of the "war on obesity," and the harmful behaviors of the diet industry and the media (Boero, 2007; Rothblum & Solovay, 2009; Wann, 2009). In addition, Fat Studies focuses on ways to embrace fatness and on social justice possibilities including activism (Rothblum & Solovay, 2009; Wann, 2009).

According to Puhl and Brownell (2003b), a fat person can cope with stigmatization by embracing the positive aspects of being fat. Joining fat acceptance groups could contribute to coping by creating a positive in-group identity and through the potentially helpful influences of social activism (Puhl & Brownell, 2003b). In addition, evidence (e.g., Muennig, 2008; Lamont, 2009) suggests that fat acceptance may help improve an individual's physical and mental health. Saguy and Ward (2011) described a new phenomenon of "coming out as fat," much like non-heterosexual individuals "come out." In coming out as fat, people (usually White women) become fat-affirming, declaring to all that they embrace the way they look, refuse to avoid "thin people" activities (e.g., going to the gym, eating what they enjoy at restaurants, wearing certain types of clothing), and are no longer trying to "pass" as on-the-way-to-normal-weight-people by dieting.

The problem, however, is that most people, especially White women, do not embrace fat acceptance. According to Saguy and Ward (2011), unlike African Americans or gay individuals, “the fact that the fat acceptance movement is *not* grounded in cohesive social groups with their own practices, values, and culture is, we would argue, the reason why the movement has not yet developed a strong counter-culture and why coming out as fat is more about rejecting negative stereotypes than about affirming group practices, beliefs, or values” (p. 69). Therefore, most women do not have the comforting and empowering experience of connecting with pro-fat groups or of fully embracing their fat identity.

Fat stigma.

There is considerable evidence (e.g., Andreyeva, Puhl, & Brownell, 2008) that large-sized people frequently endure prejudice and discrimination. The prevalence of anti-fat attitudes has increased by 66% in the past ten years, making it comparable to rates of racial discrimination (Andreyeva et al., 2008; Latner & Stunkard, 2003). In the general population, about 5% of men and 10% of women are discriminated against because of their weight, but rates are closer to 40% for individuals who have BMI levels over 35 (Puhl, Andreyeva, & Brownell, 2008). Women are three times more likely than men to experience anti-fat discrimination (Andreyeva et al., 2008).

Research has shown that this stigmatization is based on widely held negative social attitudes (Crandall, 1994; Puhl & Huer, 2009). According to Brownell (2005), a majority of people may believe that weight status is entirely within the control of the individual, that avoidance and discrimination are acceptable, that anti-fat biases help fat people to lose weight, that working to eliminate bias would worsen the “obesity

epidemic,” and that discriminating against fat people is therefore justified. In fact, *sizeism*, or discriminatory practices directed at people who are perceived as fat, appears to be the only form of discrimination that remains socially acceptable (Puhl & Brownell, 2001).

Fat people face discrimination in the work place, in relationships, in housing, in public policy, in social norms, in health care, and in almost all other domains; this discrimination also persists across the lifespan (Puhl & Heuer, 2010). Derogatory language, like “lazy, slow, and stupid” are, in some cases, openly used to denigrate people who are fat (Swami et al., 2008). In addition to well-documented anti-fat attitudes in the general public, biases have been identified in medical professionals (e.g., Brandsma, 2005; Garner & Nicol, 1998; Harvey & Hill, 2001; Pun & Tarrant, 2009) and educators (Neumark-Sztainer, Story, & Harris, 1999), which likely contribute to inferior education and health care disparities. People who are fat are oppressed by society but have been denied laws to protect them, unlike people of minority religious, racial, ability, and sexual identities (Kristen, 2002). Based on the combination of these elements, the discrimination against fat people is likely to continue. While significant and influential progress has been made regarding bias against women and African Americans, anti-fat bias has gone largely unexamined and without confrontation (Brownell, 2005). Anti-fat bias and discrimination will be discussed in more detail in Chapter 2.

Mental Health Professionals and Fat Clients

Because of the large number of fat Americans and the potentially harmful psychosocial correlates of being fat, mental health professionals are likely to frequently encounter clients who are fat. According to Rothblum (1999), “psychologists have a

major role in perpetuating errors and inconsistencies related to body weight” (p. 355).

While research (e.g., Gaesser, 2002) has detailed the dangers of dieting and poor body image, mental health professionals appear to be focusing primarily on how to assist clients in losing weight (Abakoui & Simmons, 2010; Rothblum, 1999). “Treating” clients for obesity, even though it is not a form of psychopathology, is common (e.g., Cooper, Fairburn, & Hawker, 2003; Fairburn & Brownell, 2002). Some (e.g., Abakoui & Simmons, 2010) have suggested that weight loss techniques in therapy may constitute incompetent and unethical practice, particularly because of the lack of empirical support for dieting and because of the possible negative outcomes of dieting (Gaesser, 2002). Rothblum (1999) stated that failing to provide clients with proper informed consent (e.g., sharing with them the high improbability of permanent weight loss, the myriad serious risks of dieting, and the negative psychological outcomes that can occur when clients fail) is unethical behavior.

According to Davis-Coelho, Waltz, and Davis-Coelho (2000), “Western mental health professionals are practicing in a culture in which bias and discrimination against fat people are the norm” (p. 682). Since the public holds strong negative attitudes toward people who are obese, it seems probable that mental health professionals also hold these negative attitudes toward people who are fat. Classic psychotherapy research (Gauron & Dickinson, 1969; Meehl, 1960) identified the way that visible characteristics of a client, including gender, age, and weight status, can have a major impact in the initial meeting with a client, influencing the way a therapist interacts with the client, conceptualizes the client, and formulates a diagnosis (Zadroga, 2009). Recent research (Abakoui, 1998; Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Hassel et al., 2001; Loewy, 1995;

Locker, 2011; Young & Powell, 1985; Zadroga, 2009) on anti-fat biases in mental health professionals has begun to confirm the existence of and describe the extent of anti-fat biases against clients. Researchers (e.g., Hassel et al., 2001) have declared that mental health professionals must examine their own anti-fat biases and consider the ways in which these personal beliefs influence their work. According to Aza (2009), “clinicians need to be aware of the social climate around fat when a woman of size enters the room and be sure to notice their countertransference in relation to it” (p. 14).

Mental health professionals who understand the lived experiences of fat clients are scarce (Abakoui & Simmons, 2010). Adopting a HAES perspective and assisting clients in accepting their size (see Erdman, 1995) may be essential components of competent and appropriate treatment (Abakoui & Simmons, 2010; McHugh & Kasardo, 2012). Fairburn and Brownell (2002) postulated that supportive therapeutic styles and a strong therapeutic relationship may be particularly valuable in mental health professionals who treat fat clients.

A multicultural perspective, one which requires consideration of the lived experiences of clients based on their membership in oppressed groups, may be useful in considering the problem of anti-fat biases in psychologists. In multicultural counseling, counselors focus on clients who have been marginalized and discriminated against in society, such as ethnic minority groups, women, sexual minorities, older adults, gender minorities, people with disabilities, and certain religious groups (Lee, 2007). There is considerable evidence that fat people frequently experience multi-level discrimination based on their weight status (e.g., Andreyeva et al., 2008; Kristen, 2002). Several pro-fat researchers and writers (e.g., Fikkan & Rothblum, 2011) have described fat people as a

marginalized group in the United States and suggest “putting size in the context of diversity similar to sexual orientation and race” (Abakoui & Simmons, 2010, p. 333). A chapter on *sizesim*, or discrimination based on weight, appeared in a recent multicultural counseling handbook for therapists and psychologists (Cornish et al., 2010).

The American Psychological Association’s (2002) *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (hereafter referred to as the APA Multicultural Guidelines) have outlined several standards for psychologists to employ with people from ethnic and racial minority groups. Although fat people, along with people with disabilities, are not part of the document’s purview, it is mentioned that there is “emerging data about the different needs for particular individuals and groups historically marginalized or disenfranchised” (p. 2). Because there is evidence of a pervasive pattern of discrimination against and prejudice toward people who are fat (see Andreyeva, Puhl, & Brownell, 2008; Kristen, 2002), several researchers (e.g., Abakoui & Simmons, 2010; Fikkan & Rothblum, 2011) have recently described fat people as a marginalized group for which it is reasonable to use the APA Multicultural Guidelines as an outline for treatment.

According to the first of the APA Multicultural Guidelines, psychologists must recognize that they have personal beliefs against other groups; these potentially derogatory beliefs can influence their relationships with members of those groups (APA, 2002). When therapists see clients, they not only notice the way clients present and interact interpersonally, but also take in information about clients’ personality, appearance, gender, age, ethnicity, and disability status (Kunda & Thagard, 1996). Taking in and making sense of this information can lead to the psychologist using

stereotypes and automatic biases to organize information (Kunda & Thagard, 1996). While research (Abakoui, 1998; Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Hassel et al., 2001; Loewy, 1995; Locker, 2011; Young & Powell, 1985; Zadroga, 2009) has identified the presence of anti-fat biases in therapists, more investigation is necessary to further describe these biases.

The second of the APA Multicultural Guidelines states that “psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding” (APA, 2002, p. 27). In accordance with this guideline, psychologists must have an awareness of the oppression and marginalization that many people experience. Because of the well-documented pattern of discrimination against and prejudice toward people who are fat (e.g., Andreyeva et al., 2008; Kristen, 2002), it may be important for psychologists to follow this guideline when working with fat clients. Furthermore, psychologists must be educated about the lived experiences of people in this group, including their stigmatization, dieting risks, societal pressures, discrimination, and other issues.

Accepting a multicultural framework would correspond to the recommendations of the APA Ethical Principles and Code of Conduct of Psychologists (APA, 2010) (hereafter referred to as the Code). Psychologists must work only with populations with whom they are competent, and must have an understanding of and experience in specific issues that apply to those populations (APA, 2010; Welfel, 2012). Principle A of the Code requires competence to work with diverse populations. It is reasonable to conclude that competence in clinical situations with fat clients includes possessing specialized knowledge of and competence in fat-related issues. Psychologists with knowledge

regarding the lived experiences of fat clients and with knowledge of specific interventions for these unique problems would likely be in a position to provide better services than those lacking knowledge. Furthermore, actions based on unexamined anti-fat biases and inaccurate or incomplete information may be in violation of the Code. Connors and Melcher (1993) suggested that encouraging fat therapy clients to lose weight may be unethical because it does not show respect for diversity (in this case, diversity in body size). In addition, Principle D of the Code emphasizes the rights of clients, Principle E of the Code mandates the avoidance of harm to clients, and Principle F of the Code states that psychologists should have an ongoing commitment to social justice (APA, 2010). Davis-Coelho et al. (2001) stated that trying to eliminate the influence of anti-fat biases on their work was an extremely important ethical consideration for psychologists.

In the field of psychotherapy, only eight quantitative studies (Abakoui, 1998; Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Hassel et al., 2001; Loewy, 1995; Locker, 2011; Young & Powell, 1985; Zadroga, 2009) have examined whether therapists hold anti-fat biases toward their fat clients. The existing research (e.g., Abakoui, 1998; Davis-Coelho et al., 2000; Young & Powell, 1985) has suggested that therapists tend to have biases against fat clients, tend to be more likely to diagnose them with Axis II disorders and or other dysfunction, and tend to believe they will have a worse prognosis. Crandall and Reser (2005) stated that “it is the prevalence and power of this prejudice, and its concomitant discrimination that makes research on anti-fat attitudes so important” (p. 84). Only one study, Locker (2011), has examined the influence of client weight status (thin/obese) and client ethnicity (European American/African American) on psychologists’ bias. Locker (2011), however, included non-psychologist participants in

her sample. Therefore, no study has looked specifically at psychologists and their anti-fat bias against female clients who vary by ethnicity.

The Current Study

This study examined psychologists' anti-fat biases toward female clients and the extent those biases varied based on client's ethnicity (African American and White American). It added to the existing body of research (Abakoui, 1998; Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Hassel et al., 2001; Loewy, 1995; Locker, 2011; Young & Powell, 1985; Zadroga, 2009) on therapists' anti-fat biases. This study addressed an important gap in the literature: examining psychologists' anti-fat biases toward female clients and the extent those biases may vary based on client ethnicity (African American and European American). African Americans and women were chosen for study because they are socially oppressed groups in the United States (APA, 2002; APA, 2007), and because there is only one study (Locker, 2011) that has focused on female clients' ethnicity as it relates to anti-fat biases in psychologists. The more these biases are identified and publicized, the more likely members of the field will be to examine their own attitudes and biases in order to promote more effective treatment and social justice. In addition, this study is part of a continuing effort to answer the call of Puhl and Brownell (2001), who noted the great importance of conducting research on weight-related discrimination that takes variables such as sex, race, and ethnicity into account. This study also supported McHugh and Kasardo's (2012) recommendation: to push the field of psychology to engage in more anti-fat prejudice "explication, education and eradication" (p. 617).

CHAPTER II

REVIEW OF THE LITERATURE

This chapter will provide a review of the literature on anti-fat attitudes. First, literature from studies on anti-fat bias in the general public, including measurement of anti-fat bias, workplace obesity discrimination studies, and theories of anti-fat bias, will be examined. Second, this chapter will examine studies from other professional fields, including studies on physicians, nurses, and teachers, which provide evidence that professionals in these fields hold biases against fat people. Third, publications and research studies that have examined psychologist and/or counselor bias against fat clients will be examined. After the literature is reviewed, the need for the study, the purpose of the study, and the study's research questions will be stated.

Anti-fat Bias in the General Population

A growing body of literature has shown that people in the United States and in other Western cultures tend to hold negative attitudes toward people who are obese (Puhl & Heuer, 2010). Over the past 40 years, anti-fat attitudes have become more prevalent (Latner & Stunkard, 2003) while research (e.g., Bobo, 2001) has demonstrated decreases in prejudice against other groups. In fact, researchers (Andreyeva et al., 2008) estimated that anti-fat bias leading to discrimination has increased by 66% in the past ten years,

making levels of sizeism comparable to rates of racial discrimination. About 5% of men and 10% of women are discriminated against because of their weight; however, when individuals have higher levels of obesity (usually measured as BMI greater than 35), nearly 40% report weight-related discrimination (Puhl et al., 2008). Heavy women are three times more likely than heavy men to experience weight-related discrimination, and women's rates worsen as their weight increases (Andreyeva et al., 2008).

Prejudicial anti-fat beliefs harm fat people in career settings, educational settings, health care settings, and most other life domains, including interpersonal interactions (Puhl & Heuer, 2010). Interpersonal forms of sizeism, including name-calling, occur most frequently (Andreyeva et al., 2008), but more severe discrimination can extend to interpersonal situations such as selection of romantic partners. For example, men are more likely to date a woman with chemical dependency/addiction than a woman who is obese (Sitton & Blanchard, 1995). Anti-fat attitudes have also been shown in children and adolescents (Morrison, Roddy, & Ryan, 2009). This section will focus on anti-fat biases primarily in adult populations. Anti-fat biases, however, have been shown to exist in children as young as three and are also prevalent in child and adolescent populations (for a full review see Puhl & Latner, 2007).

Measurement of anti-fat biases.

Research assessing anti-fat attitudes in the general public tends to rely on explicit or implicit measures (Morrison et al., 2009). Explicit measures directly ask participants to report their attitudes, while implicit measures test for responses that are automatic and emotion-based (Morrison et al., 2009). Explicit measures are likely to be influenced by the desire to give socially desirable responses, while implicit measures are designed to

assess more unconscious or unedited attitudes (Morrison et al., 2009). Some studies utilize explicit, general measures of biases (not focused on anti-fat bias) in order to create less face valid conditions. In addition, Hebl and Dovidio (2005) argued that interactive studies are also important in assessing fat stigma.

Explicit measures of anti-fat bias.

Several scales have been created to measure explicit anti-fat bias. According to Morrison et al. (2009), the four most common explicit measures are the Anti-Fat Attitudes Questionnaire (AFA; Crandall, 1994), the Anti-Fat Attitudes Scale (AFAS; Morrison & O'Connor, 1999), the Anti-Fat Attitudes Test (AFAT; Lewis, Cash, Jacobi, & Bubb-Lewis, 1997), and the Fat Stereotypes Questionnaire (FSQ; Davison & Birch, 2004). Semantic Differential Scales, where participants select from a 7-point, Likert-type scale assessing various characteristics through polarities (e.g., smart/stupid, good/bad, motivated/lazy), are explicit measures that have also been used to assess anti-fat bias (see Gapinski, Schwartz, & Brownell, 2006; Smith, Schmoll, Konik & Oberlander, 2007).

Most explicit measures are self-report, face valid scales. The Attitudes Toward Obese Persons (ATOP) Scale (Allison, Basile, & Yuker, 1991) measures three factors: (a) different personality: attributing negative personality traits to obese people, (b) social difficulties: believing obese people encounter social difficulties, and (c) self-esteem: believing that obese people have low self-esteem. The AFA (Crandall, 1994) helped determine that anti-fat bias can function in the same way as symbolic racism (in which prejudicial attitudes stem from perceived unwillingness to live up to an American Protestant work ethic) and that most people tend to blame fat people for their own weight status. The AFAT (Lewis et al., 1997) measures (a) social/character disparagement:

beliefs about whether fat people have socially undesirable characteristics, (b) physical/romantic unattractiveness: beliefs about whether fat people make good prospective romantic partners, and (c) weight control/blame: beliefs about whether fat people are to blame for their weight status. The AFAS (Morrison & O'Connor, 1999) is a very short measure of anti-fat attitudes.

All of these measures have been used to provide evidence that most Americans, but especially males and White women, tend to stigmatize fat. Furthermore, these biases are extremely strong, even stronger than anti-Muslim and anti-gay bias (Latner, O'Brien, Durso, Brinkman, & MacDonald, 2008). Morrison et al. (2009) reviewed the available explicit, self-report measures of anti-fat bias and concluded that the AFA, AFAS, AFAT, and ATOP are the most "reasonable choices" for researchers (p. 106).

Several researchers (e.g., Harvey & Hill, 2001; Hebl & Xu, 2001; Puhl, Wharton, & Heuer, 2009; Vroman, & Cote, 2011; Wade, Loyden, Renninger, & Toby, 2003) have used general explicit measures of bias (instead of the aforementioned measures focused on anti-fat biases) to measure anti-fat attitudes in ways that are not face valid. For example, Wade et al. (2003) examined whether personality halo effects (in this case, more positive attitudes toward a person based on lower weight status) were present in White university students. Researchers obscured the purpose of the study by claiming to be assessing differences in person perception accuracy in naive undergraduates compared to trained clinicians. In their first study, they presented participants with a vignette and photograph as information about a woman (a 4 x 4 matrix design examined Black or White by thin or overweight) and asked them to rate the individual on assorted personality traits and on attractiveness. Traits were rated on a researcher-created, seven-

point Likert-type measure using polarities (e.g., 1 = unattractive, 7 = attractive). In their second study, they used the same methods except that attitudes were assessed using the Interpersonal Adjectives Scale (Trapnell & Wiggins, 1990) which assesses traits based on the Big-5 personality dimensions. Researchers found significant halo effects for White women, in that both male and female participants rated normal Weight white women as having more socially desirable and positive personality traits than overweight white women. They interpreted these findings by suggesting that people view beauty in White women as being associated with thinness. This type of design may be better suited to access anti-fat biases than face valid, self-report measures (Fabricatore, Wadden, & Foster, 2005).

Several researchers (e.g., Morrison et al., 2009; Wang, Brownell, & Wadden, 2004) have documented the limitations of explicit, self-report measures. Even though anti-fat attitudes are prevalent, many people are influenced by social desirability (wanting to look good) or believe that outward expression of negative attitudes is inappropriate (Teachman & Brownell, 2001; Wang et al., 2004). The fact that most of these explicit, self-report instruments are highly face valid and allow people to choose to give socially desirable responses may be their greatest weaknesses. Study design that lessens face validity may lead to more accurate results.

Other measures have been used to assess explicit bias including having participants rank others based on pictures depicting body weight, asking participants to generate adjectives to describe pictures depicting various weight statuses, and asking participants to rank “with whom they would most like to be friends” based on pictures or actual people with varying weight status (Morrison et al., 2009; Swami et al., 2008).

Limitations of these methods are rooted in visual stimuli: pictures and line drawings may not be accurate, attractiveness bias may confound investigation of weight status, forced-choice procedures may lead to arbitrary/mindless selection, and that some of the methods (particularly ranking likelihood of friendship) seem to be appropriate only with child participants (Morrison et al., 2009).

Implicit measures of anti-fat bias.

Because of the problems with face validity and social desirability that influence most explicit measures, researchers (e.g., Teachman, Gapinski, Brownell, Rawlins, & Jeyaram, 2003) have recently employed implicit measures to assess bias. Implicit measures evade conscious blocks and are able to assess automatic bias (Morrison et al., 2009). There are two major types of implicit measures that have been used in studies to assess anti-fat bias: the Lexical Decision Task and the Implicit Association Test, both of which often require *in vivo* participants in a laboratory setting.

In the Lexical Decision Task, participants are presented with a series of words and non-words, and they have to quickly determine whether the stimulus is a word or a non-word. People tend to have a quicker reaction time if a word for a positively stereotyped group (e.g., White, thin) is followed by an “expected” descriptor (e.g., ambitious, confident) and if a negatively stereotyped group (e.g., Black, fat) is followed by an “expected” descriptor (e.g., lazy, insecure) (Bessenoff & Sherman, 2000; Wittenbrink, Judd, & Park, 1997). The reaction time is measured, and the strength of the implicit bias held by participants has been correlated with explicit behavioral reactions. For example, Bessenoff and Sherman (2000) correlated strong implicit anti-fat attitudes with a participant’s tendency to sit further away from an obese person in a waiting room, and

vice versa. They also found that implicit measures of anti-fat attitudes had higher predictive validity than explicit measures (Bessenoff & Sherman, 2000).

The Implicit Association Test (IAT; Greenwald, McGhee, & Schwartz, 1998) was developed as a laboratory tool to assess implicit attitudes and is the most frequently used implicit measure in research (Morrison et al., 2009). When the task is computerized, participants must quickly categorize the words that flash on the screen into four groups (insect, flower, pleasant, or unpleasant) using keys on a keyboard. Participants first learn to use one key for insect-unpleasant and another key for flower-pleasant, and response time latencies are measured. Then, participants must switch and use one computer key for insect-pleasant and another key for flower-unpleasant, and researchers measure the time differences. Researchers can then adapt the task to utilize target words being studied for implicit biases (e.g., fat, thin, chubby, good, bad, lazy, etc.). There are also non-computer versions of the task where participants must quickly sort a pile of papers containing the stimulus words into the different groups (Lemm, Lane, Sattler, Kahn, & Nosek, 2008).

Many researchers (e.g., Gumble & Carels, 2012; Roddy, Stewart, & Barnes-Holmes, 2009; Teachman et al., 2003) have used the IAT to examine anti-fat biases. Using the IAT, implicit anti-fat stereotypes have been identified in about 69% of the general public, even when participants denied explicit anti-fat attitudes (Nosek et al., 2007; Teachman et al., 2003). IAT research (e.g., Brochu & Morrison, 2007) has shown that men tend to have stronger implicit anti-fat biases than women. Implicit anti-fat stereotypes exist even in professionals who frequently work with obese individuals, even when they deny explicit anti-fat attitudes (Teachman & Brownell, 2001). Implicit biases are a better predictor of prejudicial behavior toward overweight individuals than explicit

measures, and people have stronger implicit pro-slim biases than anti-fat biases (Roddy, Stewart, & Barnes-Holmes, 2009). Researchers (Domoff et al., 2012) have also linked watching the reality television show *The Biggest Loser* to increased levels of both implicit and explicit bias.

Interactive studies.

Schnittker and McLeod (2005) stated that much of the discrimination of stigmatized groups occurs at the “meso” or interpersonal level. Interactive studies (e.g., Hebl & Dovidio, 2005; Miller, Rothblum, Felicio, & Brand, 1995) assess the stigmatized individual, the non-stigmatized individual, and the interaction between them, often in real-life encounters or in laboratory-created interpersonal situations. For a more comprehensive review of interactive studies that demonstrated pervasive anti-fat attitudes, see Hebl and Dovidio (2005).

Interpersonal studies have made important contributions to the understanding of anti-fat attitudes. Hebl, Shaprio, Turner, Singletary, and King (2004) utilized an interactive methodology to find that store personnel spent less time with obese customers and gave them more negative treatment than non-obese customers. Crocker, Cornwell, and Major (1993) found that people who are obese tend to blame themselves when they receive negative feedback, instead of blaming the feedback on the prejudicial attitudes of others. Miller et al. (1995) found that obese women tend to be “nicer” to compensate for the social prejudice they encounter from non-obese interactional partners. Miller, Rothblum, Barbour, Brand, and Felicio (1990) found that even impartial raters, blindly assessing telephone conversations between two women, rated women who were actually obese as less likable, less attractive, and possessing fewer social skills.

Researchers have also demonstrated a “mere proximity” effect, where being seen interacting with an obese individual can stigmatize a non-obese individual. Hebl and Mannix (2003) found that simply being seen with an obese person can lower others’ desirability ratings for a male job applicant. Penny and Haddock (2007) showed evidence of the “mere proximity” effect even in five- to ten-year-old children.

Other study designs.

Some other valuable studies of anti-fat attitudes do not fit neatly into any of the above categories. For example, Crandall (1995) pulled relevant information from a general survey given to all students in an undergraduate introductory psychology course (without disclosing the actual intent of the research), including weight, height, source of funding for school, family income, race, and parents’ political views. Results were compared to national norms for BMI in the age group and the extent to which the university students’ BMI values corresponded with national norms. Findings suggested that thinner individuals were overrepresented in the university population and heavier individuals were underrepresented, that parents of thinner undergraduate women were more likely to fund a college education than parents of heavyweight undergraduate women, that there was no significant correlation between male undergraduates’ BMI and parental funding, and that heavyweight women who attended college tended to pay their own way. In addition to explicit and implicit study designs, this type and other types of alternative study designs may also be helpful in identifying anti-fat biases in the general population.

Fat African Americans and stigma.

According to Andreyeva, Puhl, and Brownell (2008), “few studies have examined the vulnerability to weight bias among different ethnic groups” (p. 998). As anti-fat stigma against African Americans is of particular interest in the present study, this section will review the scarce relevant research, including studies that show significant discrepancies between European American and African American holders of anti-fat bias and targets of anti-fat bias.

Studies (e.g., Neumark-Sztainer, Story, & Faibisch, 1998) indicate that African Americans are often the targets of anti-fat stigma and discrimination. About 24% of African American women and about 13% of African American men experience weight-related discrimination (Andreyeva et al., 2008). Carr, Jaffe, and Friedman (2008) studied perceptions of interpersonal weight-related stigmatization in a national sample. They found that, in general, the more obese the individual, the more stigmatizing experiences reported. In very obese African American men, however, higher weight status did not correlate with more stigmatizing experiences. Some research (Averett & Korenman, 1996, 1999; Cawley, 2004; Heiland & Ali, 2010) has supported the fact that fat African Americans experience less fat stigmatization than White Americans. Hebl and Turchin (2005) found that, while obese Black men are still stigmatized, stigma is much more severe for obese White men.

Black people may hold fewer anti-fat biases than other groups. Latner, Stunkard, and Wilson (2005) found that African American female college students showed the lowest levels of anti-fat stigma. According to Hebl and Heatherton (1998), while Black women tended to rate obese women as less desirable than physically than slimmer

women, they did not automatically believe that obese women had any personality flaws. White women differed substantially, tending to believe that obese women—especially obese White women—were “lower in attractiveness, intelligence, popularity, happiness, relationship success, and job success” (p. 423).

The most anti-fat bias research (e.g., Heiland & Ali, 2010) has been completed on comparisons between female African Americans and female European Americans. In general, Black women receive less body-related stigmatization than White women (Hebl & Heatherton, 1998; Schooler, Ward, Merriwether, & Caruthers, 2004; Wade et al., 2003), and people may find larger Black females more attractive than larger White females (Heiland & Ali, 2010). People may believe that fat White females have undesirable personality traits, but may not believe that fat Black females have undesirable personality traits (Hebl & Turchin, 2005). When judging White women, participants tended to believe that a thin woman was more attractive, had a better personality, and was more successful in life than a heavy woman; when judging Black women, participants tended to believe that heavier Black women had better personalities and were more successful in life than thin Black women (Wade & DiMaria, 2003; Wade et al., 2003). While obese White females tend to be less likely to date, less likely to get married, and tend to have spouses who make less money, obese Black females do not have similar disadvantages (Averett & Korenman, 1996, 1999; Heiland & Ali, 2010).

Many questions remain regarding the relationship between bias and the “triple jeopardy” of multiple stigmatized traits (female, African American, fat). According to Fikkan and Rothblum (2011), it is unclear whether Black women experience more discrimination because they tend to weigh more or whether culture and stereotypes make

it more acceptable for Black women to have higher weights, leading to less discrimination. Fikkan and Rothblum (2011), however, cautioned that the discrimination that Black women receive for other reasons, such as their race or their status as females, may simply overshadow their perception of size discrimination, not imply that it is not present. White, O'Neil, Kolotkin, and Byrne (2004) found that, of obese White and Black Americans, White women reported that they had the poorest quality of life. Because White women actually had lower rates of obesity than the other study groups, researchers theorized that their poor quality of life might be correlated with having to face more hardships than are faced by males or African Americans. Overall, fat African American women may suffer less social stigmatization and have better body image than fat European American women (White et al., 2004).

Anti-fat discrimination in the world of work.

A person's status as fat can negatively influence success in the world of work (Fikkan & Rothblum, 2005; Li & Rukavina, 2009; Roehling, 1999). Discrimination has been demonstrated at all stages of employment including selection, placement, compensation, promotion, discipline, and discharge (Roehling, 1999, p. 982). As a person's weight increases, his/her probability of experiencing discrimination also increases: overweight people were 16 times more likely, obese people 37 times more likely, and severely obese were 100 times more likely to experience discrimination (Roehling, Roehling, & Pichler, 2007, p. 300). Fat women experience significantly more discrimination in work settings than fat men (Fikkan & Rothblum, 2005). According to Roehling et al. (2007), "women are over 16 times more likely than men to perceive employment related discrimination and identify weight as the basis for their

discriminatory experience” (p. 300). According to Horner (2005), of the approximately 62% of women who are overweight or obese, 60% have perceived that they have been discriminated against in the work-place.

Anti-fat discrimination in the world of work may be influenced by employer discrimination, co-worker discrimination, customer/consumer/general public discrimination, problems with the individual’s reactions to stigma, and/or unknown sources (DeBeaumont, 2009). Furthermore, discrimination in employment can be overt and explicit or covert and implicit, which makes it difficult to measure and even more difficult to stop (Kristen, 2002). This type of anti-fat discrimination has been shown to occur even when the personality characteristics of the fat person were not consistent with the commonly-held, negatively stereotyped personality characteristics of fat people (e.g., lazy) (Roehling, Roehling, & Odland, 2008).

Domains of workplace anti-fat discrimination.

First, being fat may interfere with the likelihood of being hired and with experiences during new employee training. Employers may fail to hire people who are obese (Kristen, 2002), particularly in occupations where appearance matters, such as fine restaurant waitressing, sales jobs paid on commission, and physical fitness jobs (DeBeaumont, 2009). Agerstrom and Rooth (2011) found evidence of employer discrimination against obese job applicants; results indicated that employers’ discriminatory practices in hiring could be predicted by their level of implicit anti-fat bias. O’Brien et al. (2007) asked participants to rate employability based on a job candidate description and an accompanying picture of a thin or obese individual. They found that participants viewed obese candidates as being less likely to be employed,

having poorer leadership potential, and as being less likely to succeed in the job. Sizeism therefore has obvious implications for career choice employability, and multiple experiences of discrimination could influence a person's career self-efficacy. Furthermore, if fat people are given limited consideration from some jobs, people may not be able to find positions that fit their interests. If hired for a job, research (Shapiro, King, & Quinones, 2007) revealed that, while in training, trainers expect obese trainees to have less success and poorer work ethic. Trainers also tend to give obese trainees more negative evaluations than non-obese trainees, which could have a long-term impact on the trainees' successes in the company (Shapiro et al., 2007).

In addition, sizeism might influence a fat person's level of job satisfaction. Research (e.g., Kirsten, 2002; Venturini, Castelli, & Tomelleri, 2006) has shown that people who are obese are often confined to non-face-to-face jobs. This confinement could inhibit ability to move between roles and reduce chances of being promoted within a company. If fat people are chosen to interact with customers, the customers may also discriminate against them (DeBeaumont, 2009; Klassen, Clayson, & Jasper, 1996). Job satisfaction may be lowered if fat employees are victims of interpersonal discrimination—perpetrated by fellow employees or by customers—including teasing or bullying (Kirsten, 2002; Venturini et al., 2006). Larger people may also be discriminated against by supervisors; they tend to be more harshly punished by superiors for rule violations (Bellizzi & Norvell, 1991).

Furthermore, sizeism influences monetary compensation. Statistically significantly lower rates of compensation have been shown for both male and female employees who are obese (Baum & Ford, 2004; Kristen, 2002). Typically, the fatter the

person the lower the salary, especially for women (Han, Norton, & Stearns, 2009; Haskins & Ransford, 1999; Kristen, 2002). Fat females may make almost 18% less than fat males (Conley & Glauber, 2007), and fat women's compensation is 12% less than non-fat women's compensation, even after controlling for all other variables (Register & Williams, 1990). Age of the fat person may also matter, but results are conflicting (Baum & Ford, 2004; Han et al., 2009). People who are obese are less likely to be promoted, also reducing their potential lifetime earnings (Kristen, 2002). Obesity correlates with lower compensation for women in male-dominated fields, in managerial positions, and in entry-level positions (Haskins & Ransford, 1999). Han et al. (2009) found that, when jobs required more social interaction and interpersonal skills, people with higher BMIs tended to be paid less. Fat people's level of compensation may also be influenced because they are less able to self-advocate for higher wages during the hiring process, potentially due to issues with confidence (DeBeaumont, 2009). Health-related problems, behaviors, and job discrimination may also indirectly interfere with monetary compensation (Baum & Ford, 2004). While there are individual differences in the amount of anti-fat compensation discrimination across specific job type and gender, the differences still clearly exist.

Women and African Americans.

As previously mentioned, women face the most weight-related discrimination in the workplace (Fikkan & Rothblum, 2005; Roehling et al., 2007; Horner, 2005). General stigma studies, also stating that women are disproportionately influenced by anti-fat stigma, align with these results (Griffin, 2007; Fikkan & Rothblum, 2005). Griffin (2007) noted that women in the workplace may have difficulty determining which factor is

leading to discrimination or if discrimination is multi-layered. Women are at risk for potential discrimination based on intersections between their weight and gender and, if relevant, their ethnicity, sexual orientation, ability status, and/or religious affiliations (Griffin, 2007).

Research (e.g., Cawley, 2004; Connely & Glauber, 2007; Han et al., 2009) has indicated that African Americans may experience less anti-fat discrimination in the work place than White Americans. While research (Cawley, 2004; Han et al., 2009) has shown that being fat typically leads to lower probability of employment, the only group that did not show this lower probability was African Americans (both male and female). Conley and Glauber (2007) found that workplace discrimination, in the form of lower wages, is worse for White women than for Black women. According to Cawley (2004), obese White women tend to receive lower wages than non-obese White women, but obese Black women's wages do not tend to differ from non-obese Black women's wages. African Americans may have fewer problems anti-fat discrimination in the world of work because of the previously discussed differences in anti-fat attitudes based on the target person's ethnicity.

Workplace anti-fat discrimination and the law.

There are interesting legal implications of the existence of workplace discrimination against fat people. While there is a great deal of protection for other minority groups under United States law (e.g. African Americans, Hispanic Americans, homosexuals, and people with disabilities), there is hardly any protection in place to guard against employment discrimination and other types of discrimination toward people who are obese (Griffin, 2007; Kristen, 2002). Kirsten (2002) argued that fat

people deserve legal discrimination protection, and this protection might be even more essential for fat women (Griffin, 2007).

Currently, only the state of Michigan and the District of Columbia have weight discrimination laws, and only two cities, Santa Cruz and San Francisco, have local weight discrimination laws (Griffin, 2007; Puhl et al., 2008). Griffin (2007) noted that employees/potential employees could feasibly be discriminated against simply because an employer states that he/she does not like fat people (p. 637). Most employers, however, may tend to be more subtle with their discrimination and instead give a vague and difficult to disprove reason for their behavior (for example, someone else gave a better interview) (Griffin, 2007). It seems highly inconsistent and unfair that other oppressed groups receive legal protection while fat people are almost always left unprotected.

Theories of anti-fat bias.

Many theorists and researchers (e.g., Crandall, 1994; Weiner, Perry, & Magnusson, 1988) have attempted to explain and refine the theories underlying the presence of anti-fat bias. All of these theories integrate aspects of Stigma Theory (Crocker, Major, & Steele, 1998; Goffman, 1963), which states that a *stigma* is a trait or condition that most other people perceive as negative. People who are stigmatized are perceived by others as being less socially desirable because they are associated with the negative trait or condition. Fat people may be stigmatized because they are considered unattractive aesthetically and/or because they are believed to be at fault for the negative trait (Crocker, Cornwell, & Major, 1993; King, Hebl, & Heatherton, 2005). As others

experience this reaction to the stigmatized individual, they may feel justified to avoid, reject, and/or discriminate against fat people (Crocker et al., 1998).

The Causal Theory (also known as the Attribution-Value Model of Prejudice) states that “people are prejudiced against groups that they feel have some negative attribute for which they are held responsible” (Crandall et al., 2001, p. 30). Researchers (e.g., Crandall & Reser, 2005; Weiner, Perry, & Magnusson, 1988) have demonstrated that most Americans believe that fat people are at fault for their own weight status, that weight is controllable, and that being fat is morally unacceptable. Higher levels of implicit anti-fat bias were found when participants believed that people’s choices (food intake and exercise frequency) were the primary cause of obesity (Teachman et al., 2003).

Research (e.g., Triplett, 2005) has demonstrated that attributions seem to lead to stronger stigma when fat women are the target. People may have particularly strong stigmatizing attitudes toward fat people who binge eat, likely because others see eating as a controllable activity (Bannon, Hunter-Reel, Wilson, & Karlin, 2009). Attributions may also vary by rater and target ethnicity. Popan, Kenworthy, Barden, and Griffiths (2010) found that White Americans tended to see obese Black Americans as more responsible for their own weight than other obese White Americans. Popan et al. (2010) also found that Black Americans tended to see obese White Americans as more responsible for their own weight than other obese Black Americans. The researchers concluded that intergroup bias was stronger for rater/target race than for rater weight status.

Furthermore, the method of weight loss, specifically the amount of effort people are seen as devoting to weight loss, can be predicted by the Causal Theory. Individuals

seen as making more of an effort to lose weight (through changes in diet and exercise) tend to be judged more positively than individuals who received bariatric surgery and were therefore viewed as making less of an effort to lose weight (Bullock, Stambush, & Mattingly, 2011; Fardouly & Vartanian, 2012).

Theorists believe that these attitudes are likely rooted in “a worldview consistent with the Protestant work ethic, self-determination, a belief in a just world, and the notion that people get what they deserve” (Crandall, 1994, p. 884). In accordance with this viewpoint, fatness is what people deserve when they make poor personal choices (e.g., overeating, having a sedentary lifestyle). The Justification-Suppression model, the fact that people believe that prejudicial anti-fat attitudes are justified, leads them to go unchecked (King, Hebl, & Heatherton, 2005).

In individualistic cultures, anti-fat attitudes are the strongest and the Causal Theory has the most support. Crandall and Martinez (1996) found that Americans (a highly individualistic culture) hold stronger anti-fat attitudes than Mexicans, providing further support that Protestant-based social ideology in the U.S. supports this bias. Furthermore, this bias has been shown to exist in several other individualistic cultures, but is much weaker in collectivistic cultures (Crandall et al., 2001; Hilbert, Rief, & Braehler, 2008).

Other theories may assist in conceptualizing anti-fat bias and stigma (Puhl & Brownell, 2003a). The Stereotype Content Model states that stereotypes (in this case, that fat people are “lazy” and “at fault for their own weigh status”) lead to the negative biases people hold about them (King et al., 2005). According to this model, the commonality of anti-fat stereotypes in the general population may explain the prevalence of anti-fat

prejudicial attitudes and discrimination. Realistic Conflict Theory (Sherif, 1958), which states that there are conflicts between groups over power and resources, could explain the motivation of thin people to maintain economic and social power over fat people.

Integrated Threat Theory (Stephan & Stephan, 1985) suggests that groups tend to feel threatened by each other and the conflict creates bias. These threats can be symbolic, such as threatened in-group values (Hewstone, Rubin, & Willis, 2001). In terms of obesity, thin- and normal-weight in-group members may feel that their values (e.g., discipline, thinness, motivation) are being threatened, which may create bias (Puhl & Brownell, 2003a).

A Human Evolution theory of stigmatization (Neuberg, Smith, & Asher, 2000) has been applied to anti-fat stigma (Park, Schaller, & Crandall, 2007). This theory suggests that the evolutionary drive of disease avoidance contributed to the stigmatization of fat people. Research (Park et al., 2007) has shown that people who are more concerned about communicable diseases tend to have higher implicit levels of anti-fat bias. According to this theory, fat people may be avoided because their appearance cues the presence of disease.

A Perceived Social Consensus Model may also help to explain anti-fat stigma (Sechrist & Stangor, 2005). According to this model, when other people are viewed as holding stigmatizing beliefs or stereotypes, one may adopt those beliefs in order to fit-in with the group (Stangor, Sechrist, & Jost, 2001). If others hold anti-fat beliefs, people may adopt those beliefs as a form of social consensus, especially if the views come from groups that are valued or powerful (Puhl, Schwartz, & Brownell, 2005). For example, Crandall, Eshleman, and O'Brien (2002) found that people tend to conform to social

norms even when they entailed engaging in discrimination. Fortunately, some research (Puhl et al., 2005) has shown that negative beliefs can be mitigated if positive social consensus favors obese people.

According to feminists, fat people are believed to be part of an out-group which is lower on the power hierarchy than thin or normal weight groups (Rothblum & Solovay, 2009). The in-group (thin people) may have a tendency to favor their own group and derogate the out-group (fat people), which may lead to avoidance, biased attitudes, and discrimination (Hewstone, Rubin, & Willis, 2001). In addition, Objectification Theory (Fredrickson & Roberts, 1997), specifically the commonality of the objectification of women, may explain why fat women experience more discrimination than fat men (Chrisler, 2012).

In addition, Social Identity Theory could help explain fat stigma. According to Social Identity Theory, each person conceptualizes him/herself as a member of a social group or category, and then constructs a personal identity by comparing those group memberships (Tajfel & Turner, 1986). In order to maintain a positive social identity, a person may negatively stereotype other groups and develop prejudicial beliefs against them. Non-fat individuals, who have a privileged standing in the power hierarchy, may tend to stereotype fat people and to see them as a homogeneous group. When groups have emotional reactions such as disgust and anger toward a different group, they may engage in avoidance behaviors or discrimination (Brown, 2000).

According to the Social Identity Theory, members of an in-group tend to protect themselves with a positive in-group bias; unfortunately, research has not supported the existence of positive in-group attitudes in most fat individuals (Baron & Banaji, 2006;

Brown, 2000; Hewstone et al., 2002; Puhl & Brownell, 2003a). In many other minority groups (including African Americans, gay individuals), members tend to hold favorable in-group attitudes (Hewstone et al., 2001). Individuals tend to cooperate with, trust, feel empathy for, and positively regard in-group members (Hewstone et al., 2001). While Rudman, Feinberg, and Fairchild (2002) used explicit measures and did not find that obese people held negative attitudes toward other obese people, Wang, Brownell, and Wadden (2004) found that even overweight people held explicit and implicit attitudes toward other overweight people. In addition, Schwartz et al. (2006) found that, while participants with higher weight statuses held fewer explicit and implicit biases than normal-weight participants, they still demonstrated statistically significant anti-fat bias. Wang, Brownell, and Wadden (2004) speculated that the lack of a “protective barrier” of a positive in-group identity might mean that obese people never unite and advocate for an end to discrimination against them (p. 1337).

In general, if a person feels that membership with a group is unsatisfactory or damaging, the person may try to leave the group (Brown, 2000). Most fat people may believe that exiting the “fat” group (by losing weight and avoiding other fat people) is the best way to preserve their self-esteem (Saguy & Ward, 2011). Also, fat people may choose not to identify with their own group because they see the boundary between fat and not fat as “permeable,” unlike the “solid” boundary between Black and White (Saguy & Ward, 2011). This belief would explain why many fat people spend their lives trying to lose weight instead of taking pride in their own group membership.

Brown (2000) described additional ways in which a person may leave a group: these include trying to produce a new creative take on group identity or trying to take a

social justice position and collectively advocating for the betterment of the group. As previously mentioned, some fat people are trying to collectively advocate for social change, including the members of groups such as the National Association for Advancement of Fat Acceptance (NAAFA) and the Chubsters (Saguy & Ward, 2011). In a qualitative study, MacDonald (2007) discovered that some fat people do tend to share beliefs with other fat people, share discriminatory experiences, recognize their group as discriminated against by others, and feel a sense of unity with other members of their out-group. The author concluded that, while there is insufficient evidence for the current existence of a subculture, there is certainly potential for one if members of the group start “coming together to share their common experiences” (MacDonald, 2007, p. 49).

According to Puhl and Brownell (2003a), there are “many unanswered questions about the origins of weight stigma” (p. 223). While the available theories may help to explain the prevalent and pervasive anti-fat biases in the general population, no existing theory fully captures the extent of the problem, explains the relevant research, and predicts behavior.

How bias influences fat people.

People who are fat face obstacles including “attitudinal, physical, and policy barriers that affect ordinary, daily activities like using bathrooms, going to school, and finding or maintaining employment” (Vade & Solovay, 2009, p. 167). In addition to these environmental barriers, several researchers (e.g., Puhl & Heuer, 2010; Schafer & Ferraro, 2011) have worked to identify the ways in which anti-fat stigma and discrimination influence fat people. Researchers in the fields of social psychology, medicine, and sociology have contributed to this body of literature.

When individuals identify as “overweight people” and perceive interpersonal weight-related discrimination, they can experience a negative stress reaction associated with belonging to stigmatized group (Schafer & Ferraro, 2011; Schnittker & McLeod, 2005). Medical researchers (e.g., Ashmore, Friedman, Reichmann, & Musante, 2008; Muennig, 2008) have found that a person’s status as obese might be harmful not because of associated physiological problems, but because of the stress caused by the discrimination of other people toward the obese individual. These influences of stigmatization have also been identified in other groups with lower social status, including people who have been discriminated against because of their ethnicity or ability status (Schnittker & McLeod, 2005). Research (Puhl & Heuer, 2010) has shown that the experience of anti-fat stigmatization “poses serious risks to their physical health, generates health disparities, and interferes with implementation of effective obesity prevention efforts” (p. 1019). When they are the victims of discrimination, fat people are more likely to have problems with psychological functioning, engage in unhealthy eating and lower physical activity, experience stress, have depression, have low self-esteem, have poor body image, underutilize preventative health care, exhibit eating disordered symptoms, and be diagnosed with binge eating disorder (Ashmore et al., 2008; Puhl & Brownell, 2006; Puhl & Heuer, 2010, p. 1023-1024).

Schafer and Ferraro (2011) researched the ways in which obese people’s perceptions of sizeism influenced their health and wellbeing. They found that people who believed they were discriminated against because of weight tended to perceive themselves as heavier; this perception related to negative self-concept. Researchers concluded that “the social processes of perceived weight discrimination are responsible,

at least in part, for the deleterious effects of severe obesity on health” (Schafer & Ferraro, 2011, p. 92). This anti-fat stigmatization comes from many sources, frequently including partners/spouses, friends, and family (Puhl, Moss-Racusin, Schwartz, & Brownell, 2008). Many fat people blame themselves for their weight status and tend to hold negative anti-fat stereotypes (Carels et al., 2013; Puhl et al., 2008)

Some researchers (Seacat & Mickelson, 2009) have suggested that weight status may be influenced by Stereotype Threat. According to Steele and Aaronson (1995), the fear of confirming a negative stereotype of a group with which a person identifies may actually cause reduced performance. For example, if a person identifies as “obese” and knows that obese people are stereotypically seen as lazy, the person may display inferior performance on a fitness test, even if the person does not personally believe in the truth of the stereotype. Results from Seacat and Mickelson’s (2009) study confirmed that Stereotype Threat can be a significant contributing factor in both diet and exercise choices of obese people.

According to Puhl (2005), people try to cope with fat stigma by confirming their fatness/self-blaming (e.g., agreeing with the negative perceptions of others), self-protecting (joining pro-fat groups for support), advocating for pro-fat issues, compensating (acting nicer), confronting (openly denigrating the anti-fat remarks/behavior of others), engaging in social activism (joining the pro-fat movement), avoiding situations where they are likely to be stigmatized (e.g., the gym, clothing stores catering to thin individuals), and/or attempting to lose weight. Strategies such as self-blame and avoidance appear to be the least effective in managing fat stigma (Puhl, 2005). When people who are fat believe that they are being discriminated against, they tend to

be less able to use positive coping strategies (Mallett & Swim, 2005). Research (Granberg, 2011) has even shown that the stigma of obesity can persist for people even after they have lost significant amounts of weight.

Other Professions' Self-Analysis of Anti-Fat Biases

Other professions have explored the issue of weight status and bias extensively through research. Fabricatore, Wadden, and Foster (2005) described the growing body of evidence that anti-fat bias exists in health care settings and likely influences the quality of care. Davis-Coelho et al. (2000) stated that members of the medical profession have excelled in publishing studies (e.g., Garner & Nicol, 1998; Harvey & Hill, 2001) on their own attitudes toward patients who are obese. Other reviewers (e.g., Fikkan & Rothblum, 2011) have stated that no professional fields have sufficiently focused on the presence of bias and discrimination toward fat patients and clients.

Physicians.

Research on physicians has assessed the anti-fat biases in the medical profession. Some studies have focused on how physicians perceive fat patients. Older research (e.g., Maddox, Back, & Liederman, 1968; Maddox & Liederman, 1969) demonstrated that physicians believed people who were obese were awkward, ugly, and weak-willed. Hebl and Xu (2001) reported that physicians spent less time with obese patients, which was related to physicians' negative stereotypes about obese patients. In addition, Kristeller and Hoerr (1997) found that, while most physicians thought that addressing obesity with their clients was important, many preferred not to treat the clients themselves and referred the client to someone else. Sabin, Marini, and Nosek (2012) found strong implicit and

explicit anti-fat biases in physicians, and identified anti-fat bias as “pervasive” among physicians (p. 1).

Harvey and Hill (2001) conducted a study in which British physician participants received one of four hypothetical patient case summaries. Hypothetical patient characteristics varied by weight status and smoking status. Results indicated that most British physicians held explicit negative attitudes toward overweight people, particularly toward people who were extremely overweight. They also saw overweight people as personally responsible for their weight status, although they saw them as less responsible for their health problems than smokers.

Zhu, Norman, and White (2011) reviewed published studies to assess whether health professionals’ weight status predicted their attitudes toward their patients and patient weight management. Results indicated that normal weight health professionals held more negative attitudes toward patients who were obese than did health professionals with higher weight statuses. Also, female health professionals with clinical experience in weight management had fewer negative attitudes than other professionals.

Foster et al. (2003) assessed explicit physician attitudes toward obese patients, including physicians’ perceptions of the causes of obesity, the attitudes of obese individuals, beliefs about the treatment of obese individuals, weight loss outcomes, and relative efficacy of obesity treatment. Participating physicians believed inactivity and overeating were the leading causes of the obesity. Fifty percent of the participants described their obese patients as ugly, awkward, unattractive, and non-compliant with treatment.

Brotman, Stern, and Herzog (1984) studied the reactions of first-year psychiatry resident physicians toward their patients with anorexia nervosa, obesity, and diabetes. Participants read vignettes and then rated the amount of anger, stress, helplessness, sadness, and anxiety they felt while working with each population (anorexia nervosa, obesity, and diabetes). They also rated the extent to which they believed the condition influenced their ability to care for the patient. Results indicated that psychiatry residents had many negative feelings toward the obese vignette patient including anger (77% of participants), stress (44%), helplessness (44%), sadness (67%), and anxiety (33%); 67% believed that their negative attitudes influenced the care they provided to their patients. Small sample sizes (only 29 physicians), explicit design, and non-validated questionnaires were problematic in the study, but anti-obesity bias was clearly identified.

Persky and Eccleston (2011) investigated medical students' bias against obese and non-obese patients using an analogue virtual female patient. They found that medical students tended to have negative stereotypes of obese patient. In contrast to non-obese patients, participants tended to rate the obese patient as less likely to adhere to recommendations and in poorer health.

Other studies focused on the way fat patients described their treatment by physicians. Kaminsky and Gadaleta (2002) asked bariatric patients about how they were treated by their physicians. Results indicated that approximately 17% of patients not only had perceived discrimination, but also had found the discrimination so problematic that they changed physicians. Results also indicated that social workers and psychologists were perceived as discriminatory in health care settings. Hebl, Xu, and Mason (2003) distributed a survey to patients regarding the treatment they received from their

physicians. Overweight male patients reported that physicians spent less time and gave them lower quality care than non-overweight male patients. Overweight female patients reported that physicians gave them better care than non-overweight female patients. A phenomenological qualitative study (Nyman, Prebensen, & Flensner, 2010) performed in Sweden found that obese women had a multitude of negative experiences with their physicians and midwives during their pregnancy and childbirth. These issues included feeling exposed and scrutinized, having negative emotions, feeling discomfort, and enduring humiliating treatment. The women reported that the health care professionals had been discriminatory toward them, and that the treatment made them feel upset and uncomfortable.

Some studies examined both physician attitudes toward fat patients and fat patients' perception of treatment by physicians. For example, Brandsma (2005) utilized the Bray Attitude Toward Obesity Scale (BATOS; Bray, 1972) to measure the explicit attitudes of physicians toward obese patients. She found that physicians held negative attitudes toward obese patients and that the patients tended to over-estimate the negative attitudes held by the physicians. This study spoke to both the actual presence of the negative attitudes and the extent to which patients can amplify these biases internally and inaccurately.

Nurses.

In addition to physicians, members of the nursing profession have worked to identify anti-fat bias in nurses. Maroney and Golub (1992) assessed explicit attitudes of nurses from the U.S. and Canada. Both groups reported negative attitudes and discomfort when having to work with obese patients. Brown, Stride, Psarou, Brewins, and

Thompson (2007) assessed explicit obesity-related attitudes in British nurses. Approximately 40% of nurses reported that obese patients were lazier than non-obese patients. Approximately 48% agreed that obesity is due to a lack of personal control. Canadian researchers Watson, Oberle, and Deutscher (2008) developed and validated a new instrument, the Nurses' Attitudes Toward Obesity and Obese Patients Scale (NATOOPS). They updated the Attitudes Toward Obese Adult Patients Scale (Bagley, Conklin, Isherwood, Pechiulis, & Watson, 1989), basing their new scale in attribution-value theory (Crandall, 1994; Crandall & Biernat, 1990; Crandall et al., 2001; Crandall & Martinez, 1996). The researchers described the new scale as having excellent construct validity (Cronbach's alpha = 0.81) to demonstrate obesity-related attitudes in nurses. Poon and Tarrant (2009) used explicit measures including the Fat Phobia Scale (Bacon, Scheltema, & Robinson, 2001) and the Attitudes Toward Obese Adult Patients Scale (Bagley et al., 1989) to assess nurses' attitudes about obese patients. They found that both nursing students and professional nurses held significant negative attitudes toward obese patients, and that they were unlikely to see positive attributes in these patients. Researchers concluded that these attitudes are likely to influence the quality of the care that these nurses provide to their patients who are obese.

Implicit attitudes in nurses have also been investigated. Waller, Lampman, and Lupfer-Johnson (2012) used the IAT (Greenwald et al., 1998) to investigate anti-fat attitudes in nursing students. They found that nursing students held strong biases against overweight individuals in both medical and non-medical settings. Researchers also reported that these anti-fat biases were stronger when the target was female.

Some studies looked at both anti-fat attitudes in nurses and fat patients' perceptions of treatment by nurses. For example, Garner and Nicol (1998) found that nurses denied explicit biased attitudes against obesity; while non-obese patients did not find their nurses to be biased against them, obese patients reported significant negative attitudes in nurses. In summary, Brown (2006) stated that research in nursing on anti-fat attitudes and discrimination had only begun to capture the extent of the issue.

In addition, the nursing field has developed educational programs to attempt to decrease anti-fat bias in nurses and other healthcare professionals. Falker and Sledge (2011) created and administered a "Bariatric Sensitivity Educational Module" (p. 73), designed to educate healthcare professionals on the multiple influences on weight status. One-month follow up results indicated that the module decreased stigmatization. Researchers advocated for additional education in order to decrease weight-related stigmatization of patients.

Teachers and educators.

In addition, teachers and educators have made attempts to uncover their own biases and stereotypes against people who are fat. Neumark-Sztainer, Story, and Harris (1999) assessed explicit obesity-related beliefs in teachers and school staff. They found that these education professionals perceived obese students as at fault for their high weight status. In addition, obese students were viewed as more emotional, messier, and less likely to succeed than non-obese students.

Physical therapists.

Sack, Radler, Mairella, Touger-Decker, and Khan (2009) assessed physical therapists' explicit attitudes toward obesity. Results indicated that most physical

therapists blame obesity on physical inactivity and overeating, ranking genetic factors as only the seventh most important influence. Results indicated that the participants recommended weight loss to over 52% of their obese patients, that 21.2% endorsed having negative reactions to obese patients, and that 15.6% endorsed feeling uncomfortable when working with obese people. In addition, 40.3% described obese people as “sloppy,” 40.2% described obese people as “lazy,” 51% described obese people as “weak willed,” and 53.1% described obese people as “noncompliant.” Surprisingly, the researchers concluded that “physical therapists have neutral attitudes toward people who are obese” and that physical therapists “appropriately indicated” the factors that contribute to obesity (Sack et al., 2009, p. 804).

Exercise science professionals.

Chambliss, Finley, and Blair (2004) measured implicit and explicit attitudes of exercise science students. Implicit attitude results indicated that participants tended to associate obese people with “fat” and “lazy” categories. Results also indicated that participants held explicit negative attitudes, including the belief that obese people are unattractive and responsible for their own weight status.

Dieticians.

Several dietetics studies in the 1990s had conflicting results, indicating that dieticians may have positive (McArthur, 1995), neutral (McArthur & Ross, 1997), or negative (Oberrieder, Walker, Monroe, & Adeyanju, 1995) views about people who are overweight or obese.

In a British study, Harvey, Summerbell, Kirk, and Hills (2002) examined the attitudes of dieticians toward overweight/obese people utilizing an explicit measure, the

Attitudes Toward Obese Persons (ATOP) scale (Allison et al., 1991) and a survey assessing nurses' attitudes toward obesity (Hoppe & Ogden, 1997; Ogden & Hoppe, 1997). Dieticians held some negative attitudes toward overweight and obese people, including stereotyping them having low self-esteem, health, and attractiveness, and for being responsible for their own weight. The higher a person's weight status, the more negative attitudes dieticians possessed.

Puhl, Wharton, and Heuer (2009) utilized a between-subjects analogue experimental design based on four hypothetical patient profiles. The patient profiles were only varied in terms of sex and weight of the hypothetical patient, and participants were randomly assigned to one of the four conditions (male/female, normal/obese); the obesity-related purpose of the study was not revealed to the participants. In addition to dietetics-specific questions, the participants were asked to report their attitudes toward the hypothetical patients including receptiveness to treatment recommendations, compliance with treatment, motivation for change, potential for success over time, and "how much they might enjoy working with the patient" (Puhl et al., 2009, p. 440). The participants responded to the questions utilizing a 5-point Likert-type scale. After these responses, the participants completed an explicit, self-report measure, the Fat Phobia Scale (Bacon, Scheltene, & Robinson, 2001). Results indicated that there were no statistically significant differences between the four groups regarding how much the participant would enjoy working with the patient, but that the obese patients were rated lower in all other areas.

Aphramor and Gingras (2009) authored a book chapter on their views of the disgraceful way that dietetics is handling the problem of "fatness," particularly in women.

They argued that, while dieticians have the ability and resources to promote the “fat is healthy” movement, the field stubbornly remains anti-fat. They argued that this position is a type of violence against fat people.

Occupational therapists.

Anti-fat attitudes have also been identified in students in occupational therapy (OT) training programs. Vroman and Cote (2011) measured implicit and explicit anti-obesity attitudes of students in OT training programs. To measure implicit biases, the researchers adapted the Prejudicial Evaluation and Social Interaction Scale (PESIS), originally used by Kelly, Lawrence, Smith, Hood, and Cook (1987) to measure physicians’ attitudes toward individuals with AIDS, into the Attitudes to Obesity – Prejudicial Evaluation and Social Interaction Scale. Patient descriptions were identical except the gender and weight of the person in the accompanying picture was changed (obese/non-obese, male/female). Participants also completed a 10-point Likert-type measure of Social Distance, Judgment, and Motivation. After measuring implicit attitudes, researchers also administered explicit anti-fat measures. Results indicated that, even in explicit measures, OT students demonstrated anti-obesity attitudes. Implicit measures showed stronger negative attitudes, especially in measurement of Judgment and Social Distance.

Studies on professionals working with obese patients/clients.

In two studies of a variety of professionals who work with people who are obese, Schwartz, Chambliss, Brownell, Blair, and Billington (2003) and Teachman and Brownell (2001) measured the implicit attitudes of a variety of medical professionals including physicians, researchers, dietitians, business people, pharmacologists,

epidemiologists, psychologists, and nurses. Schwartz et al. (2003) found a strong implicit bias against obese people, particularly that they were stupid, lazy, and worthless. This bias was stronger in female professionals. Teachman and Brownell (2001) found strong implicit anti-fat biases, but these biases were weaker than implicit anti-fat biases in the general population. Participants tended to view fat people as “lazy” and “bad,” but on explicit measures, participants were willing to suggest that fat people are “lazy” but less willing to suggest that they are “bad.” The researchers concluded that contact with obese people may be instrumental in reducing bias, but that it does not eliminate it.

In summary, this research presents a clear case that anti-fat attitudes exist in other professions, including medical professions and education. Also, these biases sometimes influence the quality of care or services provided by these professionals.

Anti-Fat Bias in Therapists

This section will examine theoretical, practical, and research contributions to assessing anti-fat biases in therapists.

Social work.

The field of social work has assessed anti-fat bias in recent years. Articles calling attention to the issue (e.g., Melcher & Bostwick, 1998) have appeared in several social work journals. Lawrence, Hazlett, and Abel (2011) described obese people as an oppressed population, and called for social workers to show multicultural competence in working with its members. These authors urged social workers to become aware of their own biases and the societal factors that lead to discrimination against people who are obese, and pressed for the inclusion of this obesity-related material in training programs.

In addition, Koenig (2008) called attention to potential negative countertransference reactions of social workers against clients who are obese, and the biases that cause them.

In the social work field, several unpublished theses and dissertations have been written in the past ten years to address the issue of anti-fat bias against clients. For example, Kannard (2008) qualitatively reviewed published works by the National Association for Social Workers (NASW). The researcher concluded that despite the need for a social justice approach to reduce discrimination and bias, NASW still generally holds to a biomedical model of obesity. Other researchers (e.g., Downes, 2001) have noted assumptions by social workers that a client's weight status is within his/her control.

In her doctoral dissertation, McCardle (2008) explored social workers' anti-fat biases using a survey and explicit, face-valid, anti-fat attitude assessment measurements (Attitudes Toward Obese Persons scale and the Beliefs About Obesity scale; Allison et al., 1991). Results indicated that, while social workers report generally positive explicit attitudes toward obese clients, social workers do hold some negative stereotypes about obese clients. The more social workers believed that weight was personally controllable, the more anti-fat bias they tended to report and the more negative practice behaviors they tended to report. While McCardle was one of the few researchers to study anti-fat biases in social workers, her study used only explicit, face-valid measures. This survey design is susceptible to social desirability bias, and responses may not have been an accurate representation of therapists' true attitudes.

In an unpublished quantitative study, Ahern and Tally (2009) examined the attitudes of social work students regarding body size. Explicit measures, including the Antifat Attitudes Questionnaire (Crandall, 1994), and the Attitudes Toward Obese

Persons Scale and the Belief About Obese Persons Scale (Allison et al., 1991) were given to 115 Master's level social work students. Results indicated that social work students held biases against overweight clients, but that social work students with a higher weight status reported fewer negative biases. Approximately 82% of participants reported beliefs that a client's motivation for counseling would be lower if he/she had a higher weight status. The weakness of this study was its survey design and its utilization of face-valid, explicit measures.

Qualitative studies (Dennis, 2006; Hanson, 2009), based on interviews with clinicians, have identified anti-fat biases, negative stereotypes, and judgmental attitudes in social workers. Researchers argued that these beliefs lead to negative countertransference reactions against fat clients, and advocate for better "cultural competence" training in the area of fat clients. In an unpublished thesis, Aza (2009) examined therapists' countertransference reactions to clients who are obese. The participants included 12 social workers and clinical psychologists. Findings suggested that negative countertransference can be frequent and intense, that therapists may engage in microaggressions against their obese clients (including invalidating client's experiences and blaming clients for discrimination they face), and that many therapists may not be aware of their own biases.

These contributions by the social worker profession have drawn attention to the problem of anti-fat biases of social workers. While social work contributions have enhanced the body of knowledge on anti-fat bias in therapists, it has not focused specifically on psychologists.

Psychodynamic work.

In addition to the Social Work field, the Psychodynamic tradition in psychology and counseling has documented reactions to fat clients through the study of transference and countertransference. Drell (1988) called attention to the likelihood that the psychotherapist will encounter negative biases and countertransference with clients who are obese. He stated that knowledge of these biases and the appropriate use of countertransference can lead to therapeutic gains. Similarly, Davidson (1980) discussed how negative countertransference toward a fat patient could interfere with her ability to be a good analyst. In addition, Yalom (1989) described his own negative biases and countertransference against a fat client in a psychodynamic and existential case study. He, too, stated that self-awareness of biases and work toward gaining personal knowledge about a client can lead to positive outcomes. Also in the psychoanalytic tradition, Ingram (1978) cautioned therapists that social norms about body fat could influence the therapist and his/her ability to analyze the patient's transference reactions. Ingram stated that, for that reason, weight loss should never be a goal of psychotherapy treatment (Ingram, 1978).

Like social work contributions, the contributions of these psychodynamic authors have drawn attention to the issue of anti-fat biases and their potential to influence psychotherapy. None of the psychodynamic contributions, however, have entailed actual research studies.

Research on anti-fat biases in psychologists.

Only four published studies (Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Hassel et al., 2001; Young & Powell, 1985) and four dissertations (Abakoui, 1998;

Loewy, 1995; Locker, 2011; Zadroga, 2009) have examined anti-fat attitudes held by psychologists. These contributions will be examined in order of date, beginning with the oldest work.

Young and Powell (1985).

The earliest research on anti-fat attitudes, a quantitative project assessing whether clinicians had more negative therapeutic judgments of clients who were obese, was conducted by Young and Powell (1985). Participants—120 mental health professionals—were given an identical short “case history” accompanied by one of three photographs of a White, middle-aged, female client. The photographs were a digitally-altered series of three photographs of the same woman with varying weight status (“best-weight model,” “overweight model,” and “obese model”); participants were randomly placed in one of the three weight status categories. Researchers adapted an earlier questionnaire (Settin & Bramel, 1981) which was designed to assess how mental health professionals responded to client characteristics and group memberships. The first measure was a six-point, Likert-type scale on which assessed “clinicians’ willingness to work with the client, their belief that therapeutic intervention with the client would be useful, and their belief that a favorable prognosis, contingent upon appropriate treatment, could be assigned to the client” (p. 236). The second measure had participants rate the extent to which a range of psychological symptoms exist in the client. In addition, researchers assessed whether the gender of the therapist and/or the weight status of the therapist influenced level of bias against the client.

Results indicated that there was no statistically significant difference in the mental health professionals’ willingness to work with the client, belief that intervention would be

useful for the client, or the client's prognosis based on the three client weight conditions. Mental health professionals, however, tended to believe that the "obese" client had significantly more psychological symptoms including "agitation, emotional behavior, impaired judgment, inadequate hygiene, inappropriate behavior, obsessive-compulsive behavior, self-injurious behavior, and stereotyped behavior" (p. 238) and that these symptoms were seen as more severe than those in clients of lower weight categories. No statistically significant differences were found between the "best weight" and "overweight" client conditions on any of the outcome measures. Female participants were the most likely to view "obese" clients as more symptomatic. The overweight mental health professionals' total responses on all of the outcome measures were not significantly different than the non-overweight participants.

One strength of Young and Powell's (1985) study design was that face valid anti-fat attitude scales were not used, possibly cutting down on altered responding because participants were trying to be more socially acceptable. This study, however, had some limitations. First, the sample, which was derived of "mental health professionals," was broad and does not provide specific information about psychologists. The authors' self-created case history had not been used in previous studies. The study only focused on White, middle-aged, female clients, and did not assess attitudes when the client was of a different ethnicity. Existing measures were altered and reliability information was not presented for the updated versions. Finally, results from this study, which was published over 25 years ago, are dated and may not accurately represent current anti-fat attitudes.

Agell and Rothblum (1991).

Another important quantitative study examined the ways in which a client's weight status (obese/non-obese) and a client's gender (male/female) had an impact on psychologists' therapeutic judgments (Agell & Rothblum, 1991). In this 2 x 2 x 2 experimental design, a total of 282 psychologists read one of two case histories of a client, were then separated into four conditions (obese/non-obese and male/female), and responded to outcome measures. The first outcome measure was an adapted version of Worsley's (1981) Person Perception Inventory, a semantic differential scale. The 28 item measure included polarities of personality attributes (e.g., dependent/independent), physical attractiveness (e.g., fashionable/unfashionable), and social attractiveness (e.g., rejected/accepted by others). A Case History Questionnaire was created by the researchers to investigate diagnosis, prognosis, treatment expectations, problem severity, client motivation, client self-concept, and psychologists' interest in the client (p. 224). The researchers found that although psychologists described obese clients as unattractive and embarrassed, there were no significant differences in their therapy recommendations for obese and non-obese clients. Researchers also found no statistically significant interaction effects between gender and weight.

Research strengths included the fact that only psychologists were included in the sample. In addition, researchers used an objective indicator of weight status (135 or 190 pounds). Like Young and Powell's (1985) study, face valid anti-fat attitude scales were not used, possibly cutting down on altered responding because participants were trying to be more socially acceptable. There were also some limitations to the Agell and Rothblum (1991) study. The authors' self-created case descriptions had not been used in previous

studies. In their case histories, clients were described as “unattractive.” Therefore, results may have been confounded by attractiveness bias and may not have accurately captured weight bias. Also, in their case histories, they used the term “overweight” in describing the client in the obese conditions, and did not clarify the weight status of the hypothetical client. While the researchers performed their own factor analysis on the Person Perception Inventory, no psychometric information from previous studies (including validity data) was reported for the measure. Furthermore, their Questionnaire was a self-created instrument without psychometric analysis.

Lowey (1995).

In his doctoral dissertation, Loewy (1995) investigated whether stereotypes about people who are obese led to more mistakes in information processing. He utilized an Illusory Correlation Paradigm to assess bias. In this design, participating therapists were presented with cards containing information about clients (experimentally varying by weight status: thin/fat), and then used descriptors of each client (some corresponded to prevailing stereotypes, some in opposition to prevailing stereotypes, and some neutral). Results indicated that therapists were more likely to make processing errors (defined by whether participants reported client characteristics that were not presented in actual the research material, presumably illuminating biases that the participant held) about clients who were fat than they were about clients who were not fat. Therapists who specialized in eating disorder treatment had significantly fewer errors than therapists without an eating disorder specialization.

While Lowey’s (1995) study employed a unique methodology, it had some limitations. First, the sample size included only 52 therapists. Therefore, the study

compared very small groups (25 eating disorder specializing therapists and 27 generalists) and lacked sufficient power. This research was conducted in-person by a self-described fat researcher, which might have impacted the results. Also, only local participants were involved and all were volunteers, which likely significantly limits generalizability. Although all of the participants were described as “licensed therapists,” no exact number of psychologists was given, indicating that this research may not generalize to psychologists. The ethnicity of the client was not varied in the study.

Abakoui (1998).

Abakoui’s (1998) dissertation attempted to measure how psychologists respond to “weight dissatisfied” clients. APA member psychologists ($N = 168$) participated in the analogue study. Each participant randomly received one of four case vignettes (2 x 2 design varying by male/female gender and fat/average weight). Abakoui asked psychologists to provide a diagnosis (five axes) and to rate prognosis, motivation for change, self-concept, whether the client should seek therapy, and interest in treating the client. Participants were asked to rate the probability that they would have the following treatment goals with the client: increased physical exercise, increased assertiveness, increased awareness and expression of affect, improved physical health, better developed interpersonal skills, increased level of self-acceptance, empowerment of client to make changes, improved coping skills, decreased weight, increased level of individuation, improved marital relationship, and decreased level of self-defeating thoughts. Demographics of the psychologists, including their gender, ethnicity, age, weight status, and number of years practicing therapy, were also collected.

Results indicated that psychologists had biases against fat clients. Specifically, their rating of prognosis was worse for fat clients and they tended to include the goals of decreasing weight, increasing physical health, and increasing exercise only for fat clients. Fat clients were also given lower overall GAF scores. When the fat client was a female, psychologists had a significantly higher likelihood of diagnosing the client with an Axis II personality disorder, particularly Dependent Personality Disorder. For fat clients, male psychologists were significantly more likely to choose the goal of decreasing the client's weight than were female psychologists. Female psychologists tended to assign the goals of increasing the use of coping skills, empowerment of the client, and increasing client's awareness of and expression of affect. The researcher stated that these results differed from the overall conclusion of Agell and Rothblum (1991); unlike Agell and Rothblum (1991), Abakoui's (1998) results indicated that psychologists' biases did have a significant influence on diagnosis and treatment of fat clients.

While Abakoui's (1998) study served an important purpose in specifically examining the attitudes of psychologists, it did have some limitations. The researcher mentioned that the age of the participants ($M = 49$ years) and their amount of psychotherapy practice (90% of participants had practiced for 10 or more years) may mean that the results are not necessarily generalizable to all psychologists, especially younger ones. Because this study specifically examined clients who reported dissatisfaction with their weight status (from the female/fat condition vignette: "She reported that she is concerned about her weight. She said that she is about 10 pounds overweight and that she has a history of gaining and losing weight.") (Abakoui, 1998, p. 46), it may be assessing psychologists' attitudes toward individuals who report that they

want to lose weight, not toward fat individuals in general. Finally, the researcher created new vignettes and created new measures of bias, opting not to use validated instruments.

Davis-Coelho et al. (2000).

A more recent quantitative analogue study relating to the issue of biases toward obese clients was conducted by Davis-Coelho et al. (2000). The participants, 200 psychologists, received a mailing including a hypothetical client's self-descriptive statement and randomly received one of two accompanying pictures. The same woman was depicted in both pictures, but in the second picture she wore padding and makeup making her appear fat. Participants completed a questionnaire "assessing recommended treatment modality, provisional diagnosis, prognosis, client effort, client motivation, and overall functioning" (p. 682), including a Global Assessment of Functioning (GAF) score for the client. This study found that younger psychologists tended to believe that obese clients would show less effort in therapy, that female psychologists gave a worse treatment prognosis for clients who were obese, and that possible diagnoses varied simply because of a client's status as obese or non-obese. There were no statistically significant differences in GAF scores or expected duration of treatment. Psychologists tended to give the provisional diagnosis of "eating disorder" to fat clients and the provisional diagnosis of "adjustment disorder" to non-fat clients. Psychologists were more likely to recommend the treatment goal of "improve body image" to the fat client.

A limitation of the study was that, like the previous studies, client characteristics other than weight were not experimentally manipulated. This study provides no information regarding client ethnicity as it interacts with client weight status.

Hassel et al. (2001).

In another quantitative study, Hassel et al. (2001) examined whether a client's weight status influenced the therapist's clinical judgment. While this study did not exclusively focus on psychologists, over 50% of the participants were psychologists. Researchers focused on comparing Christian therapists with non-Christian therapists. Study participants were given a short vignette about a client with an attached client picture. The study had a 2 x 2 design (client gender by client weight conditions) and asked participants to complete three different measures. First, in order to measure "pathology," participating therapists were asked to select a diagnosis for the client (a forced choice based on 10 different *Diagnostic and Statistical Manual (DSM-IV-TR, American Psychiatric Association, 2000)* options) and to give the client a score for GAF. Second, in order to measure attitudes and attributions, participants completed an adapted version of the Attitude Scale (Harris, Waschull, & Walders, 1990; Yucker, Allison, & Faith, 1995). This measure was a 7-point, Likert-type scale; Yucker, Allison, & Faith (1995) described the measure as having reliability of 0.74 to 0.76. Third, to measure explicit anti-fat attitudes, participants completed an adapted version of Attitudes Toward Obese Patients (ATOP; Bagely, Conklin, Isherwood, Pechiulis, & Watson, 1989).

Hassel et al.'s (2001) results indicated that participants rated the overweight clients as having more pathology (more serious diagnoses and lower GAF scores). Participants gave significantly lower GAF scores to overweight clients. Female participants gave significantly lower GAF scores to overweight clients than did male participants, and male participants had significantly lower (more negative) scores on the

Attitude Scale toward overweight clients. No significant differences were found between Christian and non-Christian therapists on any of the measures.

The study by Hassel et al. (2001) had a major limitation. The researchers did not report any procedures to address potential attractiveness bias. There was no mention of obtaining pre-study ratings to determine whether the male and female “clients” in the pictures were equally attractive, which could confound results. According to Young and Powell (1985), “one problem previously facing sociologists and psychologists interested in conducting research on obesity has been how to test for the effect of obesity while holding attractiveness constant” (p. 237), and this study has not been able to establish this constant.

Zadroga (2009).

In her doctoral dissertation, Zadroga (2009) used an analogue design to examine differences in client diagnosis and prognosis when client characteristics of age, weight, and gender were experimentally varied. Her participants included 68 licensed psychologists and 154 graduate psychology students. The participants read one of 12 vignettes (varying by age: young, middle-aged, or elderly; weight: normal weight or obese; and gender: male or female), completed a five axis diagnosis, and chose a prognosis of good, fair, or poor. Results indicated no significant differences between participant responses on any of the 12 conditions. While the researcher concluded that these results point to a possible lack of bias in psychologists and psychology students, the lack of significant results may have been due to insufficient power.

This study had several limitations. First, participants were gathered primarily from one geographic area, and results may not generalize nationally. Second, too few

participants led to insufficient power. Research materials were distributed in person, by mail, and through e-mail, and the researcher did not indicate whether there were significant differences in results based on these different methods of data collection. While the researcher adapted a clinical vignette from a book on differential diagnosis, the vignette was altered significantly and not previously used in research.

Locker (2011).

In her doctoral dissertation, Locker (2011) used an analogue design to examine whether manipulating client variables of gender, weight, and ethnicity impacted therapists' bias. Three short client vignettes were developed based on the work of Agell and Rothblum (1991), Young and Powell (1985), and Davis-Coelho, et al. (2000). Each vignette was accompanied by a picture of the hypothetical client. Twelve different pictures were digitally created by varying the ethnicity of the client (White/Latino/Black), the gender of the client (male/female), and the weight status of the client (non-heavy/heavy). All participants received all three vignettes (always appearing in the same order); each vignette was randomly paired with one of the 12 possible client pictures. After reading each of the three vignettes, participants were asked to assign a GAF score, choose a *DSM-IV-TR* diagnosis, and complete a 5-point Likert-type rating of perceived client motivation and client attractiveness. After the vignette sections were completed, all participants completed the Anti-Fat Attitudes Scale (AFAS; Morrison & O'Connor, 1999) to assess their general explicit anti-fat attitudes.

Locker's (2011) results indicated that participants tended to believe that heavier clients were less attractive and less motivated for therapeutic change than non-heavy clients. Therapists with stronger anti-fat attitudes, as measured by the AFAT, tended to

believe that heavier clients were more unattractive. These tendencies were present regardless of client gender or ethnicity. Results also suggested that therapists were more positive in their judgments of heavy Black female clients as opposed to all of the other heavy clients.

While Locker's (2011) study was the first to address an important gap in the literature (interaction between client weight and ethnicity), it did have several limitations. First, participants were obtained through non-random sampling. Participants were contacted electronically through an assortment of counseling and psychology electronic mailing lists, and those who received the invitation to participate were asked to pass on the information on other professionals. In addition, several of the participants were students and only about 20% of the participants were licensed psychologists. With only 144 participants and 12 hypothetical client conditions, the power in the study was insufficient. In reporting their provisional diagnosis, participants were asked to make a forced choice between adjustment problems, adjustment disorder, depression, self-esteem problems, eating disorder, body image problems, anxiety disorder, personality disorder, and other (they were asked to specify). This format may have cued the participants and led them to respond differently than if they were not cued.

Another limitation involved the client pictures. The researcher asked five graduate students to rate the pictures to ensure that the heavy clients of each gender and each ethnicity looked larger than the non-heavy clients, but no procedure was described that would ensure that all of the clients of varied ethnicities were equal in terms of attractiveness ratings. For example, there is no way to know if all participants believed that the non-heavy African American female was equal in attractiveness to the non-heavy

White and Hispanic females. If differences existed in baseline attractiveness, the study outcomes may have been confounded.

Finally, since participants read three different vignettes and randomly received one 12 pictures with each vignette, the participants may have realized that the purpose of the study was to see if the outcome measures would be significantly different when the client gender, weight status, and ethnicity was varied. This realization may have influenced the way that therapists responded to the outcome measures (especially on the second and third vignettes) and invalidated the results.

Need for the Study

As described in the previous analysis, only four published studies (Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Hassel et al., 2001; Young & Powell, 1985) and only four dissertations (Abakoui, 1998; Loewy, 1995; Locker, 2011; Zadroga, 2009) have investigated therapist bias based on client weight status. This research is vastly insufficient in volume to describe anti-fat bias in psychologists. In addition, because all of the published studies and two of the four dissertations are more than ten years old, more recent studies are greatly needed to understand current bias in the field.

While some studies assessing anti-fat biases (e.g., Abakoui, 1998; Locker, 2011; Young & Powell, 1985) have examined the extent to which biases may impact variables such as prognosis, level of pathology, and likability of client, no study has specifically examined anti-fat biases in terms of the therapist's projected working alliance with the client. Furthermore, while other studies (e.g., Agell & Rothblum, 1991; Hassel et al., 2001) have adapted other general attitude scales to assess biases, no studies have employed an outcome measure of working alliance or utilized a measure with

psychometric support. Horvath and Greenberg (1989) were the first to create a measure to assess the working alliance, considering the characteristics of the relationship between a client and a therapist. The working alliance includes the extent to which therapist and client agree on the tasks that will take place during therapy, agree on the goals of the therapeutic work, and are able to form a therapeutic relationship (Horvath & Greenberg, 1989). Burkard (1997) created and utilized an adapted measure of working alliance in his analogue study, transforming the wording of the original measure into the future tense so that his participants could predict a working alliance based on client information. While other studies examining therapist biases (e.g., Farber, 2002; Rozov, 2002) have utilized predicted working alliance to assess differences in the way therapists view clients, no studies on anti-fat biases have utilized working alliance as an outcome measure. Because working alliance has been utilized as a tool in assessing other forms of therapist bias, it is likely to be helpful as a tool to assess anti-fat biases in psychologists. A study utilizing working alliance as an outcome variable is therefore needed to more fully assess anti-fat biases in psychologists. Furthermore, because working alliance has been shown to be one of the strongest predictors of outcomes across all therapeutic work (see Duncan, Miller, Wampold, & Hubble, 2010), the extent to which psychologists' anti-fat biases might influence it is likely an important question for study.

In addition, further study is needed because other professions have taken greater initiative to examine their own anti-fat biases. Psychologists could take a lesson from research (e.g., Brandsma, 2005; Brown, 2005; Garner & Nicol, 1998; Harvey & Hill, 2001; Hebl & Xu, 2001; Neumark-Sztainer et al., 1999; Pun & Tarrant, 2009) by non-

mental health professionals such as physicians to more thoroughly assess their own biases.

Although Locker (2011) completed the only study examining differences in therapists' bias when clients' weight and ethnicity were manipulated, there were several limitations to the study. There was insufficient power to detect results and only about 20% of the participants were licensed psychologists. Therefore, the most important gap in the literature is the fact that no studies have focused exclusively on whether licensed psychologists hold biases when client ethnicity and client weight status are manipulated.

As demonstrated by the literature review, a person's status as European American or African American may significantly influence how others see the person and the extent of the biases they hold. While Locker (2011) provided preliminary support that a particular pattern of anti-fat bias exists in therapists, existing research is insufficient in determining whether this pattern holds for psychologists. If psychologists' anti-fat biases tend to be different based on the client's ethnicity, this finding would have important implications for therapy, especially in the goal of providing ethical multicultural practice.

Purpose of the Study

This study was carried out in order to contribute to the existing research (Abakoui, 1998; Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Hassel et al., 2001; Loewy, 1995; Locker, 2011; Young & Powell, 1985; Zadroga, 2009) that has examined the issue of anti-fat biases in psychologists and to call attention to the issue of therapist bias in the field of psychology. The purpose of this study was to describe the current level of psychologists' biases toward hypothetical clients when the client characteristics of weight status and ethnicity are manipulated. This 2 (hypothetical client weight status) x 2

(hypothetical client ethnicity) analogue study design included a hypothetical client vignette. Participating psychologists were randomly split into the four study conditions: 1.) average weight/African American, 2.) obese/African American, 3.) average weight/European American, 4.) obese/European American. Participants responded to a series of outcome measures to assess levels of bias.

In this study, the variable of therapist bias was operationalized in three ways. First, bias was assessed in terms overall diagnostic severity, utilizing a GAF score (APA, 2000) where lower scores indicated poorer overall functioning. If the GAF scores differed when client characteristics of weight status and ethnicity were varied and other factors were held constant, therapist bias would likely have influenced perceived level of overall diagnostic severity. To examine perceived level of overall functioning and/or diagnostic severity, previous studies on anti-fat bias in therapists (Abakoui, 1998; Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Hassel et al., 2001; Locker, 2011; Zadroga, 2009) have asked participants to provide a diagnosis, often requesting a five axis DSM diagnosis and/or a GAF score. This study mimicked these other studies by asking participants to provide a GAF score.

Second, this study examined therapist bias by assessing predicted prognosis for the vignette client. Differences in prognosis ratings by manipulated vignette client characteristics would indicate therapist bias since all other aspects of the vignette were held constant. Researchers in previous studies (Abakoui, 1998; Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Young & Powell, 1985; Zadroga, 2009) also asked participants to estimate the client's likely prognosis in treatment.

Third, this study examined bias as it impacted the therapeutic alliance (Horvath & Greenberg, 1989). This study utilized Burkard's (1997) adapted version of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). Participating psychologists reported their predicted working alliance with the vignette client. While other studies (Agell & Rothblum, 1991; Hassel et al., 2001) on therapists' anti-fat biases have adapted other general attitude scales to assess biases, no studies have employed an outcome measure of working alliance or utilized a measure with documented psychometric support.

Hypotheses

Several hypotheses were tested in this study (see Table 1). The first hypothesis stated that participating psychologists would demonstrate a statistically significant anti-fat bias against the vignette client when her weight status was "obese." Participants would indicate higher levels of diagnostic severity for the fat client. Participants would give a poorer prognosis to the fat client. Participants would give lower working alliance scores for the fat client.

The second hypothesis stated that the vignette client's ethnicity would not statistically significantly influence participating psychologists' responses. Participants would not indicate higher levels of diagnostic severity for African American clients. Participants would not give a poorer prognosis to African American clients. Participants would not give lower working alliance scores to African American clients.

The third hypothesis stated that there would be a statistically significant weight by ethnicity interaction effect. Participants would give assign the highest levels of diagnostic severity for the fat European American client. Participants would give the poorest

Table 1

Variables, Measures, and Hypotheses by Vignette Client Characteristics

Vignette Client Characteristics				
Hypotheses				
Variables	Outcome measures	Weight	Ethnicity	Weight by Ethnicity Interaction
Pathology	GAF scores ^a	H1a: Lower GAF scores for O	H2a: No difference	H3a: Lower GAF scores for EA O
Outcome	Prognosis scores	H1b: Lower prognosis scores for O	H2b: No difference	H3b: Lower prognosis scores for EA O
Alliance	WAI-T-A	H1c: Lower WAI-T-A scores for O	H2c: No difference	H3c: Lower WAI-T-A scores for EA O

Note. Vignette client characteristics denoted by: EA = European American, AA = African American, O = Obese weight status, AW = Average weight status.

Hypotheses denoted by H1 for Hypothesis 1, H2 for Hypothesis 2, and H3 for Hypothesis 3; Sub-hypotheses denoted by the letters a, b, and c.

^aLower GAF scores signify greater pathology.

prognosis scores to the fat European American client. Participants would give the lowest working alliance scores for the fat European American client.

CHAPTER III

METHOD

Participant Characteristics

Individuals currently licensed to practice psychology in one of the 50 United States and currently practicing psychologists (defined as seeing at least one client for psychotherapy or assessment in the past year) served as the participants in this study. The demographics of the participants were evaluated using a short questionnaire.

Basic demographic information was collected for each participant ($N = 196$). Of the participating psychologists, 104 were female and 92 were male. For race/ethnicity, the majority of participants ($N = 177$) were European American, four were African American, four were Asian American, one was Hispanic American, one was multi-racial, and one was Middle Eastern American. For number of years practicing psychology, participants' mean response was 21.46 years ($N = 196$; $SD = 11.51$). For type of psychology degree, 148 reported completing a Ph.D., 3 reported completing an Ed.D., and 45 reported completing a Psy.D.

Sampling Procedures

A national sample of licensed and currently practicing psychologists was recruited from two sources: the *National Register of Health Service Providers in Psychology*

(hereafter referred to as the *National Register*) and from *Psychology Today*. Participants were recruited through the websites of the *National Register* (www.nationalregister.org) between March and June, 2012 and *Psychology Today* (www.psychologytoday.com) from July through November, 2012. Use of the *National Register* ended when the site was closed for research participation. A random number list was utilized to generate a list of the 50 United States in randomized order. For both the *National Register* and *Psychology Today*, a randomized list of practitioners from a particular state was then generated. Sampling continued until a total of 20 eligible potential participants were gathered from each state. After approximately 200 potential participants were sampled, the participants were contacted. One reminder email was also sent to potential participants approximately 2 to 4 weeks after the initial request was sent. After waiting 2 to 4 weeks, additional potential participants were sampled and contacted. After 20 potential participants were identified from each of the 50 United States, sampling began again starting with the first state on the random order state list. Because the *National Register* listed a relatively small number of psychologists from some states (e.g., South Dakota, Nevada), fewer than 20 potential participants were contacted at a time for some states.

For the *National Register* sampling source, every other randomly listed psychologist was chosen as a potential participant. Potential participants were excluded if they did not have an “Email me” application on the *National Register* website.

For the *Psychology Today* sampling source, the same sampling procedures were utilized (every other randomly listed psychologist was selected), except that psychologists’ email addresses were gathered from the websites they listed in their

profiles. Participants who did not have email addresses listed on their websites were excluded. In addition, on the *Psychology Today* website, licensed psychologists were randomly listed along with other mental health practitioners. Non-psychologists were excluded from sampling.

Sample Size and Power

A target number of 194 participants (49 participants per vignette condition) was determined utilizing an *a priori* G*Power analysis (Faul, Erdfelder, Buchner, & Lang, 2009). Power analysis indicated that at least 193 usable responses would be necessary to produce adequate power based on the study design. One additional target participant was added to the power analysis estimate to ensure that each vignette condition would have an equal number of participants. An equal number of participants per condition was recommended when utilizing experimental factorial designs (Kerlinger & Lee, 2000). Potential participants continued to be sampled and contacted according to the aforementioned procedure until 49 participants were obtained for each of the four vignette conditions ($N = 194$). Survey responses that were incomplete—which occurred when participants did not finish and submit the entire survey—were discarded ($N = 12$). For the third vignette condition, four extra participants completed the study ($N = 53$). The data from the last four participants to complete the survey in the third vignette condition were also discarded so that each of the four vignette conditions had an equal number of participants.

Measures

Vignette.

A vignette (see Appendix A) containing information about a hypothetical psychotherapy client was used in this study. The vignette was adapted with permission (see Appendix B) from Zadroga's (2009) dissertation (p. 125). For her study, Zadroga adapted with permission a short case example from the book *DSM-IV-TR Case Studies: A Clinical Guide to Differential Diagnosis* (Frances & Ross, 2001, pp. 123-124). Zadroga made several modifications to the case. First, because it was not relevant to the client's symptoms or her study, Zadroga removed the following sentences from the original case example:

His mother is a quiet person, periodically "moody", remote, and depressed.

Shortly after the birth of Mr. A's sister, 3 years his junior, his mother became very depressed and was hospitalized. She responded well to ECT and had no further psychiatric care. Mr. A's father, now deceased, was successful in business but also overbearing, critical, and intimidating and drank to excess. Mr. A. says that he respected him but never felt they were close. (Frances & Ross, 2001, p. 123)

Zadroga also removed the following sentence because it directly referred to a specific diagnosis: "Although he is usually depressed, he has never had depressive episodes that met criteria for a Major Depressive Disorder" (Frances & Ross, 2001, p. 124). Zadroga removed the following passage because it was gender-specific to a male: "When he is depressed, his sex drive is reduced and he has difficulty maintaining an erection, which frightens him" (Frances & Ross, 2001, p. 124). Zadroga removed the following section because it seemed to refer specifically to older individuals and to a

particular theoretical orientation: “There is no evidence of a thought disorder or of hallucinations or delusions. His insight is impaired by his tendency to deny and repress emotionally laden material. His judgment is intact, as are his orientation and recent memory” (Frances & Ross, 2001, p. 124). In her study, Zadroga used three client age conditions, 26, 41, and 72, and converted the male character, Mr. A., to a female for half of the study conditions.

The present study used the 26-year-old female version and changed the name “Ms. A.” to a common first name, Janice. In this study, the ethnicity/race descriptor of “African American” or “European American” was added to first sentence. In the second to last sentence, the weight descriptor of “average weight” or “obese” was added.

This vignette was selected because of its previous use in a vignette study (Zadroga, 2009) measuring anti-fat attitudes in therapists. The author did not report receiving participant complaints about the understandability of the vignette. Jones, Gerrity, and Earp (1990) recommended repeating the use of vignettes to minimize variation in design across studies, eventually contributing to a more useful body of information after the completion of several studies. The design of the current study followed this Jones et al. (1990) recommendation.

Survey of Diagnostic Severity and Prognosis.

The Survey of Diagnostic Severity and Prognosis (see Appendix C) was developed specifically for this study. This measure was similar to those used in previous studies (Abakoui, 1998; Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Young & Powell, 1985; Zadroga, 2009), which also asked participants to provide a Global Assessment of Functioning (GAF) score and to estimate a hypothetical client’s likely

prognosis in treatment. The first item required participants to estimate the vignette client's GAF and enter a score between 1 and 99. The second item assessed projected client prognosis. On a Likert-type scale, psychologists were asked to choose a number corresponding to their projected prognosis for the client (1 = very poor, 2, 3 = poor, 4, 5 = fair, 6, 7 = good, 8, 9 = very good). Young and Powell (1985), Agell and Rothblum (1991), Abakoui (1998), Zadroga (2009), and Davis-Coelho et al. (2000) all asked participants to complete Likert-type items to report clients' expected prognosis in treatment. Specifically, Young and Powell (1985) used a six-point, Likert-type scale to indicate prognosis. Agell and Rothblum (1991) and Abakoui (1998) assessed prognosis on a 5-point Likert-type scale. Zadroga (2009) and Davis-Coelho et al. (2000) asked participants to choose between a good, fair, or poor prognosis. This study utilized a nine-point, Likert-type scale in order to maximize variance.

While data regarding the psychometric properties of this measure are not available, the items in this measure have been used in similar studies (Abakoui, 1998; Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Young & Powell, 1985; Zadroga, 2009). The true reliability and validity of this measure are unknown, but evidence from similar studies (Abakoui, 1998; Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Young & Powell, 1985; Zadroga, 2009) and the statistically significant results obtained in similar studies may provide preliminary support for the measures.

Working Alliance Inventory.

The Working Alliance Inventory (WAI) was created by Horvath and Greenberg (1989) to assess the characteristics of the relationship between a client and a therapist. The Working Alliance Inventory, Therapist form (WAI-T) includes 36 self-report items,

all on a 7-point Likert-type scale (1 = never, 7 = always). In the WAI-T, a therapist rates a client on the 36 items, resulting in a total score of the therapist's rating of the working alliance with the client. The measure assesses working alliance in terms of three subscales: (a) tasks: the extent to which therapists and clients agree on the tasks that will take place during therapy, (b) goals: the extent to which therapists and clients agree on the goals of the therapeutic work, and (c) bond: the extent to which the therapist and client are able to form a therapeutic relationship (Horvath & Greenberg, 1989). The WAI-T has been widely used in research. According to Tracey and Kokotovic (1989), Cronbach's alpha for the total measure was 0.84 and ranged from 0.87 to 0.93 for the subscales (Tracey & Kokotovic, 1989). According to Tichenor and Hill (1989), the WAI-T was found to be internally consistent with a coefficient alpha of .95.

An adapted version of the WAI-T (hereafter referred to as WAI-T-A; see Appendix D) was used with permission (see Appendix B) in this study to examine bias in terms of the predicted working alliance. The WAI-T-A was created to assess a therapist's perception of the potential working alliance in analogue studies (Burkard, 1997; Burkard et al., 1999). Subsequent analogue studies examining therapist biases (e.g., Crook Lyon et al., 2007; Farber, 2002; Rozov, 2002) have also employed measures of predicted working alliance to assess differences in the way therapists view clients. Burkard (1997) asked several experts to adapt the WAI-T wording into the future tense so that participants could be asked to predict a working alliance based on analogue client information. Burkard et al. (1999) presented preliminary psychometric evidence supporting the future tense adaptation of the measure. Crook Lyon et al. (2007) also utilized this adapted therapist version of the WAI in their study. Using Burkard's (1997) adaptation, Crook

Lyon et al. (2007) attained Cronbach's alphas of .75 on the task subscale, .70 on the bond subscale, .81 on the goal subscale, and .90 on the total measure. Therefore, the WAI-T-A has preliminary psychometric support for its validity and reliability. Because the Cronbach's alpha for the total measure in Crook Lyon et al. (2007) had a rating higher than the subscale ratings, this study utilized the total score on the WAI-T-A as an outcome measure.

Demographic Questionnaire.

A short Demographic Questionnaire (see Appendix E) was also developed specifically for this study. This measure was designed to capture general demographic information about the participating psychologists. The measure asked participants to provide information about their gender, ethnicity/race, number of years practicing psychotherapy and/or assessment, and type of psychology degree.

Research Design

This study utilized a 2 (vignette client ethnicity) x 2 (vignette client weight status) experimental design (see Kerlinger & Lee, 2000). Participants were randomly assigned to one of the four vignette conditions. The researcher manipulated the client characteristics in the vignette conditions, while the rest of the vignette remained identical across conditions. Diagnostic severity (measured by GAF scores), prognosis (measured by prognosis scores), and working alliance predictions (measured by WAI-T-A scores) served as outcome variables.

Because several researchers (e.g., Morrison et al., 2009; Wang, Brownell, & Wadden, 2004) have documented the limitations of explicit self-report measures, this study did not use face valid anti-fat attitude scales, possibly reducing the rate of altered

responding. The Young and Powell (1985), Puhl et al. (2009), and Agell and Rothblum (1991) studies also utilized similar designs. This type of study design, which lessens face validity, may lead to more accurate results.

In this study, the vignette and accompanying outcome measures were distributed using a confidential online survey process, the link to which was sent to potential participants by e-mail. Some researchers (e.g., Koch & Emrey, 2001), have recommended the use of online surveys as opposed to other methods (e.g., direct responses via email) because they are a more secure method of communication and allow for truly anonymous participant responses.

This study employed an analogue design: a hypothetical client vignette was utilized instead of a real client (see Kazdin, 1978). Several other recent research publications (e.g., Ehrbar, Witty, Ehrbar, & Bockting, 2008; Hatfield & Ogles, 2006; Kielbasa, Pomerantz, Krohn, & Sullivan, 2004; Pomerantz & Segrist, 2006) have utilized similar analogue, vignette-based research designs. According to Stopa and Clark (2001), analogue research affords advantages because experimental designs can be utilized; in similar inquiries with actual clients, experimental designs would be infeasible. While Jones, Gerrity, and Earp (1990) found inconclusive results in terms of validity of analogue research designs, the researchers ultimately stated that “written simulations are probably an effective research instrument for eliciting attitudes and beliefs” (p. 812).

Hypotheses

Three hypotheses were tested in this study (see Table 1). The first hypothesis stated that psychologists would demonstrate a statistically significant anti-fat bias against the client in the hypothetical vignette when her weight status was “obese.” Specifically,

psychologists would give lower GAF scores to the fat client, psychologists would give a poorer prognosis to the fat client, and psychologists would give lower WAI-T-A scores to the fat client.

Relevant literature supported the first hypothesis. Several studies (e.g., Young & Powell, 1985; Agell & Rothblum, 1991; Lowey, 1995; Abakoui, 1998; Davis-Coelho et al., 2000; Hassel et al., 2001; Locker, 2011) found evidence of anti-fat bias in therapists. In all of the studies, the bias led to more negative, pathological, or erroneous views of the fat client. Research (e.g., Brandsma, 2005; Garner & Nicol, 1998; Harvey & Hill, 2001; Neumark-Sztainer, Story, & Harris, 1999; Pun & Tarrant, 2009) from other professional disciplines also indicated that fat patients/clients tend to be viewed more negatively by professionals such as physicians, nurses, and teachers. In addition, the literature on anti-fat bias in the general population (e.g., Andreyeva, Puhl, & Brownell, 2008; Crandall, 1994; Puhl & Huer, 2009) supported the fact that most people hold negative attitudes toward people who are fat and that these attitudes are used to justify prejudice and discrimination toward fat people in most domains (e.g., the work place, relationships, housing, public policy, social norms, health care). All of these studies contributed to the likelihood that psychologists, too, would hold anti-fat biases and these biases would influence their work with fat clients.

The second hypothesis stated that the vignette client's ethnicity would not statistically significantly influence psychologists' responses. Specifically, psychologists would not give lower GAF scores to African American clients, psychologists would not give a poorer prognosis to African American clients, and psychologists would not give lower WAI-T-A scores to African American clients.

Some literature also supported the second hypothesis. For example, Locker (2011) found that African American clients were sometimes viewed favorably on explicit outcome measures, potentially due to social desirability bias. Many people may believe that they are being racist if they over-pathologize African Americans. On the other hand, other research (see APA, 2002) documents disparities in treatment between African American and European American clients, which may also influence ratings of clients.

The third hypothesis predicted a statistically significant interaction effect for vignette client variables of ethnicity and weight status, specifically in demonstrating the strongest bias against fat European American clients. Specifically, psychologists would give lower GAF scores to the fat European American client, psychologists would give poorer prognosis scores to the fat European American client, and psychologists would give lower WAI-T-A scores to the fat European American client.

Research (e.g., Cawley, 2004; Connely & Glauber, 2007; Han et al., 2009; Jackson & McGill, 1996; Nosek et al., 2007) has suggested that the American public tends to view fat African American women as “more acceptable” than fat European American women, and vice versa; Americans are less likely to discriminate against fat African American women than fat European American women. As previously mentioned, Trapnell and Wiggins (1990) found significant halo effects for White women, in that both male and female participants rated normal weight White women as having more socially desirable and positive personality traits than overweight White women. Results also suggested that participants tended to believe that a thin White woman was more attractive, had a better personality, and was more successful in life than a heavy woman; when judging Black women, participants tended to believe that heavier Black women had

better personalities and were more successful in life than thin Black women (Wade & DiMaria, 2003; Wade et al., 2003). Only one study (Locker, 2011) has examined this interaction effect in therapists. Locker (2011) found preliminary evidence that therapists tend to be more positive in their judgments of fat African American female clients and more negative in their judgments of fat European American female clients. Therefore, the fat European American vignette client in this study was hypothesized to be the target of the most anti-fat bias.

Procedure

Before beginning this investigation, approval (Protocol #29466) was gained from Cleveland State University's Institutional Review Board. Potential participating psychologists were recruited via email (see Appendix F) through the *National Register* and through *Psychology Today* according to the sampling procedures listed above. The vignette and accompanying outcome measures were distributed using a confidential, online survey process; the link to this online survey (SurveyMonkey™) was distributed to potential participants by email.

When they followed the link, participants were first presented with an informed consent statement (see Appendix G) and asked to submit an electronic signature. Next, participating psychologists read the study vignette (see Appendix A). The vignette was adapted with permission (see Appendix B) from Zadroga (2009), another study of therapists' anti-fat biases. Client weight status and ethnicity were experimentally manipulated, resulting in four different conditions: 1) average weight African American client condition, 2) obese African American client condition, 3) average weight European

American client condition, and 4) obese European American client condition. Participants were randomly assigned to one of the four conditions.

After reading the vignette, participants completed the Survey of Diagnostic Severity and Prognosis (see Appendix C). Then participants completed the WAI-T-A (see Appendix D; for author permissions see Appendix B). Finally, participants completed the short Demographic Questionnaire (see Appendix E).

Participant responses in this study were anonymous. This was achieved through the use of an online survey; there was no way for the researcher to tie specific responses to specific participants. Also, the demographic and background information collected on the participants was kept very general (including gender, ethnicity, number of years practicing psychotherapy and/or assessment, and type of psychology degree) to limit the presence of potentially identifying information. This was particularly important to ensure that participants could respond honestly to the potentially sensitive subject matter (personal opinions about people who are fat or are members an ethnic minority groups).

Because data were collected utilizing SurveyMonkey™, the researcher set the online survey to prohibit participants from leaving any response blank. If responses were left blank and participants attempted to navigate to the next page of the survey, they were given a prompt of “This question requires an answer” next to the omitted item. For that reason, there were no missing data in completed responses.

Analysis of Data

After data collection, data were examined for normality and for homogeneity of variance. A Box’s Test of Equality of Covariance Matrices was performed to determine whether the observed covariance matrices of the dependent variables were equal across

groups. If the Box's Test had been significant, level of statistical significance would have been adjusted from .05 to .01 to adjust for the heterogeneity of variance. In addition, data were examined to ensure normality. If data were not approximately normal, non-parametric tests would have been utilized to determine significance. Participant demographics and descriptive statistics were evaluated. Finally, Cronbach's α was determined for each of the WAI-T-A subscales (Task, Bond, and Goal) and for the total outcome measure.

A 2 (ethnicity) x 2 (weight status) factorial Multivariate Analysis of Variance (MANOVA) was performed to examine the main effects of vignette client ethnicity (African American or European American) and vignette client weight status (Average weight or obese), and weight by ethnicity interaction effects. Outcome measures included GAF scores, prognosis scores, and WAI-T-A scores.

CHAPTER IV

RESULTS

Data collection occurred from March 2012 to November 2012. The *National Register* was used as a sampling source from March 2012 to June 2012. *Psychology Today* was utilized as a sampling source from June 2012 until the conclusion of data collection in November 2012.

In total, 1896 psychologists were contacted to participate in the study; 200 psychologists (10.55%) completed the survey. A total of 1417 *National Register* psychologists were contacted via email. Of those contacted, 118 (8.33%) completed the survey, which accounted for approximately 55% of the participants in each of the four vignette conditions. A total of 479 *Psychology Today* psychologists were contacted via email. Of those contacted, 82 (17.19%) completed the survey, which accounted for approximately 45% of the participants in each of the four vignette conditions. As previously discussed, for the third vignette condition, four extra participants completed the study ($N = 53$). The data from the last four participants to complete the survey in the third vignette condition (all from the *Psychology Today* sample since it was collected last) were discarded so that each of the four vignette conditions had an equal number of participants. Therefore the final number of participants from the *Psychology Today*

sample source was 78. The *National Register* sampling source ($N = 118$) had a greater number of male participants ($N = 64$) and had a higher average number of years of practicing psychology ($M = 24.15$; $SD = 12.24$). The *Psychology Today* sampling source ($N = 78$) had a greater number of female participants ($N = 50$) and had a lower average number of years practicing psychology ($M = 17.40$; $SD = 8.95$).

Descriptive Statistics

In this study, the variable of therapist bias was operationalized in three ways. First, bias was assessed in terms overall diagnostic severity utilizing a GAF score (APA, 2000) where lower scores indicated poorer overall functioning. Second, this study examined therapist bias by assessing predicted prognosis for the vignette client. Third, this study examined bias as it impacted the therapeutic alliance (Horvath & Greenberg, 1989). This study utilized Burkard's (1997) adapted version of the WAI-T (Horvath & Greenberg, 1989). These three measures served as the outcome variables.

Data for each outcome variable approximated a normal curve, without indication of kurtosis or skew. The three outcome measures had the following descriptive statistics: GAF scores ($N = 196$, $M = 57.80$, $SD = 5.42$), prognosis scores ($N = 196$, $M = 6.35$, $SD = 1.35$), and WAI-T-A scores ($N = 196$, $M = 194.08$, $SD = 20.44$). For a correlation matrix, see Table 2. For GAF scores, the range was 26 (minimum = 45, maximum = 71). For prognosis scores, the range was 6 (minimum = 3, maximum = 9). For total WAI-T-A scores, the range was 115 (minimum = 132, maximum = 247). Because the assumptions of the parametric MANOVA were met, a MANOVA was performed to analyze the data.

Table 2

Correlation Matrix

Outcome Variables	1	2	3
1. GAF	-		
2. Prognosis	0.12	-	
3. WAI-T-A	0.03	0.39*	-

Note. *Significant at the .05 level

Reliability

For the WAI-T-A outcome measure, Cronbach's α values were computed to examine reliability. For the Task ($\alpha = 0.87$, $SD = 7.56$, $N = 12$), Bond ($\alpha = 0.79$, $SD = 6.67$, $N = 12$), and Goal ($\alpha = 0.85$, $SD = 7.58$, $N = 12$) subscales, Cronbach's α ranged from 0.79 to 0.87. For the total WAI-T-A ($\alpha = 0.94$, $SD = 20.44$, $N = 36$), reliability was very high, further supporting the use of the WAI-T-A total score in the analyses. The Cronbach's α values found in this study were comparable to those obtained by Crook Lyon et al. (2007): 0.75 on the task subscale, 0.70 on the bond subscale, 0.81 on the goal subscale, and 0.90 on the total measure. Because the other two outcome measures (GAF score and prognosis score) included only one item, no reliability analysis could be performed.

Multivariate Analysis of Variance

To establish equality of variance, Box's Test of Equality of Covariance Matrices was not significant ($F = 0.96$, $p = 0.51$), indicating no statistically significant differences in variances across study groups.

A 2 (ethnicity) x 2 (weight status) factorial MANOVA was conducted utilizing the outcome measures of GAF scores ($N = 196$, $M = 57.80$, $SD = 5.42$), prognosis scores ($N = 196$, $M = 6.35$, $SD = 1.35$), and WAI-T-A scores ($N = 196$, $M = 194.08$, $SD = 20.44$). For the model, there were no statistically significant differences according to vignette client weight [$F(1, 192) = 1.46$, $p = 0.23$], vignette client ethnicity [$F(1, 192) = 0.77$, $p = 0.51$], or weight by ethnicity interaction [$F(1, 192) = 0.28$, $p = 0.85$] (see Table 3).

Table 3

Factorial MANOVA Results

Main and Interaction Effects	Wilks' Lambda ($N = 196$)	
	$F(1, 192)$	p
Weight	1.46	0.23
Ethnicity	0.77	0.51
Weight by Ethnicity Interaction	0.28	0.85

The first hypothesis (see Table 4) was that participating psychologists would demonstrate a statistically significant anti-fat bias against the vignette client when her weight status was “obese.” There were no statistically significant differences according to vignette client weight status [$F(1, 192) = 1.46, p = 0.23$]. Therefore, the first hypothesis was not supported. Participating psychologists did not give statistically significantly lower GAF scores, prognosis scores, or WAI-T-A scores to obese vignette clients.

The second hypothesis (see Table 5) was that the vignette client’s ethnicity would not statistically significantly influence participating psychologists’ responses. There were no statistically significant differences according to vignette client ethnicity [$F(1, 192) = 0.77, p = 0.51$]. Therefore, the second hypothesis was supported; participating psychologists did not give statistically significantly different GAF scores, prognosis scores, or WAI-T-A scores based on vignette client ethnicity.

The third hypothesis (see Table 6) was that there would be a statistically significant interaction effect for vignette client weight status and ethnicity, indicating that fat European American clients were seen the least favorably. There were no statistically significant ethnicity by weight interaction effects [$F(1, 192) = 0.28, p = 0.85$]. Therefore, the third hypothesis was not supported. Participating psychologists did not give statistically significantly different GAF scores, prognosis scores, or WAI-T-A scores based on the interaction between vignette client weight status and ethnicity.

In short, participants’ responses were analyzed utilizing a factorial MANOVA. For the model, there were no statistically significant differences according to vignette client weight [$F(1, 192) = 1.46, p = 0.23$], vignette client ethnicity [$F(1, 192) = 0.77, p = 0.51$], or weight by ethnicity interaction [$F(1, 192) = 0.28, p = 0.85$] (see Table 3).

Table 4

Hypothesis 1: Vignette Client Weight Status

Variables	Outcome measures	Vignette Client Weight Status ($N = 196$)			
		M	SD	$F (1, 192)$	p
Pathology	GAF scores	57.80	5.42	2.13	0.15
Outcome	Prognosis scores	6.35	1.35	2.69	0.10
Alliance	WAI-T-A	194.08	20.44	0.15	0.70

Table 5

Hypothesis 2: Vignette Client Ethnicity

Variables	Outcome measures	Vignette Client Ethnicity (N = 196)			
		<i>M</i>	<i>SD</i>	<i>F</i> (1, 192)	<i>p</i>
Pathology	GAF scores	57.80	5.42	0.13	0.72
Outcome	Prognosis scores	6.35	1.35	0.14	0.71
Alliance	WAI-T-A	194.08	20.44	2.18	0.14

Table 6

Hypothesis 3: Vignette Client Weight by Ethnicity Interaction

Variables	Outcome measures	Vignette Client Weight by Ethnicity Interaction (N = 196)			
		<i>M</i>	<i>SD</i>	<i>F</i> (1, 192)	<i>p</i>
Pathology	GAF scores	57.80	5.42	0.01	0.91
Outcome	Prognosis scores	6.35	1.35	0.07	0.80
Alliance	WAI-T-A	194.08	20.44	0.47	0.50

Outcome measures included GAF scores ($N = 196$, $M = 57.80$, $SD = 5.42$), prognosis scores ($N = 196$, $M = 6.35$, $SD = 1.35$), and WAI-T-A scores ($N = 196$, $M = 194.08$, $SD = 20.44$). Cronbach's α was computed for the total WAI-T-A ($\alpha = 0.94$, $SD = 20.44$, $N = 36$); reliability was high, supporting the use of the WAI-T-A total score in the analyses.

CHAPTER V

DISCUSSION

This study was carried out in order to contribute to the existing research (Abakoui, 1998; Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Hassel et al., 2001; Loewy, 1995; Locker, 2011; Young & Powell, 1985; Zadroga, 2009) that has examined the issue of anti-fat biases in psychologists and to call attention to the issue of therapist bias in the field of psychology. The purpose of this study was to describe the current level of psychologists' biases toward hypothetical clients when the client characteristics of weight status and ethnicity are manipulated.

While other studies (Agell & Rothblum, 1991; Hassel et al., 2001) on therapists' anti-fat biases have adapted other general attitude scales to assess biases, no studies have employed an outcome measure of working alliance or utilized a measure with documented psychometric support. In addition, this study was carefully planned to yield adequate power in completing analyses. Therefore, the methodology of this study was a contribution to the literature, adding a more rigorous methodology and introducing a new tool by which to examine therapist biases when client weight status, ethnicity, and weight-by-ethnicity interaction were manipulated.

The current study did not find evidence of psychologists' bias. When vignette client characteristics of ethnicity and weight were manipulated, there were no statistically significant differences in psychologists' responses on outcome measures.

First, the results of this study did not support the first study hypothesis that psychologists would give statistically significantly lower GAF scores, prognosis scores, or WAI-T-A scores to the fat client. The lack of significant results of this study's first hypothesis was consistent with some previous literature. On the variable of diagnostic severity, the results of this study were consistent with previous literature from Davis-Coelho et al. (2000), which found no differences in GAF scores, and Zadroga (2009) which did not find statistically significant differences in diagnostic severity based on client weight status. On the variable of prognosis, the results of this study were consistent with two other studies (Young & Powell, 1985; Zadroga, 2009) which did not find statistically significant differences in prognosis based on client weight status. While no previous studies specifically examined working alliance as a variable, some measured constructs similar to those included in the WAI-T-A. For example, Young and Powell (1985) found that there were no statistically significant differences in therapists' willingness to work with fat clients or beliefs that intervention would be useful for clients based on weight status. In addition, Agell and Rothblum (1991) found no statistically significant differences in therapy recommendations based on client weight status. The current study contributed to the literature by supporting these results. The current study also improved upon previous studies by utilizing a measure of working alliance that had psychometric support, by ensuring adequate power for analyses, and by utilizing a national sampling procedure.

On the other hand, several previous studies (e.g., Young & Powell, 1985; Agell & Rothblum, 1991; Lowey, 1995; Abakoui, 1998; Davis-Coelho et al., 2000; Hassel et al., 2001; Locker, 2011) found that therapists held anti-fat biases which led to a more negative view of the fat client. In addition, other professional disciplines have studied anti-fat bias and found that fat patients/clients are viewed more negatively by professionals such as physicians, nurses, and teachers (Brandsma, 2005; Garner & Nicol, 1998; Harvey & Hill, 2001; Neumark-Sztainer, Story, & Harris, 1999; Pun & Tarrant, 2009). Researchers (e.g., Andreyeva, Puhl, & Brownell, 2008; Crandall, 1994; Puhl & Huer, 2009) who have studied the general population have found that the majority of Americans hold negative attitudes toward people who are fat; these are sometimes utilized to justify prejudice and discrimination toward fat people across multiple domains (e.g., the work place, relationships, housing, public policy, social norms, health care).

Specifically, the results of this study's first hypothesis were inconsistent with several results from previous similar studies. Regarding diagnostic severity, the results of this study were inconsistent with findings by Abakoui (1998) and Hassel et al. (2001), both of which found that fat clients were given statistically significantly lower GAF scores and more severe diagnoses. In addition, Young and Powell's (1985) results indicated that therapists saw fat clients as having more symptoms than non-fat clients. Davis-Coelho et al. (2000) found that fat clients were given different diagnoses than non-fat clients. Regarding prognosis, the results of this study were inconsistent with previous research (Abakoui, 1998; Davis-Coelho et al., 2000) which found that therapists tended to assign poorer prognoses to fat clients. In addition, Davis-Coelho et al. (2000) found that therapists believed fat clients would show less effort in therapy. Locker (2011) found that

therapists believed that fat clients were less motivated for change. While no previous studies specifically examined working alliance as a variable, some measured constructs similar to those included in the WAI-T-A and found statistically significant differences for fat versus non-fat clients. Results of previous research (Abakoui, 1998; Davis-Coelho et al, 2000) indicated that therapists tended to set different goals for fat clients; these results were inconsistent with the current study's results. In addition, other research (Hassel et al, 2001; Locker, 2011) found that therapists had statistically significantly more negative attitudes toward fat clients than toward non-fat clients. This study's lack of statistically significant results on the outcome variable of WAI-T-A was inconsistent with those studies.

Second, the results of this study did support the second study hypothesis: that ethnicity would not statistically significantly influence psychologists' responses. In this study, participating psychologists did not give statistically significantly different scores (GAF scores, prognosis scores, or WAI-T-A scores) based on the vignette client ethnicity of European American or African American. This result was consistent with the literature (e.g., Locker, 2011), and may have been the result of social desirability bias, a self-selected sample, and/or the limits of the sample size. While other research (see APA, 2002) documents major disparities in treatment between African American and European American clients, the design of this study did not yield statistically significant differences based on vignette client ethnicity.

Third, the results of this study did not support the third hypothesis: that there would be a statistically significant ethnicity by weight status interaction effect, with the vignette client with the characteristics of obese and European American receiving the

lowest scores on outcome measures. This result is inconsistent with the literature on the general population (e.g., Cawley, 2004; Connely & Glauber, 2007; Han et al., 2009; Jackson & McGill, 1996; Nosek et al., 2007), which suggests that Americans tend to view fat African American women as “more acceptable” than fat European American women, and vice versa. In addition, the results of this study were inconsistent with Locker’s (2011) findings, which provided evidence that therapists tend to be more positive in their judgments of fat African American female clients and more negative in their judgments of fat European American female clients.

Interpretations

Based on the results of this study, there are several potential interpretations. First, currently licensed, practicing psychologists may not be biased against clients based on weight status, ethnicity, or the interaction of weight status by ethnicity. While this interpretation would be consistent with some findings from similar previous studies (Agell & Rothblum, 1991; Davis-Coelho et al, 2000; Young & Powell, 1985; Zadroga, 2009), it seems unlikely considering the substantial body of research support for the existence of these biases in psychologists (Abakoui, 1998; Davis-Coelho et al, 2000; Hassel et al, 2001; Locker, 2011; Young & Powell, 1985). Also, social work research (Ahern & Tally, 2009; Aza, 2009; Dennis, 2006; Hanson, 2009; McCardle, 2008) has supported the existence of biases in therapists. Other literature (Abakoui & Simmons, 2010; Davidson, 1980; Downes, 2001; Drell, 1988; Ingram, 1978; Kannard, 2008; Koenig, 2008; Lawrence et al, 2011; Melcher & Bostwick, 1998; Yalom, 1989) has described the existence of biases in therapists. Finally, a lack of bias in currently licensed,

practicing psychologists also seems infeasible given the pervasiveness of anti-fat biases in the general population (see Andreyeva, Puhl, & Brownell, 2008).

A second potential interpretation of this study's results is that psychologists may hold biases, but the present study design was not able to detect them. Research (e.g., Young & Powell, 1985; Agell & Rothblum, 1991; Lowey, 1995; Abakoui, 1998; Davis-Coelho et al., 2000; Hassel et al., 2001; Locker, 2011) suggests that therapists hold anti-fat biases; in the studies, the bias led to more negative, pathological, or erroneous views of the fat client. Research (e.g., Brandsma, 2005; Garner & Nicol, 1998; Harvey & Hill, 2001; Neumark-Sztainer, Story, & Harris, 1999; Pun & Tarrant, 2009) from other professional disciplines has indicated that fat patients/clients tend to be viewed more negatively by other professionals (e.g., physicians, nurses, and teachers). A substantial body of research (e.g., Andreyeva, Puhl, & Brownell, 2008; Crandall, 1994; Puhl & Huer, 2009) has shown strong anti-fat bias in the general population, has demonstrated that most people hold negative attitudes toward people who are fat, and has indicated that that these attitudes are used to justify prejudice and discrimination toward fat people in most domains (e.g., career, relationships, housing, public policy, social norms, health care). All of these studies contribute to the likelihood that psychologists do hold anti-fat biases and these biases influence their work with fat clients. The fact this study's results conflict with several studies (e.g., Young & Powell, 1985; Agell & Rothblum, 1991; Lowey, 1995; Abakoui, 1998; Davis-Coelho et al., 2000; Hassel et al., 2001) on therapist anti-fat bias and with the only other similar study (Locker, 2011) points to the great need for additional research on anti-fat bias in psychologists and the way in which client ethnicity impacts these biases.

Limitations

This study had several limitations. First, while national sampling procedures were employed in this study, there are still some limitations regarding sampling. While many licensed psychologists in the United States are listed through the *National Register* and *Psychology Today*, a truly random sample of all practicing psychologists in the United States was not obtained because not all licensed psychologists were listed. The licensed psychologists listed in the *National Register* and on *Psychology Today* may be significantly different than the licensed psychologists who are not listed, which may limit the generalizability of the results. In addition, some of the psychologists listed on the *National Register* and on the *Psychology Today* site did not include email contact options. These psychologists were excluded from receiving an invitation to participate. Psychologists without listed email contact options may be significantly different than those who include email contact options; these differences may impact the study results and generalizability. In addition, the psychologists that choose to participate in the study may be significantly different than the psychologists that do not choose to participate. These sampling issues likely diminish the external validity of the findings, limiting the generalizability of the results of this research.

In addition, the fact that the words *obese* and *average weight* were used as weight descriptors in the vignettes is a potential limitation. These weight descriptors were employed because they would be most likely to be seen in actual clinical notes by a psychologist, and other methods of describing weight may have cued participants that weight status is an experimental variable in the study. While the word *obese* is currently the most common descriptor used to indicate high weight status in the psychological

literature, researchers (Smith, Schmoll, Konik, & Oberlander, 2007) have found that different descriptors for large-sized women evoke different responses. Smith et al. (2007) found that when using a variety of words to describe the high weight-status of a person, inclusion of words like *fat* to self-identify weight status of a hypothetical person's self-advertisement led to more negative feelings toward the hypothetical person by participants. The stigma of labels and the choice of certain words over others, such as choosing *fat* over *full-figured*, may therefore influence outcomes (Smith et al., 2007). The term *large-sized* or the provision of objective information (e.g., physical statistics such as 5'4" and 197 lbs.) were found to be neutral; *overweight*, *obese*, and *fat* were found to be negative, and *full-figured* was found to be positive (Smith et al., 2007). The fact that linguistic descriptors had the potential to skew this study's results was a limitation.

An order effect may have been another limitation of this study. After reading the vignette, participants completed the Survey of Diagnostic Severity and Prognosis (see Appendix C), the WAI-T-A (see Appendix D), and the short Demographic Questionnaire (see Appendix E). Because these measures were always presented in the same order (as listed above), there may have been an order effect. Future research could employ a similar design but counter-balance the presentation of the measures.

Several similar analogue studies (Davis-Coelho et al., 2000; Hassel et al., 2001; Locker, 2011; Young & Powell, 1985) on anti-fat biases in therapists have included a photograph of a potential client, often instead of or in addition to text descriptors. For some of the studies (e.g., Locker, 2011), the use of photographs of varying gender and ethnicity was a design limitation because no procedure was described that would ensure that all of the clients of varied ethnicities were equal in terms of attractiveness ratings. If

differences existed in baseline attractiveness, the study outcomes may have been confounded. In this study, use of photographs was not an option because the study was examining differences between a European American client and an African American client. Digital alteration of skin color in an originally European American individual would not accurately capture African American facial features. If two separate models were used, there would be potentially confounding influences of attractiveness bias. Therefore, only linguistic descriptors were used in this study, which may be a limitation.

This study utilized explicit measures as opposed to implicit measures. Social desirability bias, involving participants altering their responses because they want to present themselves in a more favorable light (Paulhus, 1991), may have influenced results in this study. While this study attempted to minimize the influence of social desirability bias in responses by not providing participants with complete information about the purpose of the study, there was still a chance that social desirability bias may have influenced responding.

In addition, this study's sample size was a limitation. Although this study was designed to include a sufficient number of participants to have adequate power for a 2 x 2 factorial MANOVA, a larger sample size may have resulted in higher power. More participants may have further reduced the likelihood of a Type II Error or a "false negative" (see Kerlinger & Lee, 2000). In addition, with more participants, this study may have had sufficient power to complete additional analyses. First, a potential limitation of this study was the inadequate power to run a 2 x 2 x 2 MANOVA, including the two sampling sources (the *National Register* and *Psychology Today*) in the overall analysis. Had there been a larger sample size, this analysis may have been possible. In

addition, a greater number of participants might have allowed for analysis of whether participant gender, weight status, ethnicity, or number of years practicing might have impacted responses. To the researcher's knowledge, no studies with sufficient power were able to analyze connections between participant characteristics and anti-fat bias in psychologists.

Finally, this study's analogue design was a limitation. The use of vignettes and/or other forms of analogue research, such as watching a video of a client or listening to an audio recording of a client, has been criticized (e.g., James & Haley, 1995; Lee et al., 2003) because these incomplete presentations may not capture processes that occur in real therapeutic interactions. Less information may lead to a person's over-reliance on stereotypes, a process that might not occur in therapy. Kazdin (1978) described analogue studies as having issues with external validity, meaning that they may not generalize to practice with actual clients. In addition, according to Jones, Gerrity, and Earp (1990), "researchers who use written simulations and readers of studies that use them, must accept some degree of uncertainty about their validity" (p. 805). Criterion validity, the problem of whether vignettes lead to the same reactions in psychologists as do actual clients, was a concern in this study. Participating psychologists reading the client vignettes in this study may not have used the same clinical judgment used in work with actual clients. Not all participants who read the vignette in this study may have interpreted it similarly, and the vignette may not have produced a valid representation of an actual client. Therefore, the results obtained in this study may not fully generalize to practice. While the results of this analogue study may be useful, Stopa and Clark (2001) recommended that findings of analogue study designs be validated with actual clients. On

the other hand, while Jones et al. (1990) found inconclusive results in terms of validity of analogue research designs, the researchers ultimately stated that “written simulations are probably an effective research instrument for eliciting attitudes and beliefs” (p. 812).

Suggestions for Future Research

While this study did not yield statistically significant results of psychologist biases based on the client characteristics of weight status, ethnicity, and weight-by-ethnicity interaction, further research is required to fully assess the issue psychologist bias in these areas. As described, only four published studies (Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Hassel et al., 2001; Young & Powell, 1985), four dissertations (Abakoui, 1998; Loewy, 1995; Locker, 2011; Zadroga, 2009), and the current study have investigated therapist bias based on client weight status. Only one previous study (Locker, 2011) and the current study examined client ethnicity and weight-by-ethnicity interaction. Therefore, an insufficient amount of research exists to describe these biases in psychologists.

First, future researchers could replicate and expand upon the current study through continued utilization of analogue research designs. In particular, future research could build on the current study by replicating it with greater sample sizes. Studies could also explore various additional outcome variables along with the diagnostic severity, prognosis, and working alliance variables assessed in this study. Finally, researchers with adequate power could conduct an in-depth examination of therapist variables (e.g., therapist gender, weight status, ethnicity, identity development) to assess whether these variables impact levels of bias. Some research on the general public (e.g., Conley & McCabe, 2011) has indicated that individuals’ characteristics (e.g., BMI, ethnicity,

gender) might predict anti-fat bias toward others. Well-designed research is necessary to determine whether psychologists' characteristics predict anti-fat bias toward clients.

Second, future researchers could employ *in vivo* study designs such as interactive studies. Because much of the discrimination of stigmatized groups occurs within interpersonal interactions (Schnittker & McLeod, 2005), future research could attempt to assess bias by examining interpersonal interactions between psychologists and fat clients. Other interactive studies on the general public (e.g., Hebl & Dovidio, 2005) have detected differences between the way people treat fat people and the way they treat non-fat people, both in real life and in laboratory settings. For example, researchers could examine recordings of *in vivo* professional interactions between psychologists and clients. Ideas could include assessing differences through recordings of waiting room interactions or in the first few minutes of the initial client contact. Differences (based on client weight status, ethnicity, and gender-by-ethnicity interaction) in the way psychologists greet and/or begin work with clients could be useful indicators of anti-fat bias.

In addition, future research could focus on utilizing implicit measures of anti-fat attitudes in psychologists. As previously described, these measures assess automatic bias without results being influenced by face validity and social desirability (Morrison et al., 2009). Because research (e.g., Bessenoff & Sherman, 2000; Nosek et al., 2007; Teachman et al., 2003) has identified anti-fat biases in nearly 70% of the general public even when they denied explicit anti-fat attitudes, implicit research specifically assessing psychologists might indicate similar levels of bias.

Finally, additional research on anti-fat biases in psychologists could employ qualitative research designs. Some social work research on therapist attitudes and/or client experiences (e.g., Aza, 2009) has yielded themes of therapists' emotional/countertransference reactions to fat clients, microaggressions toward fat clients, and a lack of therapist awareness of anti-fat biases. Utilizing qualitative designs, future research could investigate similar manifestations of biases in psychologists and examine how they might impact client treatment. Interview questions for study could include direct questions about fat clients or might examine potential biases utilizing more indirect questions (e.g., requesting a case conceptualization of a fat client). Qualitative research could also assist in describing fat clients' experiences in therapy, could assess whether fat clients report instances of discriminatory treatment by psychologists, and could explore if/how client ethnicity impacts psychologists' biases.

As additional data emerge from continued study, the psychology profession as a whole may be able to react to evidence of biases based on client characteristics of weight and ethnicity. In particular, education on awareness of biases and on the systemic oppression of fat people may move the field toward greater competence in working with fat individuals. As previously mentioned, should research eventually indicate a clear presence of anti-fat bias in psychology, competent treatment according to the APA Multicultural Guidelines (APA, 2002) and the Ethics Code (APA, 2010) may require addressing these issues.

Summary

This study examined psychologists' biases toward female clients when client weight and ethnicity were manipulated. Its purpose was to add to the existing body of

research (Abakoui, 1998; Agell & Rothblum, 1991; Davis-Coelho et al., 2000; Hassel et al., 2001; Loewy, 1995; Locker, 2011; Young & Powell, 1985; Zadroga, 2009) on psychologists' biases and to draw additional attention in the field toward issues of anti-fat bias. While the results of this study were non-significant, additional research is required to fully describe biases in psychologists. The more these biases are understood, the more likely members of the field will be to examine their own biases against fat people and the way client characteristics of weight and ethnicity might interact.

Currently, while psychologists ought to be heeding research (e.g., Gaesser, 2002) that details the dangers of dieting and its harmful influences on mental health, they appear to be focusing on how to assist clients in losing weight, accepting the view that fatness is a disease that needs to be cured (Abakoui & Simmons, 2010; Rothblum, 1999). While researchers (e.g., Hainer et al., 2001; Munnig, 2008) have found that weight is largely genetically determined and that factors such as lifestyle choice have limited influence on BMI, health and mental health practitioners may continue to encourage an unhealthy obsession with size. Their own anti-fat biases may lead to negative differential treatment including differences in diagnoses, treatments, and interpersonal interactions (Puhl & Latner, 2007). Treating clients for "obesity" without proper informed consent (e.g., sharing the high improbability of permanent weight loss, the myriad serious risks of dieting, and the frequent negative psychological outcomes) may be unethical behavior (Rothblum, 1999). As previously stated, psychologists may benefit from adopting a view of fat clients as members of an oppressed and marginalized group (Abakoui & Simmons, 2010; Fikkan & Rothblum, 2011). Psychologists could instead focus on facilitating client wellness through healthy eating, sleeping, and exercising.

In order to provide ethical and competent treatment, psychologists must familiarize themselves with the research and recognize the lived experiences of fat clients (Abakoui & Simmons, 2010), and with the way client weight-by-ethnicity interactions might impact therapeutic work. Extensive evidence (e.g., Andreyeva, Puhl, & Brownell, 2008; Kristen, 2002) suggests that fat people frequently experience discrimination based on their weight status; discrimination occurs in the work place, in relationships, in housing, in public policy, in social norms, in health care, and in almost all other domains. Furthermore, these biases are extremely strong, even stronger than anti-Muslim and anti-gay bias (Latner, O'Brien, Durso, Brinkman, & MacDonald, 2008).

Sizeism appears to be the only form of discrimination that remains socially acceptable (Puhl & Brownell, 2001). A majority of people may believe that anti-fat biases help fat people to lose weight, that weight status is entirely within the control of the individual, and that discrimination against fat people is justified. While anti-fat bias has gone largely unexamined and without confrontation (Brownell, 2005), psychologists' Ethics Code promotes social justice work. Instead of contributing to the oppression of fat people in society and doing little to advocate for this group, psychologists must begin to take this problem seriously (McHugh & Kasardo, 2012). Psychologists have the opportunity to advocate for acceptance of body diversity and for a reduction of discriminatory practices toward fat people (Saguy & Riley, 2005). Psychologists have the ability to enact social justice and assist individuals in attaining both physical and mental wellness at all sizes.

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APPENDICIES

APPENDIX A

VIGNETTE

Janice, a 26-year-old, [African American/European American], unmarried accountant, seeks consultation because “I feel I am going nowhere with my life.” Problems with her career and boyfriend have been escalating and are causing her increased distress. Janice recently received a critical job review. Although she is reliable and her work is accurate, her productivity is low, her management skills are poor, and she has conflicts with her boss over minor issues. The client’s fiancée recently postponed their wedding date. He said that, although he respects and loves her, he is ambivalent because on many occasions she tends to be remote and critical and she is often uninterested in sex.

Janice describes herself as a pessimist who has difficulty experiencing pleasure or happiness. She says that, as far as she can remember, she has always been aware of an undercurrent of hopelessness, feeling that her life is hard and not worth living. Janice grew up in a suburban community and attended public schools. The client did well academically in high school and college. She participated in some social activities but was shy and was considered gloomy and not fun to be with by most of her classmates.

In college, Janice benefited from counseling after breaking up with her first boyfriend. During this time an internist gave her fluoxetine, which provided good relief from both her headaches and her feelings of hopelessness. In retrospect, she feels that this was a very good period of her life. She began a new job and relationship, functioned well, and almost seemed to enjoy life. However, when she discontinued the medication after 3 months, she seemed to slip slowly and insidiously back into her previous state of pessimism and hopelessness.

Janice has never been suicidal or had prominent suicidal ideation, and she has not experienced significant problems with weight loss, insomnia, or psychomotor activity. For months at a time, however, Janice’s energy levels are diminished and her ability to concentrate is impaired. She views herself negatively, feeling that she has little to offer. She is always surprised when people like and respect her.

Janice has periods when she withdraws from friends and social activities, but with effort she always goes to work. Some weekends, she stays in bed in a state of profound inertia. In the past, she would sometimes drink excessively but now has only an occasional glass of wine. She does not recall ever having periods of excessive energy or elation. Janice says that she recognizes her strong need to please others, to obtain approval, and to avoid conflicts. She feels extremely anxious when forced to deal directly with a hostile situation. She takes pride in her acknowledged perfectionistic traits.

Janice appears early for her appointment, is conservatively dressed, appears [average weight/obese], and initially appears outgoing and affable. Her intelligence appears to be high-average.

APPENDIX B

AUTHOR PERMISSION

Permission to use Zadroga (2009) vignette

Mon, Sep 26, 2011 at 12:49 PM

Cristina.E.Zadroga@kp.org<Cristina.E.Zadroga@kp.org>
To: l.varkula@csuohio.edu

Hi Lindsay,

Dr. O'Toole forwarded on your email to me about wanting to use the vignette in my dissertation. You have my permission to use it. Best of luck to you, I remember the process as if it was yesterday and your topic sounds very similar to mine. Just remember to stick with it; you are almost done!

Cristina Zadroga, Ph.D.

Kaiser Permanente

Permission to use the WAI-T-A

From: Burkard, Alan <alan.burkard@marquette.edu>
To: Lindsay Varkula <l.varkula@csuohio.edu>
Date: Thu, Sep 22, 2011 at 7:15 PM
Subject: RE: Question regarding your 1999 publication: White counselor trainees' racial identity and working alliance perceptions

Lindsay,

I am afraid the copy that I had on computer was corrupted a few years ago. The article is based on my dissertation and there is a copy of the modified WAI in the appendices. Let me encourage you to request my diss through your library and that should get you what you need. Yes, you have my permission but you may also want to obtain permission from Adam Horvath the developer of the WAI.

Good luck in your research.

Alan W. Burkard, Ph.D.

Associate Professor/Department Chair

Coordinator of the School Counseling Program

President-Elect, American School Counselor Association

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Permission to use the WAI



SIMON FRASER UNIVERSITY
THINKING OF THE WORLD

Mrs. Lindsay Varkula
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Urban Education
2082 E. 4th St.
Cleveland OH
44115
USA

March 26, 2012

LIMITED COPYRIGHT LICENSE (ELECTRONIC) # 2012263.04

Dear Mrs. Varkula

You have permission to use the Working Alliance Inventory (WAI) for the investigation:

"ANTI-FAT BIAS IN PSYCHOLOGISTS: DOES FEMALE CLIENT ETHNICITY INFLUENCE PSYCHOLOGISTS' BIAS?"

This limited copyright release extends to all forms of the WAI for which I hold copyright privileges, but limited to use of the inventory for not-for-profit research, and does not include the right to publish or distribute the instrument(s) in any form.

I would appreciate if you shared the results of your research with me when your work is completed so I may share this information with other researchers who might wish to use the WAI. If I can be of further help, do not hesitate to contact

me.
A handwritten signature in black ink, appearing to read "Adam O. Horvath".

Dr. Adam O. Horvath
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APPENDIX C

SURVEY OF DIAGNOSTIC SEVERITY AND PROGNOSIS

Based on the client vignette, please provide an estimated Global Assessment of Functioning (GAF) score between 1 and 99 per the American Psychiatric Association's *Diagnostic and Statistical Manual, Fourth Edition, Revised (DSM-IV-TR)*. Please utilize the following anchors:

- **99 – 91: “superior functioning...no symptoms”**
- **90 – 81: “absent or minimal symptoms”**
- **80 – 71: symptoms are “transient and expectable reactions”**
- **70 – 61: “mild symptoms”**
- **60 – 51: “moderate symptoms”**
- **50 – 41: “serious symptoms”**
- **40 – 31: “major impairment”**
- **30 – 21: “serious impairment”**
- **20 – 11: “gross impairment”**
- **10 – 1: “persistent danger” (APA, 2000, p. 34)**

GAF Score: *(participants were able to enter one or two numerical digits)*

Based on the client vignette, I believe the prognosis for this client is:

(participants will be able to select one radio button corresponding to one number from the following choices)

1	2	3	4	5	6	7	8	9
very poor		poor		average		good		very good

Reference

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

APPENDIX D

ADAPTED WORKING ALLIANCE INVENTORY, THERAPIST FORM (WAI-T-A)

The following are sentences that describe some of the different ways a person might think or feel about Janice, the client in the vignette. Next to each statement there is a seven point scale:

1 Never, 2 Rarely, 3 Occasionally, 4 Sometimes, 5 Often, 6 Very Often, 7 Always

Please predict how you, the therapist, would view therapy after 5 sessions with Janice. If the statement describes the way you predict you would always feel (or think) choose the number 7; if it would never apply to you choose the number 1. Use the numbers in between to describe the variations between these extremes. Work fast; your first impressions are the ones I would like to see. PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.

1. I would feel uncomfortable with Janice.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
2. Janice and I would agree about the steps to be taken to improve her situation.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
3. I would have some concerns about the outcome of these sessions.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
4. Janice and I would both feel confident about the usefulness of our current activity.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
5. I feel I would really understand Janice.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
6. Janice and I would have a common perception of her goals.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
7. Janice would find what we are doing in therapy confusing						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. I believe Janice would like me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
9. I would sense a need to clarify the purpose of our sessions for Janice.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
10. I would have some disagreements with Janice about the goals of these sessions.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
11. I would believe the time Janice and I are spending together is not spent efficiently.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
12. I would have doubts about what we are trying to accomplish in therapy.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
13. I would be clear and explicit about what Janice's responsibilities are in therapy.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
14. The current goals of these sessions would be important for Janice.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
15. I would find that what Janice and I are doing in therapy is unrelated to her current concerns.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
16. I would feel confident that the things we do in therapy will help Janice to accomplish the changes that she desires.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
17. I would be genuinely concerned for Janice's welfare.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
18. I would be clear as to what I expect Janice to do in these sessions.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

19. Janice and I would respect each other.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
20. I would feel that I am not totally honest about my feelings toward Janice.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
21. I would be confident in my ability to help Janice.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
22. We would be working towards mutually agreed upon goals.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
23. I would appreciate Janice as a person.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
24. We would agree on what is important for Janice to work on.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
25. As a result of these sessions Janice would be clearer as to how she might be able to change.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
26. Janice and I would have built a mutual trust.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
27. Janice and I would have different ideas about what her real problems are.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
28. Our relationship would be important to Janice.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
29. Janice would have some fears that if she says or does the wrong things, I would stop working with her.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

30. Janice and I would have collaborated in setting goals for these sessions.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
31. Janice would be frustrated by what I would ask her to do in therapy.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
32. We would have established a good understanding between us of the kind of changes that would be good for Janice.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
33. The things that we would do in therapy don't make much sense to Janice.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
34. Janice would not know what to expect as the result of therapy.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
35. Janice would believe the way we are working with her problem is correct.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
36. I would respect Janice even when she does things that I do not approve of.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

APPENDIX E

DEMOGRAPHIC QUESTIONNAIRE

Please provide the following demographic information:

What is your gender?

(participants select one radio button corresponding to one of the following choices)

Female

Male

Trans

What is your ethnicity/race?

(participants select one radio button corresponding to one of the following choices)

African American

Asian American

European American

Hispanic American

Multi-racial

Other (please specify)

How many years of experience do you have conducting psychotherapy and/or assessment? *(participants will be able to enter one or two numerical digits)*

Which type of psychology degree do you hold?

(participants select one radio button corresponding to one of the following choices)

Ed.D.

Ph.D.

Psy.D.

Other (please specify)

APPENDIX F

E-MAIL TO POTENTIAL PARTICIPANTS

Dear Dr. [Name],

I am a 4th year Counseling Psychology doctoral student at Cleveland State University. I am collecting data for my dissertation from practicing psychologists regarding their assessments of client problems. I am asking you to participate in a short, online study which will likely take approximately 20 minutes to complete. This study has been approved by the Cleveland State University Institutional Review Board.

I would sincerely appreciate your participation. Although you will not receive any direct benefits or compensation for your participation, you will be contributing to the existing body of research in applied/clinical psychology.

To participate, please click on [hyperlink to survey] or copy and paste the link into your Internet browser. Please contact me with any questions or concerns.

Thank you,
Lindsay

Lindsay C. Varkula, M.A.
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APPENDIX G

STATEMENT OF INFORMED CONSENT

Dear Participating Psychologist:

My name is Lindsay Varkula and I am a 4th year Counseling Psychology doctoral student in the APA accredited program at Cleveland State University. My dissertation chair is Elizabeth Welfel, Ph.D. I am asking you to participate in an online study of individuals who are licensed, practicing psychologists in the United States. I am collecting data on practicing psychologists regarding their assessments of client problems. This study will require you to read a short clinical vignette, respond to questions about the client in the vignette, and complete a short general demographic questionnaire. This online process will take approximately 15 to 20 minutes.

Your responses to the SurveyMonkey™ online questions will be anonymous. Your name will not be collected and no identifying information (e.g., IP address or e-mail address) will be available when the online data is obtained by the researcher. Only numerical data will be sent to the researcher, and the researcher will not be able to tie specific responses to specific participants. Also, the demographic and background information collected from you will be kept very general. As it is received, the data will be entered into SPSS and analyzed. Data will be stored on Dr. Elizabeth Welfel's Cleveland State University password-protected computer for 3 years after the approval of the dissertation.

Participation is completely voluntary and you may withdraw at any time. There is no reward for participating or consequence for not participating.

For further information regarding this research please contact Lindsay C. Varkula at (216) 374-9163, e-mail: l.varkula@csuohio.edu, or Dr. Elizabeth R. Welfel, Cleveland State University Faculty Dissertation Chair, at (216) 687-4605, e-mail: e.welfel@csuohio.edu.

If you have any questions about your rights as a research participant you may contact the Cleveland State University Institutional Review Board at (216) 687-3630.

You may print a copy of this form for your records. Thank you in advance for your cooperation and support.

Please indicate your agreement to participate below.

I am 18 years or older. I am a licensed psychologist in the United States and I have seen at least one client for psychotherapy and/or assessment in the last year. I have read and understood this consent form and agree to participate.

*[Participants will be able to select an online button for **Agree**]*