WEIGHT BIAS AMONG COUNSELORS-IN-TRAINING: A QUALITATIVE INQUIRY

Except where reference is made to the work of others, the work described in this dissertation is my own or was done in collaboration with my advisory committee. This dissertation does not include proprietary or classified information.

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WEIGHT BIAS AMONG COUNSELORS-IN-TRAINING: A QUALITATIVE INQUIRY

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DISSERTATION ABSTRACT

WEIGHT BIAS AMONG COUNSELORS-IN-TRAINING: A QUALITATIVE INQUIRY

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Despite the increasing rate of overweight and obesity among individuals and issues caused by the trend, individuals who are overweight and related issues have not been addressed properly in the field of professional counseling. The purpose of the current study was to examine the extent of bias that counseling graduate students might have towards clients who are overweight, and student's perceptions of the issues overweight clients may present in counseling. Fifty-six counselors in training in graduate programs at two southeastern universities participated in the qualitative study. Students responded to a case study including photographs of a client who is displayed either as overweight or normal weight. Seven themes emerged from the study. The primary finding was that the participating counselors in training have implicit negative bias

towards clients who are overweight. Implications for further research, counselor education, and counseling practice were presented.

ACKNOWLEDGEMENTS

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I. INTRODUCTION

The number of persons who are overweight has been increasing in the United States at an alarming rate in the last few years. The Centers for Disease Control (2007) reports that excess weight in the US has doubled among adults between 1980 and 2000, reporting that approximately 30% (6 million) of the adult population is now overweight. The National Institutes of Health (2007) reports an even higher percentage, 34.1% of adults are overweight. As the rates of persons who are overweight increases concurrently the problems related to weight based discrimination increase.

The issues of weight bias include but are not limited to: discrimination in hiring practices, employment and compensation (Averett & Korenman, 1996; Pingitore, 1994; Roehling, 1999); lack of clear legal guidelines for weight based discrimination (Roehling, 1999); less access to education (Smith & Niemi, 2003); social discrimination, particularly among overweight women (Averett & Korenman, 1996; Brownell, 2005; Cecil, et al., 2005; Crossrow, 2001); and bias in healthcare and mental health care service delivery (Teachman & Brownell, 2005; Young & Powell 1985). With these difficulties possibly experienced by overweight individuals it is of particular importance that counselors understand the difficulties faced by persons who are overweight to appropriately engage them in effective counseling practices.

Persons who are overweight have difficulty attaining equal financial compensation, and they lack any means of legal recourse as a result of weight status discrimination. Individuals who are overweight suffer with a myriad of problems related to career success. Research has shown that persons who are overweight are more likely to encounter problems in all phases of employment, particularly in the early selection phase (Pagan & Davila, 1997; Pingitore, 1994; Roehling, 1999). For example, weight has been shown to be the variable that accounted for 34.6% of the variance in hiring decisions. Participants in one study demonstrated more negative attitudes toward overweight employees than toward ex-felons and former mental patients (Pingitore, 1994). This study suggests that many Americans would rather work with criminals than with those who are overweight, suggesting that being overweight is a moral failure worse than illegal activity.

In one study, overweight employees were rated by their employers as having more absences and poorer work habits. Further, overweight individuals were also rated as having more emotional and/or personal problems by supervisors and co-workers. Most of the weight discrimination that occurs in employment practices is not illegal by current standards (Roehling, 1999). There are no laws in place at this time to protect the rights of persons who are overweight, and as research indicates that individuals who are overweight suffer significant stigma in the hiring process and in the workplace, the lack of existence of such laws is particularly disturbing (Pagan & Davila, 1997; Register & Williams, 1990; Roehling, 1999). The Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 (RHA) do not allow accommodations for persons who are

overweight per se, leaving them no legal recourse when they are discriminated against by an employer or others.

Weight status affects salary. Mildly overweight White women earn 5.9% less than their normal weight counterparts; morbidly overweight White women earn 24.1% less (Pingitore, 1994). Moreover, studies (Pagan & Davila, 1997; Register & Williams, 1990) have found that overweight women earn less than their standard weight counterparts, while for men this trend is reversed. Overweight European American men earn more than standard weight men. In other words — if you are female; as the number on the scale rises, the number on your paycheck lowers. Adding to the financial burden of overweight women, they are also less likely to be married and as a result have lower household incomes (Averett & Korenman, 1996). Evidence from the literature indicates that women are more severely judged for being overweight than are men (Roehling, 1999).

As in the workplace, children who are overweight are discriminated against at school. Children who are seen as less desirable often have difficult interactions in school, with teachers and other children. In the field of education, studies regarding teacher bias and any effects it may have on overweight children are few. However, one study found that the more a girl is overweight, the lower her teachers rate her intelligence (Smith & Niemi, 2003). Bauer, Yang and Austin (as cited in Neumark-Sztainer & Eisenberg, 2005) report that adolescents recount instances of having teachers and staff make negative comments to them regarding their weight and athletic abilities, causing the students to feel less like participating in physical activities and more like withdrawing, increasing their self consciousness.

Pingitore (1994) also found that adolescents are less likely to finish high school and adults are less likely to complete higher education if they were overweight as children. Cecil and colleagues (2005) found that obesity rates among children in lower socio-economic circumstances are more prevalent in the United Kingdom. Vieweg, Johnston, Lanier, Fernandez and Pandurangi (2007) found the same was true among school children in the United States. Low socioeconomic status is an important risk factor for individuals who are overweight.

The U.S. Department of Health and Human Services (2007) reports that there is disparity in the prevalence of persons who are overweight based on race, ethnicity, gender, age and socioeconomic status. Further, they report that women of lower socioeconomic status are 50% more likely to be overweight than those with a higher socioeconomic status. Weight bias is inextricably linked with other types of discrimination such as race, gender and socioeconomic status (Averett & Korenman, 1996; Brownell, 2005; Cecil et al., 2005; Crossrow, 2001).

In the United States, 81.6% of African American women are overweight, 75.4% of Hispanic women are overweight, and 58% of European American women are overweight (U.S. Department of Health and Human Services, 2007). Ethnic groups that have lower socioeconomic status and higher rates of racial and cultural discrimination also have higher rates of persons who are overweight. There are significantly more overweight African American and Hispanic women than European American women. This puts overweight women of color at particular risk of economic hardship and social inequity (Averett & Korenman, 1996; Roehling, 1999, Sobal & Stunkard, 1989).

Most studies of weight bias and discrimination have found that the affect of discrimination on women is much higher than that of men (Averett & Korenman, 1996; Brownell, 2005; Cecil et al., 2005; Crossrow, 2001; Friedman & Brownell, 1995; Herva et al., 2006; Heo et al., 2006; Loh, 1993; Pingitore et al, 1994; Roehling, 1999; Teachman & Brownell, 2001; Young & Powell, 1985). Crossrow (2001) found in her qualitative study examining weight stigma that women and men both perceived that weight bias was higher toward women in general. In this study, women reported more negative experiences related to weight. A participant reported that her grandmother often said to her "'Well you better not eat that! You will never get a husband!' That is a classic thing for her to say…" (p. 210). Another participant said,

> I think a man can carry around 25 or 50 pounds extra weight and he's still a babe magnet and truly, he can still attract a large number of women…. I think women are more tolerant of men who have gained a little weight than men are of women who have gained a little weight. (Crossrow, p. 212)

There is an abundance of research on health care costs related to persons who are overweight in the United States. There is limited research, however, on stigma that is displayed among mental health professionals against those who are overweight. The relationship between helper and those being helped is complex. Counselors must have knowledge of their own bias to be effective (Sue & Sue, 2004). Research completed in the fields of medicine and social psychology has indicated that helping professionals have bias against persons who are overweight. Teachman and Brownell (2001) found that health care professionals who specialize in treatment of persons who are overweight have

weight bias against their patients, although it was less bias than indicated by the general population.

Health care professionals specifically trained in the care of overweight patients are apparently not immune to the constant negative messages of our culture against overweight persons. Young and Powell (1985) also found that weight affects the clinical judgments that mental health workers make about their clients. They gave clinicians a case study with pictures of a client attached; one of the photographs was of a client who is overweight and the other of a normal weight client. They found that clinicians rate overweight clients more harshly on a number of dimensions such as addiction, antisocial behavior, sexual dysfunction, and inadequate hygiene.

Several studies (Amici, 2003; Davis 1998, Hassell & Lynn, 2003, Young & Powell, 1985) found that weight bias was higher among young, female, less experienced mental health professionals. Given this information, it is of grave importance that weight bias is addressed in the training of counselors, as the preponderance of counseling students are young and female.

Statement of the Problem

Despite the increasing rate of persons who are overweight and issues caused by the trend, it has not been addressed properly in the field of professional counseling. There are a number of implications of this oversight in the counseling literature, which will be developed throughout the remainder of this chapter:

1) There is no content in the multicultural counseling texts or counseling literature on weight bias.

2) Counselors often perceive weight as a medical issue.

3) As a profession, counselors do not have any background or training in the concept of weight bias.

4) We have scant understanding of the experiences of children related to their weight.

5) Children express a great deal of weight bias toward each other and this is not well understood by counselors.

Further, extant research in related fields identify the following:

6) Low expectations of individuals who are overweight creates poorer outcomes for them.

7) Clinicians who are young and female tend to have more bias toward overweight persons.

8) There are no differences in bias among different types of helping professionals (Christian or non-Christian).

9) There is an established need for education on this subject, which is shown to reduce bias.

10) Helping professionals who are themselves overweight tend to hold less bias.

11) There are identified strengths those persons who are overweight hold.

12) Helping professionals are likely to give more severe diagnosis to persons who are overweight.

13) Implications for training suggest that in addition to appearance, client verbal cooperation is an important factor in client success in therapy.

14) There are genetic and medical factors that contribute to individuals' weight status.

15) There is a link between mood disorders and weight status.

16) Judeo-Christian values pay a role in weight status.

17) The medical establishment and their treatment of overweight persons.

18) Professors need to model attitudes of compassion toward those who are overweight.

19) Covert bias is prevalent toward persons who are overweight.

In a survey of articles on multicultural counseling pedagogy in the *Journal of Multicultural Counseling & Development* and in the *Journal of Counseling & Development* dating back to 1997, there was no mention of issues related to weight status as content in any of the articles. In 2001, Pope-Davis, Ligiero, Liang and Codrington conducted a content analysis of the *Journal of Multicultural Counseling & Development*. They used 14 categories to describe the types of content in the journal. There was not a category for weight, fat, obesity, overweight, weight bias or any related term. There have been three (3) articles in the *Journal of Counseling & Development* addressing persons who are overweight; all of these articles were focused on assisting clients in weight loss. None of the articles mention weight bias as an issue.

Likewise in a content analysis of multicultural articles in the *Journal of Counseling & Development* (Arrendondo, Rosen, Rice, Perez & Tovar-Gamero, 2005), the categories were as follows: age, culture, ethnicity, gender, language, physical/mental well being, race, sexual orientation, social class. No mention of weight status was made in this analysis.

Multicultural counseling texts do not place emphasis on weight bias. Most multicultural counseling texts used in graduate training contain chapters dedicated to particular groups of people who might experience bias in America. Examples of such are chapters on Pacific Islanders, African Americans, or persons with disabilities. In the seven texts reviewed there is not a chapter on weight bias. Additionally weight status is not even mentioned in any of the seven reviewed multicultural counseling texts currently being used (see Aldarondo, 2007; Bryan, 2007; Daniels & Ivey, 2007; Lee, et al., 2007; Parker & Fukuyama, 2007; Stone, 2005; Sue & Sue 2006). The American Counseling Association code of ethics (ACA, 2006) makes no mention of weight status. The Council for Accreditation of Counseling and Related Programs (CACREP, 2001) makes a brief mention of physical characteristics in Section 2 part 2, social and cultural diversity. However, the standards make no mention of weight status as a diversity issue.

Conceivably, being overweight has been seen by counselors (and others) as a medical issue (Jutel, 2005; Oliver, 2005), and therefore outside the scope of practice for counselors. One could argue that being overweight is not a permanent condition such as gender or race, and therefore not a genuine diversity issue. However, given the extreme prejudice that persons who are overweight suffer, it is critical that counselors understand the effect of stigma upon the social, physical and identity development of their clients. Counselors must also understand how discrimination affects their clients who are overweight at work and in romantic relationships (Brownell, 2005).

As a natural result of limited attention to weight issues in the profession of counseling, weight bias that counselors-in-training might have toward persons who are overweight has not been studied. There are no studies evaluating bias that graduate

students may have toward overweight or persons who are overweight in any counseling literature.

Given the disturbing increase persons who are overweight in the United States and the damaging effects of discrimination and bias on individuals, it is of great value that counselors understand the particular effects of discrimination and bias upon overweight clients. Counselor educators need to understand counseling graduate students' perceptions of persons who are overweight, and the bias and prejudices that they might have towards these individuals. Through this understanding, the counseling profession in general, and counselor educators in particular, will be able to address issues of weight bias properly and develop future professional counselors to be more effective with the increasing overweight population and their needs.

Purpose of the Study

The purpose of the current study was to identify and describe the levels of bias that counselors-in-training might have toward a client who is overweight. Also a related goal was to understand their perceptions of people who have issues related to being overweight, by examining counseling graduate students clinical attitudes and behaviors.

Research Questions

How do counselors-in-training report their perceptions of overweight clients across the following seven areas?

1. Usefulness of therapeutic interventions
2. Client prognosis

3. Willingness to work with overweight clients
4. Client diagnosis
5. Client's level of functioning
6. Client's social support
7. Client's barriers or challenges to counseling

Significance of the Study

This study is important because it will provide imperative information on weight bias among counselors in training in the counseling literature. This study will bring attention to the issue of weight bias to counselor educators. This study can provide information on the possible bias that is displayed toward clients who are overweight and to increase self-awareness in the area of weight bias. It will add to the body of knowledge on diversity issues in counseling. Moreover, this information will allow faculty to create inclusive language and training modalities to effectively train beginning counselors in working with persons who are overweight.

Definition of Terms

Bias: an inclination of temperament or outlook; especially a personal and sometimes unreasoned judgment (www.m-w.com, 2007; Brownell, 2005).

Body Mass Index (BMI): a mathematical formula that measures a person's weight relative to their height. The body mass index formula was developed by Belgium statistician Adolphe Quelet (Centers for Disease Control, 2007). Each number represents

the percentage of body fat relative to the weight of other body parts such as muscle, bones, organs, etc. The BMI chart follows:

Designation	BMI
Under weight	Below 19.5%
Normal weight	18.5% – 24.9%
Overweight	25.0% – 29.9%
Obese	30.0% & above

Covert bias: Bias that is expressed in subtle actions such as avoiding those in the identified group, not making eye contact with those in the identified group, and creating interior barriers against persons of certain groups. Refers to bias that is not readily seen through an overt action (www.m-w.com, 2007; Brownell, 2005).

Explicit bias: refers to overt thoughts that individuals will admit to having regarding persons who are overweight and persons who are overweight (Brownell, 2005).

Implicit bias: covert (subconscious) thoughts, which are unknown or unspoken by individuals (Brownell, 2005).

Obese: a body mass index score (BMI) over 30%.

Overweight: any weight over the Metropolitan Life Standard Weight Charts (Metropolitan Life Insurance Company, Inc., 2000), but below the 30% BMI cut off for obesity. For this study the term overweight will be used to include traditional definitions of obese and overweight.

Prejudice: preconceived judgment or opinion; and adverse opinion or leaning formed without just grounds or before sufficient knowledge; an instance of such

judgment or opinion; an irrational attitude of hostility directed against an individual, a group, a race, or their supposed characteristics. Prejudice or hostility is a possible outcome of bias (www.m-w.com, 2007, Brownell, 2005)

Stereotype: something conforming to a fixed or general pattern; *especially* a standardized mental picture that is held in common by members of a group and that represents an oversimplified opinion, prejudiced attitude, or uncritical judgment (www.m-w.com, 2007).

Stigma: a mark of shame or discredit and in this case is carried by the person who is the victim of prejudice (www.m-w.com, 2007; Brownell, 2005).

II. LITERATURE REVIEW

There has been scant research on weight bias in the field of counseling. As a result most of the literature for this study was taken from other social science fields such as sociology, education, psychology, and human resources. Additionally research in medicine and nursing were reviewed. Discussion in this chapter will include: (a) weight bias among helping professionals; (b) factors that contribute to overweight and obesity, and (c) factors that contribute to weight bias and stigma.

Weight Bias amongst Helping Professionals

Health Care Professionals

Early studies of helping professionals (e.g. nurses, physicians, social workers, educators and psychologists) indicated that there were strong negative feelings toward overweight individuals. Fabricatore, Wadden, and Foster (2005) in a review of literature report a number of studies in the 1960's through the 1980's in which physicians report that overweight patients were weak-willed, in active, and unintelligent. Other reports (Fabricatore, Wadden & Foster 2005) indicated that overweight patients were dishonest, had poor hygiene and were likely to have unproductive if not difficult interactions with their health care professionals.

Recent studies have shown some improvement in helping professionals' attitudes toward persons who are overweight, but there are still many negative attitudes. Foster and colleagues (2003) surveyed primary care physicians about their attitudes toward overweight patients. They found, of the 620 respondents, that 50% agreed with the statement "persons who are overweight are awkward, unattractive, ugly and non-compliant" (p. 31). It appears that physicians in this more recent study are not judging the overweight patients by character qualities such as weak-will and low intelligence as much as in past studies; however, they continue to have negative personal evaluations of persons who are overweight.

Teachmann and Brownell (2001) posed the question if anyone is immune to anti-fat bias. Similar to the other studies cited, in their study of 84 health care professionals who work with overweight patients they found that these health care professionals had moderate anti-fat bias although not as high as the general population. They attribute this bias, even among specialists educated to work with persons who are overweight, to the overwhelming and near constant negative media attention to weight and emphasis on weight loss. They state that the body image obsessed culture in which we live promotes negative body image even among those who work most closely with persons who are overweight, who understand the causes of excess weight, and who vicariously experience the daily struggles of persons who are overweight.

To further demonstrate this point, Schwartz, Chambliss, Brownell, Blair and Billington (2003) gave the Implicit Association Test (IAT) to 389 health professionals (physicians and nurses) at a conference focused on the treatment on those who are overweight. The results showed that the professional's explicit attitudes were modest

while implicit negative attitudes were vigorous. Additionally they found that when the participants were female, young, had normal weight, and did not work with overweight patients, they were more likely to hold negative attitudes toward persons who are overweight. This study demonstrates in a most revealing way that health care professionals are careful about stating bias against anyone (explicit), but that they still hold bias against these persons privately (implicit). In this study young, female health care professionals held more weight bias than older more experienced peers. This is a particularly relevant point in relation to the current study as most counseling graduate students are women in their twenties.

While the previous studies indicated that there was bias among health care professionals, the following study sought to decrease bias through education. Wiese, Wilson, Jones and Neises (1992) studied first year medical students and found that they perceive that persons who are overweight are "lazy (57%), sloppy (52%), and lacking in self control (62%)" (p. 863). The researchers developed an educational intervention based on Petty and Cacioppo's (2000) elaboration likelihood model. They found that the medical students who received the intervention rated overweight patients much higher in genetic determinates and less likely to blame overweight patients for their conditions than the control students. The participating students continued in these beliefs five weeks after the study and again one year after the intervention. This study demonstrates that education about weight gain and its causes may decrease weight bias.

Experiences of Individuals Who Are Overweight with Helping Professionals

Rogge, Greenwald and Golden (2004) designed a qualitative study in which they interviewed 13 overweight individuals and 5 of their family members. In this study they

sought to bring to light the experiences of persons who are overweight, for their fellow nurses, highlighting in particular the continuous social experiences that persons who are overweight have and that remind them that they are outside the norm. These social experiences include negative media images, financial difficulties, and difficulty establishing significant other relationships for example. Studies such as these are essential if helping professionals are to understand and effectively work with persons who are overweight.

A review of the literature in medicine finds that health care professionals persist in the perception that persons who are overweight are unmotivated and lazy. Several of these studies focused on being overweight as a social construct (which will be explored later in this chapter) and on the effects that stigma and bias have on patients lived experiences and upon the health professional-patient relationship.

Education Professionals

There is little research on weight bias in education. What exists is primarily in the literature on bullying and teasing. As this is a significant problem for children, it will be addressed briefly. The focus of this study, however, is the perceptions of professional helpers toward overweight children. The National Education Association (1994) states the problem as:

> For fat students, the school experience is one of ongoing prejudice, unnoticed discrimination, and almost constant harassment. From nursery school through college, fat students experience ostracism, discouragement, and some times violence. Often ridiculed by their peers and discouraged by even well meaning education employees, fat students develop low self-esteem and have limited

> horizons. They are deprived of places on honor rolls, sports teams and cheerleading squads and are denied letters of recommendation. (National Education Association, 1994, as cited in Solovay 2000)

Children suffering in this way may be unlikely to complete their educations. Pingitore (1994) found that adolescents are less likely to finish high school and adults are less likely to complete higher education if they were overweight as children. Given the dire situation for children who are overweight, there is a great need for understanding the experiences of children related to their weight. In a weight-obsessed culture, children are not immune to negative images of persons who are overweight, and they are at particular risk because of the double vulnerability of being both a child and a person who is overweight.

In Latner and Stunkard's (2003) study which replicated Richardson et al. (1961) study, Latner and Stunkard found that children have very low opinions of their overweight peers. In this study, they produced a sample of 458 fifth and sixth graders and asked them to rank six drawings in how well they liked the children depicted in the drawings. The participants consistently ranked drawings of overweight boys and girls lowest. Furthermore, this low ranking of overweight children had increased by 41% from the original 1961 study. This seems to imply that our increased cultural "political correctness" has had little effect on the perceptions of children toward those who are overweight.

Unfortunately, similar studies (Goodman et. al. 1963; Kraig & Keel, 2001; Lerner & Gellert, 1969; Maddox et al., 1968; Neumark-Sztainer, Story & Faibish, 1998) all found that school age children have significant bias toward children who are overweight.

Research indicates that children learn that overweight children are undesirable playmates by age 3 (Latner & Schwartz, 2005). A number of studies indicate that parents (Adams, Hicken & Salehi, 1998; Davison & Birch, 2004) and the media (Greenberg & Worrell, 2004) contribute to weight bias among children. Unwitting teachers may also contribute to stimulating this bias that children hold (Solovay, 2000).

In addition to children having bias against other children who are overweight, Schroer (1985) found that of the 200 teachers surveyed in their study, a majority rated overweight children lower on traits such as attractiveness, energy level, leadership and self esteem. Another study examining weight bias among teachers had similar results. Quinn, (1987) presented 599 educators with two pictures, one of a normal weight child and one of an overweight child. The researcher found that the average weight child was rated higher in academic tasks and that the overweight child was rated higher for recommendations for psychological referral. This study may bring into awareness the character and pathology issues that are associated with persons who are overweight for many. Teachers are also applying these judgments to their students. Smith and Niemi (2003) likewise found similar results. This study found that teachers rated overweight girls as being less intellectually able than their average weight female classmates.

Neumark-Sztainer, Story, and Harris (1999, as cited in Latner & Schwartz, 2003) asked somewhat different questions to obtain more specific beliefs that teachers may hold about children who are overweight. They conducted a study of 115 science, health, home economics, physical education teachers, school nurses and school social workers from 17 middle and high schools in a large urban school district. They found that many of the teachers endorsed stigmatizing views about obesity. Over half believed that obesity is

caused primarily by one's own behaviors and approximately one fourth (20–25%) believed that persons who are overweight are more emotional, less tidy, and less likely to succeed at work, and have different personalities and more family problems (p. 61). Approximately one fourth agreed with the statement "one of the worst things that could happen to a person would be for him/her to become overweight" (p. 312). Neumark-Sztainer and colleagues also discovered that one-third of educators agreed with statements such as "Overweight people should not expect to lead normal lives." This study demonstrates that teachers concurrently hold the child who is overweight responsible for his or her weight and are concerned for the child's well being.

In a related and relevant study Shapiro, King and Quinones (2007) postulated that the stigma that a trainer demonstrates toward an overweight trainee could affect the quality of the training experience for both trainer and trainee. Their study concluded that female trainers expected less from overweight trainees and evaluated the training more negatively than training for average weight trainees. Trainer bias can affect the outcome of training and the perceived outcome of training as well. This study has far reaching implications for teaching and counseling in that counselor and teachers' discriminative expectations of persons who are overweight can lower the quality of the counseling or teaching intervention.

Mental Health Professionals

Models used for studies conducted among mental health professionals differ considerably from those of health care professionals and educators. In the mental health literature studies tend to focus on bias as implied by the mental health professionals' diagnosis, prognosis and treatment planning for an overweight or overweight individual.

Therefore the following section will primarily discuss how bias against persons who are overweight and overweight affects the clinical assessment of the client.

Counselor's first impressions of their clients develop quickly and are significantly related to counselors' impressions at termination. Counselors' opinion of their clients has implications for diagnosis, treatment and the outcome of counseling (Wills, 1978). A number of studies in psychology and related mental health fields have been conducted to examine bias amongst mental health professionals toward overweight clients. Davis (1998) performed a study to examine the influence that a client's weight had on the psychologist's clinical judgment and treatment planning. Participants were mailed a self-description and a photo of the same European American client at a fat and not-fat weight. She found that if a client was overweight, the psychologist had a significantly more negative view of that client, rating the client higher in pathology and lower for a positive therapeutic outcome. She also found that the psychologists estimation of treatment outcomes and predicted client effort were lower for overweight clients. Female, less practiced and younger psychologists demonstrated more bias toward overweight clients.

Two recent studies on mental health professional's bias conducted at Fuller Theological Seminary had similar findings. In the first study conducted by Amici (2003), 87 female and 76 male mental health professionals were provided a generic case study and a photograph of an average weight or an overweight male or female client. Participants in the study were asked to make diagnoses and give client characteristics. The study found that the overweight clients were assigned more pathology and negative characteristics than were the average weight clients. Correspondingly, in the second study

Hassel and Lynn (2003) assessed the clinical judgments toward individuals who are overweight of those who identified themselves as Christian mental health professionals and non-Christian mental health professionals. They gave 95 Christian mental health professionals and 68 non-Christian mental health professionals a case study and a picture of an average weight and an overweight client and then asked them to make clinical judgments regarding pathology and client characteristics. The researchers found that Christian and non-Christian mental health professionals both ascribed more negative pathology and characteristics to overweight clients. This study demonstrates that a mental health professional's religious orientation appears to make no difference in their bias against clients who are overweight.

Loewy (1994) conducted a study to ascertain if stereotypes about persons who are overweight affect the perceptions of mental health professionals. The participants in this study were 25 mental health professionals who specialized in working with persons with eating disorders, and 27 mental health professionals who did not specialize in this group. The study investigated whether the information processing of the mental health professionals toward persons who are different sizes were congruent with prevailing stereotypes of those persons. The second part of the study compared the two groups in terms of mistakes made regarding information about weight status and information processing. Mental health professionals made more mistakes about person who are overweight than they did about thin people. Mental health professionals who specialized in eating disorders made fewer mistakes in information processing than those mental health professionals who did not specialize. This study brings up an important matter by

exploring how cultural stereotypes affect what we "know" about persons who are overweight.

Young and Powell (1985) completed perhaps the seminal work in this area. In their study, they sent a case study to 120 mental health workers along with a photo of the same middle aged European American woman at an average weight and at an overweight weight through computer enhancement. Similar to the other studies cited, they found that mental health workers evaluated the overweight client more negatively than the average weight client. The mental health professionals in this study rated the overweight client higher in addiction, anti-social behavior, inadequate hygiene, and sexual dysfunction. Their scores did not differ, however, in their outlook on prognosis or their willingness to work with overweight clients, which was high. They found that younger, less experienced and female mental health professionals rated more harshly, and that overweight mental health professionals were less likely to differentiate between the different weights of the clients in terms of characteristics.

In another study that gives more depth to the discussion of weight bias on the part of mental health professionals, Agell and Rothblum (1991) sent written case histories to clinicians including information of the client's height and weight. They found four significant differences between standard weight and overweight clients as rated by clinicians. In this study, fat clients were rated as "softer" and "kinder" than standard weight clients. Fat clients were also rated more physically unattractive and "embarrassed" by clinicians. Conversely, this brings up an interesting point in that it is the first research that indicates that persons who are overweight may be seen as having positive qualities.

Indicating as such might inappropriately affect the clinical decision making of the clinician.

Davis-Coelho, Walts, and Davis-Coelho (2000) confirmed Young and Powell's (1985) findings that younger, less experienced psychologists had particularly prejudiced views of fat clients. The researchers sent three paragraph self-descriptions written by the "client" in the provided photographs. Younger psychologists rated fat clients as demonstrating less effort in therapy and having a worse prognosis than standard weight clients. These two factors could affect the outcome of therapy in a major way. However, more importantly it was found that psychologists were more likely to assign a lower Global Assessment of Functioning (GAF) score and an eating disorder to clients who are overweight, while non-fat clients were more often given diagnosis of adjustment disorders. This may imply that the standard weight client is merely reacting to normal stressors, while the client who is overweight has psychological distress. The psychologists were also more likely to rate the fat clients as needing help with increasing sexual satisfaction, although this was not mentioned in the research materials.

These studies have shown that there is weight bias among mental health professionals, and that there is more evident bias among women practitioners and younger mental health professionals. The consistent results across these studies indicate that weight bias exists, and that the extent of this bias differs by age, gender, years of clinical experience, knowledge of the population, and weight status of the helping professional. The repetitive finding that young inexperienced female practitioners hold more bias is particularly relevant to this research, as there is an obvious need, as indicated by these studies, for early training regarding weight bias in mental health education.

Further, it indicates that changing the misconceptions that clinicians have about persons who are overweight is essential in order to more effectively work with persons who are overweight as is increasing understanding of how weight actually affects persons, rather than allowing stereotypical character judgments to cloud professional counselors' perceptions of client's diagnosis and assessment of functioning.

Conversely, there are studies in which clients' attitudes and behaviors have more salient impact on counselor's preference of clients and building counseling relationship than appearance. Lewis, Davis, Walker and Jennings (1981) conducted a study in which they examined the effects of client attractiveness, in session behavior, and age on counselor perceptions of the client. They found that counselors tend to favor clients that are young, attractive, and verbal in sessions. However, they found that client attractiveness was based more on client behavior than on appearance — that is, verbal clients were favored over less verbal clients, regardless of appearance. Brunner (1995) also found that client attractiveness was not as salient a feature as client trustworthiness in creating a productive counseling relationship through the fourth session. These studies indicate that attractiveness may be a broad term that includes factors far beyond how a client looks, and includes socially appropriate behaviors.

Factors that Contribute to Persons Being Overweight

The National Institutes of Health (2007) has the following policy statement regarding obesity:

> Obesity has risen to epidemic levels in the U.S. It causes devastating and costly health problems, reduces life expectancy, and is associated with stigma and

> discrimination. A multitude of factors likely contribute to obesity, from inherent biological traits that differ between individuals relevant to body weight; to environmental and socioeconomic factors; to behavioral factors—which may have both molecular and environmental influences. Thus, the diverse efforts of many federal agencies and public and private organizations will be valuable in working towards reducing obesity. (p. 143)

From this statement one can ascertain that the factors that affect obesity are far more complex than the traditional manner in which obesity has been treated through diet and behavioral changes. This indicates that a simplistic view of lifestyle only interventions would not be appropriate in effectively helping persons who are overweight. There are four major contributing factors that increase the likelihood that someone can become overweight they are (a) biological traits, (b) behavioral factors, (c) environmental and socioeconomic factors, and (d) psychological factors.

Biological Traits

It is far outside the scope of this study and the expertise of the researcher to have a medical discussion on the factors that contribute to an individual being overweight. However, a brief outline of recent medical findings concerning weight gain and its possible causes might be helpful in understanding the role that bias and stigma play in overweight individuals lived experiences.

A survey of the research (National Institutes of Health, 2007; Solovay, 2000) indicates a number of factors that contribute to persons being overweight. The first is genetic predisposition. A child with one overweight parent is 40% more likely to be overweight and a child with two overweight parents is more than 80% more likely to be

overweight. Although it is difficult to separate genetic factors from lifestyle factors, most researchers agree that both factors play a role in a child being overweight.

Further studies demonstrate that an adverse environment in-utero can cause low birth weight in infants, which is linked with being overweight and metabolic syndrome later in life (Candib, 2007). This is referred to as thrifty phenotype and is thought to be caused by starvation in the womb that causes later food hording behaviors.

A number of illnesses also contribute to persons being overweight such as hypothyroidism, Cushing's syndrome, and Polycystic Ovary Syndrome (Centers for Disease Control, 2007). Health conditions such as sleep debt can contribute to weight gain by increasing inflammation throughout the body and decreasing immune functions (Simpson & Dinges, 2007). Certain medications cause weight gain such as steroid hormones, contraceptives, diabetes drugs, some antidepressants, and blood pressure medications. Many individuals take these medications as life sustaining measures (Centers for Disease Control, 2007; Keith, 2006; National Institutes of Health, 2007).

Epidemiologists have been studying obesity as a worldwide epidemic, as it is prevalent in both industrialized and developing nations and growing at vigorous rates (Atkinson, 2007; Vasilakopoulou, 2007). Recent research (Atkinson, 2007) indicates that a virus may cause some individuals to become overweight. The virus, adenovirus-36, is much like the common cold and has been studied in humans for its link to weight gain. In a study (Vastag, 2007) of 502 overweight and normal weight individuals, 30% of overweight individuals tested positive for adenovirus-36 while only 11% of normal weight persons test positive for the virus.

Peters et al. (2007) have proposed a theory of individuals who are overweight that they call "selfish brain theory". Briefly this theory posits that the brain assigns the highest priority in regulating its own energy. That is, rather than orchestrating metabolism throughout the human body, the brain saves the energy for its own preservation. The system initiates allocative behavior (i.e. allocation of energy from body to brain), ingestive behavior (intake of energy from the immediate environment), or exploratory behavior (foraging from the distant environment). Cerebral projections coordinate all three behavioral strategies in such a way that the brain's energy supply is guaranteed continuously. In an ongoing learning process, the brain's request system adapts to various environmental conditions and stressful challenges. Disruption of a cerebral energy-request pathway is critical to the development of obesity: if the brain fails to receive sufficient energy from the peripheral body, it compensates for the undersupply by increasing energy intake from the immediate environment, leaving the body with a surplus. Excess weight develops in the long term.

While none of the aforementioned factors individually cause an individual to become overweight, taken together they are contributing factors to becoming overweight in many individuals.

Behavioral Factors

The preponderance of research and the majority of media reporting about persons who are overweight focus on lifestyle issues (i.e. Solovay, 2000; Teachman & Brownell 2004). Eating less healthy foods that are processed and fried are cheaper and more readily available to the public is indicated as a contributing factor. This is referred to as

nutritional transition. Nutritional transition has taken place in large part in lower socio economic conditions (Candib, 2007).

Individuals living in the twenty first century are less active, walk less, consume high fat convenience foods, work more hours in sedentary jobs and take less vacation days than their ancestors living in the nineteenth and early twentieth centuries (Candib, 2007; Centers for Disease Control, 2007). Certainly eating habits and lack of exercise contribute to persons becoming overweight, but separating these behavioral issues from biological issues is difficult (Keith, 2006; National Institutes of Health, 2007).

Environmental and Socio-economic Factors

Environmental factors affect an individual's weight status. In the last twenty years the rate of persons who are overweight has risen and it would be difficult to say that human genetic make up has changed, but our environment has changed.

Industrialization has affected the health of many individuals. Moving to cities from rural areas set up conditions in which fresh locally raised foods were no longer available. Further, people living in industrialized areas tend to less get physical exercise daily (Candib, 2007; Keith, 2007). In addition, pollution created by industry affects hormone regulation (Edwards & Myers, 2007; Keith, 2007; Tuma, 2007). Researchers posit that central air conditioning and heating prohibit the body from working to regulate its temperature, creating metabolic excess (Keith, 2007).

Recently researchers have studied the relationship between exposures to bisphenol A and excess weight. Bisphenol A is commonly found in plastic products such as baby bottles and can liners. In studies young mice were exposed to bisphenol A, at a dose 10 times lower than the average person receives. They found that the mice exposed

to bisphenol A had abnormal growth and were overweight later in life. Given that global production of bisphenol A is seven billion pounds a year these findings are disturbing (Tuma, 2007).

Studies have also found that diethylstilbestrol (DES), an estrogen prescribed in the 1940s-1970s for pregnancies at risk of miscarriage, is linked to persons becoming overweight and glucose control problems in mothers and their children exposed in the womb. In addition tributylin, another chemical used in plastic production, causes permanent physiological changes in those exposed, predisposing them to excess weight gain (Stemp-Morlock, 2007).

As stated earlier in this paper, having a low socioeconomic status is a risk factor for being overweight. Women of lower socioeconomic status are 50% more likely to be overweight than those with a higher socioeconomic status (Averett & Korenman, 1996; Brownell, 2005; Cecil et al., 2005; Crossrow, 2001). Although this is not fully understood, researchers posit that the availability of cheap high fat convenience foods and cultural factors play into this relationship. Migration appears to have some affect on ones propensity to have excess weight (Candib, 2007). Research demonstrates that with in 20 years of immigration to the United States the prevalence of diabetes increases. Asian American and Hispanic American adolescents are twice as likely as their first generation parents of being overweight (Candib, 2007).

Finally, globalization appears to have an affect on individuals becoming overweight. Pressures from global food markets make most of the decisions about what foods are readily available. For instance the price of high fructose corn syrup is extremely low compared to the price of fresh corn. Global corporations are offering sedentary jobs,

such as call centers world wide, changing the weight landscape of developing nations (Candib, 2007, World Health Organization, 2008).

Psychological Factors

There is no causal relationship established in the literature between weight status and emotional and psychological distress. There is however a relationship between the two. To try and give a visual representation of this phenomenon Brownell (2005) represents the relationship that bias, stigma and discrimination have on various factors. These factors such as diminished income and education, less access to health care and diminished self-esteem, increased poor heath, psychological disorders and poor recovery from disease. With the large amount of discrimination on persons who are overweight, weight bias itself contributes to keeping overweight persons at their present weight and in this chart increases illness and death. The following figure represents the relationship of weight and psychological factors.

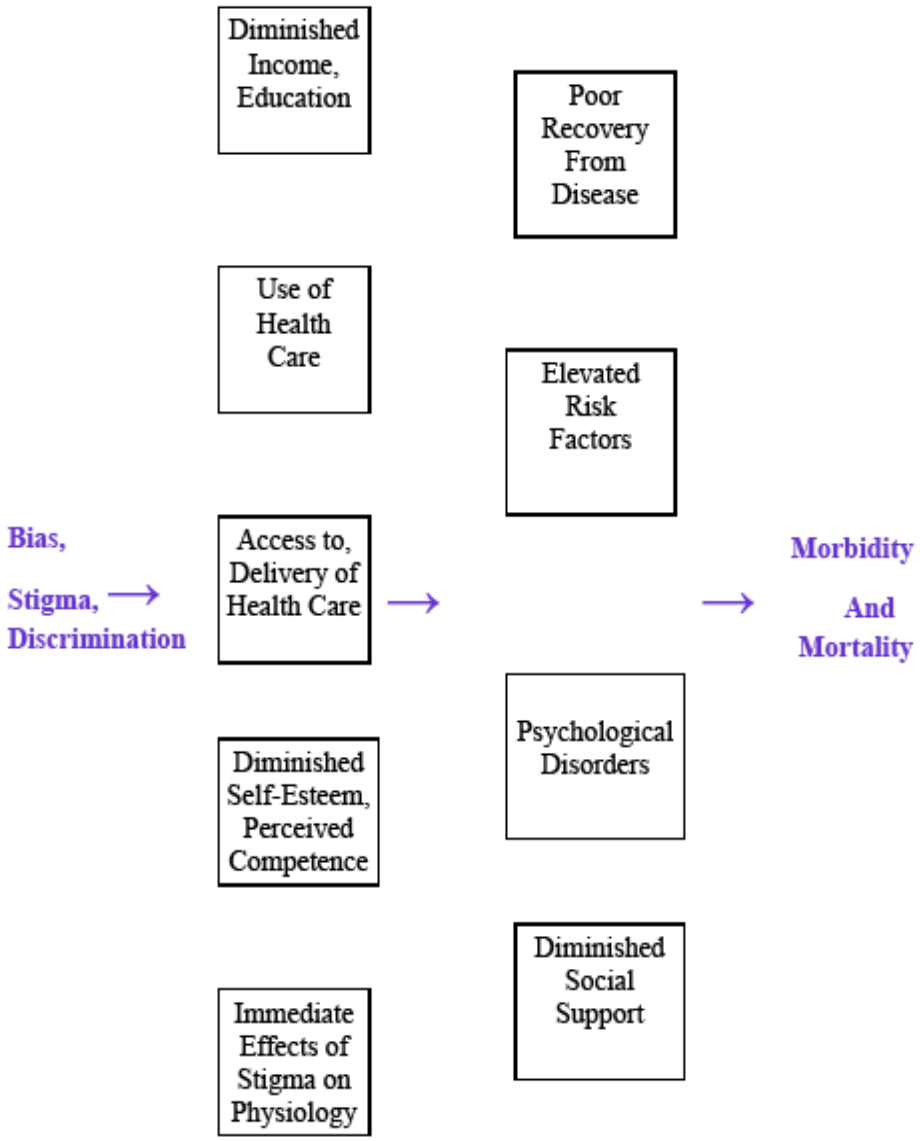

Figure 1. Relationship of Weight to Psychological Problems (Brownell, 2005).

Research demonstrates that those who are overweight have much higher rates of depression, anxiety, low self-esteem, poor body image and suicidal thoughts and actions than those of normal weight. The reality of this is that those suffering from depression are less likely to recover if they are overweight because of the intractable nature of their weight status. Attributes given to those who are overweight in our culture such as the initial weight gain is controllable, and that if one just "works harder" one can loose, creates pressure for the overweight individual that demonstrates itself in negative thinking about one's inability to change one's weight. This type of thinking over time is detrimental to one's mental health.

Early research on the relationship between psychological disorders and weight gain were inconclusive. More recent research has shown a growing trend toward a strong causal relationship between persons who are overweight and psychological disorders (Goodman & Whitaker, 2002; Heo et al., 2006; Herva et al. 2006; Jones & Carney, 2006; Simon et al., 2006). Simon and his colleagues conducted a large national study of 9,125 respondents who gave information on their height, weight and psychiatric diagnosis. The researchers had trained non-clinical interviewers question each participant. The researchers discovered that there is a significant positive relationship between individuals who are overweight and a number of anxiety and mood disorders. They also found that one quarter of the cases of persons who are overweight are attributable to the connection with a mood disorder. What they cannot determine is causation, whether weight gain causes mood disorders or mood disorders cause weight gain. They did establish however a strong statistical relationship between the two, and these findings did not vary between men and women. European American women who were overweight reported depression

at higher rates than women in other racial groups. Quinn and Crocker (1999) found that overweight women who endorsed a protestant ethic that values individualism and sees failure as a moral issue also had lower self esteem and scored higher in depression and anxiety measures.

A major study conducted by Heo et al. (2006), found that weight and mood disorders are related. This study had 44, 800 participants via telephone interviews, investigating depressed mood among different adult groups (age, sex, race) to ascertain if there were group differences that might be helpful for professionals in early identification of depression. The researchers found that young, overweight women, particularly Hispanic women, were more likely to report depressed mood than non-overweight women or men or older women. They found that women who are overweight were 44–80% more likely to experience depressive mood than their average weight counterparts. The study also showed that 14% of overweight women, compared to 7% of overweight men, suffer from depressed mood. This article again cites differences in beauty standards for men and women as a possible cause for this difference.

Much like the results in the Heo et al. study, there is thought to be a link between metabolic syndromes and psychopathology. Jones and Carney (2006) conducted a study with medical records using multivariate logistic regression. They examined a relationship between metabolic syndromes (thought to contribute to weight gain) and mental disorders. Metabolic disorders would include obesity, hypertension, diabetes, glucose intolerance, hypercholesterolemia, and hypertriglyceridemia. They found that metabolic syndrome was more prevalent among those with mental illness.

The previous studies were conducted with adult populations; there are similar results in the adolescent populations as well. In three child and adolescent studies researchers found that depressed mood in adolescence can predict overweight status in adulthood and that an individual who is overweight in adolescence may also be depressed in adulthood (Goodman & Whitaker, 2002; Herva et al. 2006). Herva et al. conducted a longitudinal study in Finland that followed 8,451 children born in 1966 from birth until they were 31 years of age. The main finding of this study was that teenagers who are overweight is predictive of depression in adult women and that abdominal weight is associated with depression in males. Goodman and Whitaker similarly found that depression among adolescents is predictive of excess weight among adults. Their study demonstrated that if a teenager was depressed the likelihood of that individual becoming overweight was double that of teenagers who were not depressed. Pine, Goldstein, Wolk, and Weissman (2001) conducted a study using 6 to 17 year old children, ninety (90) children with a clinical diagnosis of major depression, and 87 children without a clinical mental health diagnosis. They followed up with the children 10 to 15 years later to assess their BMI. They found that childhood depression was associated positively with higher body mass index that cannot be explained by other variables.

The preponderance of evidence linking mood disorders and overweight status is striking. This is particularly fitting when training mental health professionals, as they will often be the first line of therapy for persons with mood disorders. It is necessary to understand the complex relationship between mood disorders and weight to effectively help clients who are overweight. A brief review of medical, environmental, psychological and sociopolitical research indicates that there are many factors that contribute to an

individual being overweight. They include: biological traits, behavioral factors, environmental and socioeconomic factors, and psychological factors.

Factors that Contribute to Weight Bias

We have looked at a number of factors that affect individuals who are overweight. Understanding some of the theoretical constructs of bias and stigma are integral in helping individuals deconstruct these experiences. In understanding the social model of obesity bias and stigma, the following constructs will be examined briefly (a) Judeo-Christian values in bias, (b) the role of the medical establishment, (c) the role of the diet industry, and (d) overweight persons self perception. Further (e) civilized oppression, (f) covert bias, (g) stigmatizing environments, (h) attribution theory, and (i) social consensus in contributing to conditions that encourage weight bias to flourish will be briefly explored.

Judeo-Christian Values

Rogge, Greenwald, and Golden (2004) identified four main contributors to the social construction of obesity. The first is western society's moral foundation of Judeo-Christian values that promotes self-denial and discipline. There is emphasis on spiritual purity through several means, one of which is fasting. Obviously those who are overweight would be counter to these foundational beliefs, and considered by some to be gluttonous.

Likewise, Quinn and Crocker (1999) found that women who professed to have a strong protestant ethic and who feel that they are overweight are more likely to have increased risk of psychological distress. The protestant ethic for this study was described

as a belief in individualism, that the hard work of the individual leads to success, and that lack of discipline and moral indulgence leads to lack of success. Therefore overweight women view themselves as "moral failures" (p. 412). These researchers propose that the protestant ethic is a vulnerability factor for the psychological health of women who feel very overweight.

Role of the Medical Establishment

Secondly, Rogge et al. (2004) identify the medical establishment as playing a role in the social construct of obesity. Medical associations such as the Centers for Disease Control and the American Heart Association identify obesity as a disease that it is damaging to ones health and is an abnormal condition. They also emphasize that an individual who is overweight has control over the disease, through personal labors of diet and exercise. As a result, medical professionals essentially place blame on persons who are overweight for their condition.

Role of the Diet Industry

The diet industry has a role in the social model of obesity. Book publishers, pharmaceutical companies, food manufacturers and the like stand to gain a great deal from selling their products to those who feel they can change their situation by using weight loss products. The fashion and advertising industries play a role by promoting an ideal body image that is unattainable for most people that contribute to the social model of obesity (Rogge et al., 2004).

Self Perception

Another critical contributing factor to the social model of obesity is from individuals who are overweight themselves. Their belief that if they would just work

harder, become more focused, and find the right diet, they would be able to lose weight contributes to having no sense of belonging to a group, which could be a protective factor against weight bias (Rogge, et al., 2004). This is also referred to as attribution theory and will be discussed more in depth later in this chapter.

Civilized Oppression

Rogge, Greenwald, and Golden (2004) discuss Harvey's concept of civilized oppression in relation to weight bias. They outline civilized oppression in the following way:

> Characteristics of civilized oppression come into play in the day-to-day relationships and experiences of overweight individuals. According to Harvey, key elements of these oppressive relationships are that they (1) are non-peer, power-laden relationships, (2) involve interactions that diminish and control the recipient who has little recourse, (3) pose cumulative acts of omission and commission that distort the relationship(s), (4) cause harm or disadvantage to the subject, (5) may be without malicious intent, and (6) are insidious and obscured in routine or daily encounters. (p. 306)

Further, Rogge, Greenwald, and Golden (2004) have labeled this civilized oppression. They call for nurses who are trained to respect all persons to understand their own biases toward overweight patients and to develop self-awareness about the "overt and covert messages" (p. 313) that they are sending to their overweight patients. Moral failure for past weight loss disappointment is not part of the lexicon suggested by these researchers, as it is part of a social construct that blames the patient for his or her condition. They call on nurses to oppose the oppression of those who are overweight and

further implore nursing professors to "model attitudes of caring and compassion" (p. 314) toward overweight individuals.

Covert Bias

King, Shapiro, Hebl, Singletary, and Turner (2006) found that bias against overweight persons in the workplace is interpersonal or covert in nature. As such they propose that this type of discrimination is much more difficult to identify and ameliorate than overt forms of discrimination. Covert discrimination is defined as lack of eye contact, shorter periods of engagement, decreased smiling, and increased rudeness. In this study researchers sent overweight and standard weight shoppers into the mall and they rated the customer service each received. They found that overweight individuals face covert discrimination, especially when the customer service personnel felt justified that the person's obesity was controllable.

Stigmatizing Environments

Goffman (1963, as cited in Crocker, Cornwell & Major, 1993) outlined three types of stigmatizing environments. The first is tribal stigmas such as membership in a disadvantaged or hated ethnic, racial, socioeconomic or gender group. The second is abominations of the body, which includes disfiguring conditions and physical disabilities. And lastly, Goffman describes blemishes of individual character, such as alcoholism, criminal record, or homosexuality. In using this construct Crocker, Cornwell and Major point out that being overweight carries with it two types of stigma: a) abominations of the body, for being overweight is certainly not something one can hide, and b) blemishes of the character, because in our culture one is seen as having control over one's weight, and therefore has a character flaw that causes the lack of self discipline and the ensuing

weight gain. Those who are overweight carry the double burden of being aesthetically displeasing and having a character stigma that also carries shame and guilt.

Teachman, Gapinski, Brownell, Rawlins and Jeyaram (2003) conducted a study that demonstrates some of the aforementioned principles quite well. In one study they went to a beach and invited passersby to participate in the study, and they had 144 participants. Participants received one of three conditions or primes: (a) no prime, (b) a recently published news article indicating the causes of being overweight are controllable through behavior, or (c) a recently published news article indicating the cause of being overweight was genetic. One article discussed new research that indicated that genetic predisposition was the primary cause of being overweight and the other article discussed overeating and lack of exercise as the primary cause of being overweight. Participants were given the IAT and the Fat Phobia Scale. Results indicated that participants who received the prime that attributed excess weight to personal factors such as overeating had much higher implicit anti-fat/pro-thin bias.

In a second and related study (Teachman et al., 2003) they recruited female students at Yale and presented them with three primes: a) a personal story of an overweight woman and the discrimination she had experienced, b) a personal story of discrimination of a person in a wheel chair, and c) no prime. They sought to ascertain if evoking empathy for an overweight person made any difference in explicit and implicit bias scores. They did not find any statistically significantly differences among scores. The authors concluded that these two studies indicate that anti-fat attitudes are deeply culturally ingrained.

Attribution Theory

Unlike other groups that experience discrimination, persons who are fat often do not support one another or have "fat pride". They do not have a "fat day" parade or stand defiantly with "fat power". Certainly even the mention of these terms seems ridiculous. In many cases persons who are overweight confirm cultural norms by identifying with the mainstream views thinking that they will lose weight and no longer are a member of the stigmatized group (Crocker, Cornwell, & Major, 1993; Quinn & Crocker, 1999; Puhl, 2005; Wang, Brownell, & Wadden, 2004). In a number of studies persons who are overweight endorse the social rejection they experience and do not blame the person rejecting them. For example, in their study Crocker, Cornwell and Major (1993) found that overweight women who were rejected by a male peer attributed the rejection to their weight and not to other factors. Additionally, the overweight women in the study did not feel that the male peer was prejudiced against them because of their weight. They did not externalize the outcome of this interaction to stigma. It is important to understand that persons who are overweight will tend to self-blame and will feel ashamed of themselves and their bodies and as a result will avoid activities. These behaviors deprive overweight persons of the self-protection that other stigmatized groups gain from being members of their group.

Crandall and Reser (2005) discuss the significance of attribution to the stigma that overweight individuals suffer. They propose that persons who are overweight are seen as being responsible for their conditions and as such, ought to be able to take some action against it. The public gives reason for the attribution, such as "she has no self control." The author uses HIV/AIDS as an example; people attribute contraction of

HIV/AIDS to drug use or homosexual activity, and will often ask AIDS patients which one they participated in to contract the disease. The moral judgment that is inherent in fat prejudice is inescapable; being overweight is a sin in the court of public opinion and not a disease.

Social Consensus

A number of researchers have found that racial and ethnic differences contribute to the amount of bias evident in a culture. Crandall and Martinez (1996) believed weight bias rests squarely on the western ideal of individualism and test this theory by comparing weight bias in the US and in Mexico. He found that there was less anti-fat bias among participants in Mexico than in the United States. There are cultural differences within the United States with a number of studies finding that African American women preferred thinness (Hebl & Heatherton, 1998) but attributed fewer negative stereotypes to overweight women, and had higher body image (Roberts, Feingold, Cash & Johnson, 2006). For example Davis, Clance, and Gailis (1999) found that African American women tend to be dissatisfied with their bodies in direct proportion to their acculturation to the dominate culture which prizes thinness. African American women who identified with African American culture acted as if it were a protective factor against body dissatisfaction for overweight women. It may demonstrate that in the United States persons who have cultural, racial or ethnic identity outside of the dominant culture may be protected from some of the bias that overweight persons in the dominant culture suffer. In other words, racial, cultural or ethnic identity serves to work as a protective factor against weight bias within their communities.

Sechrist and Stangor (2005) have a body of work on race bias. In their work they found that social consensus is an important feature of sustaining stereotyping beliefs. They found in their experiments that if an in-group member expressed negative beliefs about a racial group, other in-group members would tend to have a lower opinion of that group. Conversely if an in-group member expressed a favorable attitude toward a particular racial group, other in-group members would have more positive attitudes toward that group.

Across a number of studies presented here the perceived causes of a person being overweight appears to make a difference in how people react to that person (Crandall & Reser, 2005; Crocker, Cornwell, & Major, 1993; King et al., 2006; Quinn & Crocker, 1999; Puhl, 2005; Teachman, et al. 2003; Rogge, Greenwald, & Golden, 2004; Wang, Brownell, & Wadden, 2004). If there is a perceived medical or genetic cause of excess weight people appear to hold less bias, and if the cause if perceived to be controlled by the person who is overweight (presumably by eating less and exercising more), there appears to be more bias present. Persons who are overweight also hold this bias against themselves, feeling like moral failures because they attribute their weight to their own shortcomings, such as over eating or failing at weight loss attempts (Crocker, Cornwell, & Major, 1993).

Judeo-Christian values, the medical establishment, the diet industry, civilized oppression, covert bias, stigmatizing environments, attribution, and social consensus combine and intertwine in our culture. This interplay to creates conditions that make prejudice and stigma against overweight individuals an everyday occurrence in our culture.

III. METHOD

Introduction

This study was designed to explore impressions that counseling graduate students may have toward persons who are overweight. The study used a stimulus qualitative research method, of the phenomenological tradition of analysis. Participants were asked to evaluate a case history that included an accompanying photograph of the client. Specifically, the study intended to investigate the nature and extent of weight bias, particularly in understanding counseling students willingness to work with overweight clients, the extent to which they believed that the interventions would be helpful to overweight clients, their belief in a favorable prognosis for their overweight clients, their perceptions of the overweight clients' diagnosable pathology, their perception of social support available to the client and their perceptions of the barriers and challenges that overweight persons may experience in counseling.

This chapter includes a methodological overview, an explanation of the role of the researcher, a description of the pilot study, a discussion of the instrument used and its development for this study, selection of participants, data collection procedures, data analysis procedures and issues related to credibility.

Methodological Overview

Phenomenology allows the researcher to identify a phenomenon, in this case weight bias amongst counseling students, and open up the phenomena to be understood and examined through field data, in the case of the present study answers to open ended questions (Creswell, 1998). Phenomenology is appropriate for this study as narrative data was produced and as such is experiential in nature. Hegel describes phenomenology as the "science of describing what one perceives, senses and knows in one's immediate awareness and experience" (Moustakas, 1994).

Phenomenology as Philosophy

Phenomenology is a branch of philosophy, owing its origin to the work of Edmund Husserl (1859–1938), a German mathematician, and later writers such as Heidegger and Sartre, who took the ideas into existentialism (Creswell 1998; Moustakas, 1994; Wilson 1992). The goal of phenomenology, according to Husserl, is to study human phenomena without considering their causes, their objective reality, or even their appearances. Human phenomena are experienced in consciousness, in cognitive and perceptual acts, as well as how they may be appreciated. A key concept is intersubjectivity; phenomenology seeks to understand how persons construct meaning. Wilson (1992) states

> Our experience of the world, upon which our thoughts about the world are based, is intersubjectivity because we experience the world with and through others. Whatever meaning we create has its roots in human actions, and the totality of social artifacts and cultural objects is grounded in human activity. (p. 1)

Phenomenology was appealing to psychologists in the early twentieth century and phenomenological psychology exists as a thriving sub-discipline of psychology where the emphasis is on understanding a person's experience of a problematic situation. 'The people in question tell their own story, in their own terms. So "fidelity to the phenomenon as it is lived" means apprehending and understanding it in the lived context of the person living through the situation (Wilson, 1992, p 4). *Phenomenological research approach* from the previously discussed philosophical tenets' four main themes has emerged in phenomenological research (Creswell, 1998; Moustakas, 1994). First, within in the phenomenological tradition there is a return to the tasks of philosophy. This refers to a return to the Greek concept of wisdom, prior to a focus on "scientism". Secondly, in phenomenology the researcher is to suspend all judgments about what is real. Husserl refers this to as epoche and others as bracketing. Thirdly, one's conception of reality is always related to one's awareness of it. In other words, there is no subject or object. This places emphasis on the meaning of an object rather than on whether it is real or not. And lastly, there is a refusal of the subject-object dichotomy (Creswell, 1998). Objects can only be perceived through the meaning that an individual assigns to that object.

In general phenomenological research follows a number of guidelines. Questions focus on exploring the meaning of an experience. In this study comparing and contrasting participant responses glean meaning. Data is collected from persons who have experienced the phenomenon. In this research, the counselors-in-training are the persons who have experienced their perceptions of diverse clients. The researcher must employ bracketing or epoche in considering the data, which was employed in this study by using

bracketing. Data analysis consists of reading the entirety of the data to get a sense of the whole. In this study, verbatim transcripts were read and data was horozonalized through this process. The researcher reads the same description slowly and looks for transitions in meaning with the intention of discovering the meaning. From this meaning, units or themes are developed. The researcher then eliminates redundancies and clarifies the themes. To clarify themes, the help of peer analysis was sought in reviewing themes and discussing them. The researcher then interrogates each theme to develop concrete language that describes the essence of the situation. To achieve this end, the researcher used negative cases. Themes were written and re-written until they were clear. The researcher then synthesizes and integrates the insights into a description of the themes (Creswell, 1998; Giorgi, 1985 as cited in Moustakas, 1994).

Phenomenology is particularly useful when studying the lived experiences of individuals. Further, Shutz (Wilson, 1992) proposes that in the social sciences 'research objects' that are themselves interpreting the social world that we, as scientists, also wish to interpret. People are engaged in an ongoing process of making sense of the world, in interaction with their fellows and we, as scientists, are seeking to make sense of their sense making. In doing so, we must inevitably make use of the same methods of interpretation, as does the person in his or her 'common-sense world'. What distinguishes the researcher, however, is that the researcher assumes the position of the neutral observer.

Rationale for Use of Phenomenology in this Study

Phenomenological research was chosen for the present study for a number of reasons. The most important of which, is that this study is seeking to understand and

describe the perceptions of counselors-in-training toward overweight persons. Further this study sought to identify the salient features of weight bias. Moreover, the study targets toward meaning of the experience of weight bias among counselors-in-training and concerns itself with understanding the perceptions of the participants. Giorgi (1979) outlines two descriptive levels in the phenomenological approach. Level one is a naïve description obtained through open-ended questions. Level two describes the structures of the experience based on reflexive analysis. This study engaged in both levels. Phenomenology is preferred in this type of study because its descriptive approach essentially allows the participants to speak for themselves. This method is preferred particularly for this reason, it was important for readers to see the research and draw their own conclusions.

Role of Researcher

Qualitative study requires some attention to the role of the researcher (Lincoln & Guba, 1985). I became interested in this topic one night during a class when a professor mentioned that the most widely held bias these days is against people who are overweight. This was of immediate interest to me because I had thought about this many times in my counseling work with clients. The source of this insight into weight bias was in career development literature (Roehling, 1998). As I had been a career counselor for a number of years and understood that weight was an issue in preparing, particularly female students, for job interviews I was intrigued. I began to question why this had not been addressed in counseling literature. These lines of thinking lead me to undertake this dissertation research.

After completing a full literature review I felt that a qualitative study might be of particular use in this field as most of the available data was quantitative and in evaluating the language used by participants I might be able to gather some information about the covert nature of bias. I have particular use in the interest in language as my undergraduate degree is in Speech Communications and Theatre.

I administered most of the surveys and asked for student participation. I analyzed all of the results using Moustakas' (1994) method. I worked with my advisor in confirming thematic categories and had two peers confirm these themes as well. I worked diligently to bracket all of the data as I sorted it for purposes of discerning themes.

Pilot Study

The pilot study was conducted with three counselors in training. Two of these students had just graduated from a master's program in counseling, and one was in the last semester of a masters program in counseling. All had completed an internship, but none had yet begun professional work. Each of the pilot surveys was administered in the presence of the researcher so that participant questions and comments could be gathered to adjust the study as needed. The researcher gave no direction in terms of answers or interpretation of questions, but rather noted areas where participants appeared to struggle to answer questions.

As a result of the pilot study, questions four and five were changed. Originally questions four and five read:

4. What types of diagnosis would you give this client?
5. What is the client's level of functioning?

Pilot study participants expressed difficulty verbally to the researcher regarding questions four and five. All three of the participants asked questions about what were expected in their responses and were hesitant generally to answer questions four and five. One of the participants stated that she didn't feel qualified to answer questions four and five, but after encouragement from the researcher she made a tentative attempt at answering the questions. All stated that they would need more information, or that they would need the DSM IV-TR to answer the questions properly. Given these responses by all three pilot study participants the questions were changed to give the students more opportunity to identify symptoms and then give a diagnosis. The lists of symptoms were adapted from the Young and Powell (1986) study to give students more narrow choices which would elicit more specific diagnosis. Further description of these changes will be given in the following sections.

Instrument

The instrument and stimulus (case history) used in this study has been adapted from Young and Powell's (1985) study of weight bias among practicing clinicians. They adapted their questionnaire and stimulus (case history) from the work of Settin and Bramel (1981) addressing gender and class bias among mental health professionals.

Original Instrument

The instrument used in the Young and Powell (1985) study used two sections of the Settin and Bramel (1981) study that measures mental health professionals' responses to particular client variables, such as race, class, gender, etc. The two sections used by Young and Powell (1985) were the part of the inventory that measured clinician's

willingness to work with clients, their belief that therapy would be useful to the client, and their belief in a positive prognosis for the client. Participants in their study responded to these items on a Likert scale. The second section Young and Powell (1985) used estimates the mental health professional's perceptions of the client's level of dysfunction. Again, a Likert scale was used for participants to rate psychological symptomology. A case history was provided to the participants. The history describes a middle aged White woman who is having suicidal ideation and difficulty in her marriage related to her husband's busy schedule. Further, the client has had difficult in her family of origin in that her stepfather and mother were quite strict and emphasis was placed on the misbehavior of the children. The client feels that her mother always sided with her stepfather against her. The client is of average intelligence and is quite insightful. She showed evidence of weight loss and sleep disturbance. She was trembling at the beginning of the clinical interview, had low eye contact and was quiet. Young and Powell (1985) also attached a photograph of the client; in their study they used three altered photographs: "best weight", "over best weight" and "overweight".

Reliability and Validity of Original Instrument

This instrument has been used in some form in a number of published studies (Settin & Bramel, 1981; Stein, Green & Stone, 1972; Stein, Green & Stone, 1978; Young & Powell, 1985). There is an established precedent in the literature for using parts of the original study in ascertaining clinician attitudes about particular client attributes (Settin & Bramel, 1981; Young & Powell, 1985). Its original form was adapted from items in the Strong Interest Inventory (Stein, Green, & Stone, 1972) to group clinicians with similar attributes. The origins of the instrument used in the present study sought to understand

therapists' attitudes toward clients based on patient diagnosis and social class (Stein, Green, & Stone, 1972). Further studies adjusted the instrument to understand the interaction between social class and gender in clinician treatment planning (Settin & Bramel, 1981; Stein, Green, & Stone, 1978) and to understand the effect of client weight status on clinical judgment (Young & Powell, 1985).

The case histories were originally adapted by Stein, Green, and Stone (1972) from the work of Deutsch and Murphy (1955) and Kurtz and Kurtz (1968) that obtained satisfactory agreement among several experienced clinicians on the diagnosis and degree of psychological impairment. The case histories used in the Stein study obtained 100% agreement among seven raters on diagnosis and degree of impairment.

Revisions of Instrument for this Study

For this study I made some changes to the original instrument. First, I revised the questions to elicit qualitative data. I wanted to conduct a qualitative study as I feel that there is sufficient evidence in the literature that weight bias exists among mental health practitioners, and this bias affects the selection of clinical treatments. What is not present in the literature to any degree is description of and understanding how the weight bias is actually held. I felt it was important to explore the nature of weight bias. I also felt that there may have been significant changes over time. The Young and Powell study was conducted in 1985 and shows how we view people who are over weight and what language is used when discussing clients who are overweight. It is my hypothesis that cultural pressure to be thin has increased while cultural acceptance for the overt expression of bias has decreased. I was interested in understanding how counseling students might express bias. This interest was predicated by an interest in how we might

teach counselors-in-training to gain awareness of their bias so that they may add knowledge about the experiences of overweight persons and skills in working with persons with weight issues.

Making these changes to the case history and survey may adversely affect the reliability and validity of the original instrument. So for this study, the original instrument was viewed as a structure to be used for developing questions and organizing the data in this study. It was a starting place, if you will, for understanding the nature of weight bias and its intersection with clinical judgment. It also gave me a point of reference for analyzing responses given by participants. Because of possible changes over time in counseling methodology and because of particular counseling concerns, two questions were added to the study. In recent years counselors have become concerned with social support available to clients, and in perceived barriers to effective counseling. In a number of studies (Brownell, 2005; Solovay, 2001) researchers have found that persons who are discriminated against may have less social support and more barriers to effective counseling. These questions were added to ascertain how these factors were perceived by counselors-in-training toward over weight clients.

To establish validity of the stimulus case study I sought input from four experienced (68 years combined) licensed professional counselors working in a clinical setting, and two doctoral students in counselor education. There was 100% agreement among raters that the client in the case history was depressed.

The content of the questions of Young and Powell's study have remained intact; however, the format has been changed for this study to illicit qualitative data. An example of one such change is in Young and Powell's (1985) study they asked

participants to rate, on a Likert scale ranging from zero to five, with zero being "Symptom is not at all characteristic of client" to five being "Symptom is very characteristic" for such items as the "Usefulness of therapeutic intervention" (Young & Powell, 1985, p. 239). In the current study the question is posed in the following manner: "How useful do you feel therapeutic interventions will be with this client? Explain briefly why you feel this way?"

After discussion with committee members, two additional questions were added to the original Young and Powell (1985) study of five questions. Questions six sought to understand counselor-in-training perceptions of social support available to the client, as research indicates that there are differences in social support for persons who are overweight. Question seven sought to understand if counselors-in-training perceive additional barriers or challenges that overweight and overweight persons may experience in counseling. The questions in the study were:

1. How useful do you feel therapeutic interventions will be with this client? Explain briefly why you feel this way?
2. In your opinion what is the prognosis (long term outcome) for this client?
3. How willing are you to work with this client?
4. What types of symptoms does this client display? (Circle all that apply)

Addiction	Agitation	Antisocial Behavior
Disorientation	Egocentrism	Emotional Behavior
Hypochondrias	Impaired Judgment	Impulsive Behavior
Inadequate Hygiene	Inappropriate Behavior	Incoherent speech

Intolerance of Change	Obsessive-Compulsive Behavior	Reminiscence
Self-Injurious behavior	Sexual dysfunction	Stereotyped behavior
Suspiciousness	Thought disorder	

5. Given the above listed symptoms; what diagnosis would you give this client?

6. What types of social support are available to this client?

7. What are some barriers or challenges that this client may experience in counseling?

Students received identical stimulus case histories (see Appendix C) with differing photographs (see Appendix B). The photographs were identical, until one photograph was digitally altered to make the client in the photograph appear overweight. By having the same person in the photograph, attractiveness, and other factors such as clothing remain constant with the only variable being weight.

A European American woman is being used for the study because research indicates that overweight White women are stigmatized for being overweight more than other groups (Averett & Korenman, 1996; Brownell, 2005; Cecil et al., 2005; Crossrow, 2001; Friedman & Brownell, 1995; Herva et al., 2006; Heo et al., 2006; Loh, 1993; Pingitore et al, 1994; Roehling, 1999; Teachman & Brownell, 2001; Young & Powell, 1985). Further, the age of the client in the case study was adjusted from 45 years of age in the Young and Powell (1985) study to 25 years of age in the current study. This change

was made because the average age of counseling graduate students is 26 years old; therefore, there was a control for discrimination based on age.

Selection of Participants

Fifty-six participants who were currently enrolled in graduate level counseling programs from two southeastern universities (Auburn University and University of West Georgia) participated in the study. Given human subjects research considerations; permission was obtained from the Institutional Review Boards at Auburn University and University of West Georgia to conduct the study in each location. Permission of the counseling department chairpersons and each professor of participating classes were also sought and given. Four faculty members who had one to three classes each agreed to allow their classes to participate in this study for purposes of data collection.

Participants selected for this study were enrolled in graduate level counseling classes, and participated voluntarily near the end of each class period. Cluster sampling was used, as one to three classes were selected at each university based solely on convenience to the researcher. The following participant demographic data were collected: (a) degree sought: masters' or doctoral; (b) area of study: school counseling, community counseling, counselor education; (c) gender; (d) age; (e) ethnicity; (f) years of clinical experience, and (g) if they have taken a course in diagnosis.

Data Collection Procedures

The research was conducted at each university, with permission of the faculty member and the institutional review boards of each institution. The researcher and two

representatives went to the professor's class and distributed the survey packets. The researcher administered the survey in five classes and each of the representatives administered the survey in one class each. The representatives were given specific instructions with color-coding to ensure that all survey materials were distributed in the proper order, to maintain the deception used in the study. Additionally, they were given instructions to read to each class on the purpose of the study and how they might participate in the study. Both representatives were doctoral students in the counseling program at Auburn University. The professor left the room to prevent any coercion to participate. Students who chose to participate were given twenty to thirty minutes to complete the survey packet. All data were anonymous and were placed in a database with no identifying information on the question responses or the demographic sheet. In the survey packet the students received a consent form, demographic data sheet, a case history, photograph and the survey. Students were not advised of the purpose of the study as this would bias the study. They were told that the study sought to examine case conceptualization skills.

Students received identical case histories (see Appendix C) with differing photographs (see Appendix B). One photograph was of an overweight twenty-five (25) year old European American woman, and the other photograph was of a twenty five year old European American woman who is of average weight. The photographs are identical, with one photograph digitally altered to make the client in the photograph appear overweight. By having the same person in the photograph, attractiveness and factors such as clothing remained constant with the only variable being weight. Twenty five year old women have been chosen for the study to reduce any error in age bias, as most graduate

students are approximately twenty-five years old. The model for the photograph is a twenty five year old graduate student who gave her permission to have her photograph taken, altered and have it attached with the case history. The graduate student is not in the counseling program and was not known to any of the participants in the study. The researcher took the photograph and altered it using Adobe Photoshop (see Appendix B).

Students were selected randomly in each class to receive the different photographs (conditions) to reduce any error in both selection and to account for differences that may exist in the counseling programs at each university. For example, if there were thirty students in a class, fifteen received the average weight condition and fifteen received the overweight stimulus. The different stimuli were handed out carefully when students were seated at tables, so that all students at a table received the same condition. This prevented students from viewing different conditions and further protected the study from error.

Data Analysis

The responses were analyzed using the concepts of phenomenology. This study sought to understand what counseling graduate students perceived about overweight and overweight individuals.

Moustakas (1994) developed steps for analyzing data in phenomenological study. His methods for analyzing data were used in this study. This approach was chosen because it is highly structured and allows the data to organize thinking and reporting about the topic. The method includes the following steps to follow: horizonalizing individual statements, creating meaning units, creating themes and advancing structural

and textural descriptions (Moustakas, 1994). Horizonalizing data refers to taking every statement and treating it with equal value. From these statements, meaning or meaning units are listed. These meanings are grouped to create themes. The themes are used to develop textural descriptions of the experience.

There are four main propositions that are overarching in Moustakas' (1994) method that address validity. They are epoch, phenomenological reduction, imaginative variation and synthesis. For proposition one, epoch (from here on referred to as bracketing) refers to the researcher setting aside one's own judgments to see things with a fresh mind. I used bracketing throughout the process by constantly questioning my assumptions, seeking the input of important others, and by diligently using the methods described herein.

In proposition 2, phenomenological reduction, refers to a process by which we understand the experience of perceiving. In other words, we begin to focus on the experience and not just the phenomenon itself. This is achieved through descriptive procedures such as thick description. In this study I consciously developed a way of questioning personal thinking about the participant responses to try to understand their points of view.

In proposition three, imaginative variation, I targeted toward meaning by using imagination to vary the frame of reference to see the phenomenon from a different perspective thereby creating a structure for understanding the phenomenon. To achieve this observation in phenomenological reduction, the participant's responses were used to vary the point of view in understanding the responses. Further, these observations were discussed in depth with important others to get their perspectives on possible reasons why

participants responded the way they did. Openness was key in accepting many possible points of view and not just adhere strictly to one viewpoint. What participants were not saying was considered as much as what was said in their responses, thereby giving another possible point of imaginative variation.

In proposition four, synthesis, integration of the thick description (themes), and structural descriptions (variations) were used to create a statement that captured the essence of the phenomenon, in this case counselors-in-training perceptions of clients who are overweight.

Credibility

To address issues of credibility, the work of Lincoln and Guba (1985) was used. Contextual similarity is important is establishing credibility. In this study contextual similarity is achieved because counseling students are the participants and we can therefore assume that counseling students in any CACREP-approved counseling program in the country would be similar. Further Lincoln and Guba (1985) propose that in qualitative research one must establish trustworthiness of the data. This is achieved through a number of activities; the salient activity for this study is triangulation. Further, one engages in peer debriefing, negative case analysis, and referential adequacy.

Triangulation requires that multiple and different sources of data collection and analysis are conducted. To this end two universities were used in this study, thereby providing two sources of data. The universities are quite different, although both in the Southeastern United States and both CACREP-accredited programs; one is a large research institution and the other a mid-sized regional university. Each attracts a different

type of student, so there is more opportunity for variety in the data because of the demographic differences of the students. Because the instrument and case history were similar to the Young and Powell (1985) study, results can be analyzed in light of the results of their study. Direct comparison cannot be made, however, because of the changes made in the instrument. Moreover, triangulation was achieved by allowing peers to evaluate the coding categories and data analysis.

Peer Debriefing

Peer debriefing (Lincoln & Guba, 1985) was used as a tool to establish credibility. As stated earlier, two peers in the doctoral program reviewed the data and confirmed thematic categories. This act allowed me to remain "honest" when evaluating the data and gave me new points of view. For example, one of the peer reviewers suggested that I look at expectations for certain types of persons. This questioning of expectations of certain types of behaviors for certain types of people allowed me to understand the covert language demonstrated by participants more clearly, and establish implicit bias in the findings of this study. Further peer debriefing was helpful in being able to talk with someone about the data. The process of being able to talk about coding was invaluable in organizing thematic categories.

Inter-Analyst Agreement

In evaluating how often the three peer analysts agreed, I found that there was agreement 92% of the time. All raters agreed on the thematic codes, but interpretations of the categories sometimes differed. For example, I was concerned about what I saw as a disturbing trend in the data assigning more suicidal ideation to the normal weight client. The peer reviewer also saw this but didn't feel that it reached the level of a trend or

thematic category. My advisor also agreed with the assessment of the peer reviewer that the amount of concern about suicidal ideation did not differ among client types and was therefore unclear in the data. Although I felt that there was a trend that indicated that participants had more concern for the suicidal ideation of the normal weight client, I accepted the perspectives of the two persons giving a fresh look at the data. This being the case, I dropped this item from consideration.

Negative Case Analysis

Negative case analysis is a process by which hypotheses are rejected based on new data collected. Negative case analysis occurs in the field while data is being collected. In this study for example, the early data showed that there were no differences in the responses to the case histories based on weight. As more data was collected, however, differences were revealed and the early assumption that there were no differences was rejected (Lincoln & Guba, 1985).

Referential Adequacy and Transferability

Referential adequacy is providing artifacts of the study so that they can be compared to the data coding at a later date. In this study the verbatim transcripts of all participant responses are provided in Appendix F. These transcripts are provided without comment from the researchers or peer analysts to allow readers to draw their own conclusions about the data and to allow the participants to speak for themselves, as it were.

In qualitative research it is the researcher's job to provide data that "makes transferability judgments possible on the part of potential appliers" (Lincoln & Guba, 1985, p 316). To this end I have provided verbatim transcripts of each question in the

study. Stimuli and question number organize data, so that future researchers can make determinations about the use of this data for themselves.

Dependability and Confirmability

An internal audit was conducted to ensure dependability and confirmability of the data. Individuals who were not involved in the study and are doctoral students in counselor education reviewed verbatim transcripts, confirmed coding categories, made suggestions for thematic interpretations, and evaluated data analysis procedures (Creswell, 1998; Lincoln & Guba, 1985; Moustakas, 1994). Further, the dissertation committee also had input on the coding and thematic considerations. A pilot study was conducted with three counseling graduate students to ascertain if the questions are appropriate and if they elicit rich and detailed responses, necessary for qualitative study. The study was designed so that students may choose to participate. Care was taken to maintain deception throughout the study so that participants did not know that they were being evaluated on differences in responses of the client's weight status.

Limitations of the Study

This study is qualitative in nature and is meant to describe the perceptions of graduate students enrolled in two public universities in the southeastern United States; as such, its application to other settings may be limited. Even though the study was open to all graduate students in the programs, it was prone to selection bias as students interested in research may be more likely to participate. Researcher bias is also a factor in that even though rigorous procedures such as triangulation and bracketing were used to analyze data, there may be bias in the interpretation of the data.

Summary

The methods used in this study are based on phenomenological theory that describes perceptions that people have toward a phenomenon. In this study rigorous procedures to ensure credibility were employed. Particular focus on triangulation, referential adequacy, transferability and negative case analysis were engaged. Further, the instrument used in this study has been used in this fashion in previous studies. The instrument was adjusted to elicit qualitative responses. The methods employed are grounded in the literature in qualitative research (Creswell, 1994; Lincoln & Guba, 1985, Moustakas, 1994) and as such have rigor.

IV. RESULTS

The goal of this phenomenological research is to describe the perceptions of counselors-in-training toward clients who are overweight. This study was designed to explore bias that counseling graduate students may have toward persons who are overweight. Further, the study investigated the nature and extent of this bias, particularly in understanding counseling students' willingness to work with overweight clients, the extent to which they believe that the interventions may be helpful to overweight clients, their belief in a favorable prognosis of the overweight client, their perceptions of the overweight clients' level of dysfunction, their perception of social support available to the client, and their perceptions of the barriers and challenges that overweight persons may experience in counseling.

The data analysis of the study was based on the Moustakas (1994) method, which consists of four steps. Each step was completed on the verbatim transcription of each question in the study. Two doctoral students in counselor education reviewed the coding categories to confirm the categories and give alternate perspectives. The dissertation chair of the committee also confirmed the thematic categories, and gave input on each step of data analysis.

Participants

Fifty-six counseling students participated in the study, forty (71.4%) students were enrolled at the University of West Georgia and sixteen (28.5%) students were enrolled at Auburn University. Among participants 71.4% were seeking masters' degrees in counseling, 1.7% were seeking doctoral degrees, and 25% were seeking Educational Specialist degrees. Most of the participants (60.7%) were in a school counseling program, 39.2% were in a community counseling program, and 1.7% were enrolled in a rehabilitation counseling program. About 85.7% of the participants were female and 12.5% were male. The age of the participants was as follows: 33% were under 24 years of age, 39.2% were 25 to 30 years of age, 3.5% were 31–34 years old, 5.3% were 35–40 years of age, 7.1% were 41–44 years old, 1.7% were 45–50 years of age, and 1.7% were 51 and above. Of the participants, 75% identified themselves as European Americans, 23.2% identified themselves as African American, 1.7% identified as Hispanic, and 1.7% did not respond. Exactly 50% of the participants had taken the pathology/diagnosis course in their respective programs. Clinical experience was generally low with 67.8% of participants indicating that they have not had any clinical experience, 8.9% of participants had completed an internship, 26.7% had one through five years of clinical experience, 1.7% had completed six through ten years of experience, and 1.7% had completed eleven or more years of clinical experience.

From this data one can see that the majority of participants are young (30 years or less, 63.1%), women (85.7%) of European American descent (75%) enrolled in a masters' program (71.4%) in school counseling (60.7%). Further, the majority (89.2%) of

participants have five years or less of clinical experience, and 50% of participants have had the diagnosis/pathology course offered in their program.

Thematic Portrayal

Implicit Bias Against Client who is Overweight

As a result of systematic and exhaustive analysis, generally and specific, seven themes emerged. Overall, the most salient and important theme to emerge in this study is that participants perceive the client who is normal weight differently than they perceive the client who is overweight. The differences are implied rather than stated overtly. There are differences in the types of words used when talking about the two weight conditions and the participants appeared to have implicit preconceived notions about the behaviors expected from each person. For example, in answer to question one, "How effective do you feel therapeutic interventions will be with this client?", a participant with the overweight client stated,

> Relatively effective: The client has a moderate level of insight and seems relatively able to self-disclose. She has become cognizant of the ways in which her cognitions and behaviors are leading to her unhappiness. Note: Client will likely have to work on issues related to dependency on others; particularly her husband.

This participant uses language that qualifies her answer. Conversely, a participant who received the normal weight client answered the same question thus:

> I feel that therapeutic interventions will be extremely useful w/this client. I feel this way because the case identified the client as being insightful and of average

intelligence and being able to have insight into one's self makes the probability of the success of interventions rise."

These two answers are very similar in content, both answers address the client's insight and apparent willingness to enter a therapeutic relationship. What is present with the overweight client, however, is the use of conditional qualifiers (relatively effective, client will have to work) to the client's eventual success. This use of conditional qualifiers indicates a bias toward the overweight client by giving a generally positive answer with more exceptions than we see toward the normal weight client.

This trend of subtle bias is constant and consistent throughout the participant responses. Supporting this assertion are the participant answers to question three, "How willing are you to work with this client?" Of the overweight client the participant stated, "Willing as long as she is willing." And "I am willing to work with her. However I would want her to be evaluated medically as well. Physiological issues could evoke similar behaviors." Statements made about the normal weight client were more along these lines: "I would be very willing to work with this client." Again we see a nuanced response leaning toward more restricting assessments of the overweight client.

Self-esteem is an issue that was identified for the normal weight client and the client who is overweight. However, there were differences in the way self-esteem issues were addressed with each type of client. More participants presented the client who is overweight as dealing with self-esteem and dependency issues as an unchangeable character trait. The client who is overweight was perceived to be "experiencing periods of anxiety and low self esteem for a long period" by a participant. Accordingly, she was recommended to obtain "outside assistance for self esteem issues" by another participant.

Similarly, dependency issues were presented only for the client who is overweight. She was viewed "to only be comfortable when she feels people 'NEED' her" and as having a need for becoming "empowered."

Interestingly, self-esteem issues were address with the normal weight client; however, these issues were revealed in answers to question five, which focuses on diagnosis of the client. This reveals a possible implicit bias toward overweight clients in that a normal weight individual's self-esteem issues are seen as changeable therapeutic issues. An overweight client's self-esteem and dependency issues are perceived to be an unchangeable character trait.

Throughout the data there are also indications that the client who is overweight is perceived as needing to take certain actions to obtain a positive prognosis. Again a number of qualifiers appeared as conditions to the eventual success of the overweight client. In question one, for example, the client who is overweight is seen as needing to take medication, work hard, take responsibility for relationships and be cooperative in therapy to be successful in the future.

The remaining six specific themes include three domains of findings: similarities, differences and the unexpected. In content the participants provided responses that had more similarities for both client types (overweight and normal weight) in the following areas: therapeutic intervention, prognosis, willingness to work with, and social support. On the other hand, the participants responded differently to psychological symptoms and barriers to counseling that the two clients may find. One theme that was not guided by research question emerged unexpectedly: diverse diagnosis skills among participants. The remaining five themes include (a) Usefulness of therapeutic interventions, (b) Positive

prognosis, (c) Social support, (d) More psychological symptoms identified, (e) More barriers against effective counseling, and (f) Diagnosis skills vary.

Usefulness of Therapeutic Interventions

The participants appear to feel that therapeutic interventions with both types of clients (client who is overweight, and client who is normal weight) will be similarly useful to the client. One participant stated of the overweight client:

> Useful because as stated in the case study the client was found to be of average intelligence and quite insightful. She knows that she is experiencing is not a true example of her characteristics and she had already phoned in to ask for help in the past.

The participant appeared to focus on personal characteristics rather than physical appearance in evaluating the usefulness of therapeutic interventions for the client who is overweight. Of the overweight client a participant stated, "She is aware of her presenting problems as 'problems'." While another participant stated "I feel that therapeutic interventions will be useful for this client because she needs to reevaluate her thinking process. She is depressed, lonely, low self-esteem, and some other problems that need to be addressed." Likewise another participant stated "Very useful – it seems as though she has been experiencing periods of anxiety and low-self esteem for a long period – she may have been repressing these feelings for a period but the stress brought on by her husband's illness may have triggered episodes of anxiety and depression."

Referring to childhood issues, a participant confirmed the usefulness of therapeutic interventions for the client by stating, "I think she could definitely benefit

from therapeutic interventions. She has on-going unsettled issues from losing her father/ opposite sex parent at 6 [years old]."

Participants reported the usefulness of therapeutic interventions by identifying issues, among them the client's own beliefs about her problems and stress and childhood issues. These types of issues can be generally addressed in counseling sessions. In relation to interventions and their usefulness, participants appear to focus more on personal characteristics of the client than they focus on the weight or appearance of the client.

Positive Prognosis

Prognosis for both types of clients is, on the whole, perceived as being positive. The normal weight client was perceived as having a positive long-term prognosis. One participant stated, "Depression, long-term prognosis appears to be good as client seemed to have good pre-morbid features." Likewise for the overweight client, participants stated:

> "Good—when she addresses her issues."
>
> "This client is dealing with several issues of neglect as a child, neglect from a spouse, and most importantly self-defeating emotions. She needs to have on-going counseling."
>
> "With effort put in from client to work through her depression and anxiety, I would give a good prognosis."
>
> "She will probably be on depression/anxiety drugs in conjunction w/prolonged therapy. She should be able to live a normal life."

> "She needs to learn better coping skills. She will be given more support from her family and husband, but must develop a life that is not co-dependent on others to make her happy."

Accordingly the participants were "willing" to or would "love" to work with both overweight and normal weight clients.

Social Support

Largely, the participants see clients who are both normal and overweight as having a variety of social support. Those social supports include family, friends, church, group counseling, support groups, seminars, clubs, and classes. One participant stated that "She [the client who is overweight] could participate in group/classes, seminar or interests like scrap booking or a book club — be around people that validate her and are not likely to abandon [her]" and "support group for children of controlling parents" for both types of clients.

However, there is a difference in perceived support from the client's husband. The normal weight client is seen as having more support from her husband than the overweight client with only three participants indicating her husband as a possible source of support by saying: "her spouse seems supportive (still together and no mention of a split)".

More Psychological Symptoms Indentified

Most of the types of symptoms assigned to the normal weight and overweight clients were similar. However, there were some differences in the total number of symptoms, in the frequency of particular symptoms, and the ranking of symptoms for each client type. This may indicate differences in the way participants perceive the

problems of overweight and normal weight clients. Moreover, the overweight client was assigned sixteen symptoms versus thirteen symptoms identified for the client who is normal weight. The three additional symptoms assigned to the overweight client were anti-social behavior, hypochondrias, and addiction. Intolerance of change was listed as a symptom for the client who is overweight while incoherent speech was listed as a symptom for the client of normal weight. The participants identified less self-injurious actions for the overweight client than for the client who is normal weight. On the other hand, they appear to see the overweight client as being more agitated, emotional, suspicious, impulsive, and intolerant of change and as demonstrating inappropriate behavior than the normal weight client. The frequency and percentages of psychological symptoms are provided in Table 1 with discussion following.

Table 1

Frequency and Rank Order of Psychological Symptoms

Normal Weight (n = 26)			Over Weight (n = 30)		
Symptoms	# Responses	%	Symptoms	# Responses	%
Self-Injurious	23	88%	Self –Injurious	21	70%
Emotional Behavior	22	84%	Emotional Behavior	25	83%
Agitation	17	65%	Agitation	26	86%
Impaired Judgment	10	38%	Impaired Judgment	13	43%
Thought Disorder	7	26%	Thought Disorder	12	40%
Impulsive Behavior	5	19%	Impulsive Behavior	10	33%
Suspiciousness	5	19%	Suspiciousness	11	36%
Disorientation	4	15%	Disorientation	2	6%
Inappropriate Behavior	3	11%	Inappropriate Behavior	8	26%

(table continues)

Table 1 (continued)

Normal Weight (n = 26)			Over Weight (n = 30)		
Symptoms	# Responses	%	Symptoms	# Responses	%
Reminiscence	2	7%	Reminiscence	7	23%
Egocentrism	2	7%	Egocentrism	2	6%
Obsessive-Compulsive Behavior	1	3%	Obsessive-Compulsive Behavior	2	6%
Incoherent Speech	3	11%	Incoherent Speech	0	0%
Intolerance of Change	0	0%	Intolerance of Change	9	30%
Antisocial Behavior	0	0%	Antisocial Behavior	2	6%
Hypochondrias	0	0%	Hypochondrias	2	6%
Addiction	0	0%	Addiction	1	3%

Table 1 demonstrates differences in the ways counselors-in-training perceive the problems that clients have based on their weight. Participants clearly see that both client types have issues and could benefit from counseling. There are subtle differences, however, in the types of issues they feel clients are dealing with. Something to note is the obvious concern (88%) that participants feel for normal weight clients and their possible suicidal intentions. Participants do not appear to have the same level of concern for the overweight client (70%). One can only suppose that they think that normal weight clients may be more likely to take action. Another area of difference is that participants appear to feel that overweight clients are intolerant of change (30%) and that normal weight clients are not (0%). This may perhaps indicate that participants feel that unhealthy lifestyle is a response to an inability to change. It should be noted that participants indicated that they felt the normal weight client was demonstrating incoherent speech (11%) and that overweight client (0%) were not seen to demonstrate this quality. This might be an area for future research.

Another salient feature of the data regarding diagnosis of clients is the manner in which participants administered the diagnosis for each client. For the overweight client participants tend to give cut and dry diagnosis, for example "depression", "Major depressive disorder, single atypical episode." Whereas for the normal weight client there is often more tentative language used. "I would say that she is depressed and possibly has a mood disorder or something to that extent." Or "I would not diagnose as I am not qualified to do so—since I don't have a DSM IV in front of me it will be hard to even make a stab at it … but off the top of my head … dysthymia perhaps?"

More Barriers Against Effective Counseling

Participants appear to perceive the client who is overweight as having more barriers to counseling than client who is normal weight. The client who is overweight is seen as "feeling inadequate" and "dealing with feeling of inferiority" and having "self-defeating beliefs" and low self esteem as barriers. There is some mention of low self-esteem in the normal weight client in relation to treatment; none of these other barriers is mentioned. Additionally the overweight client is seen as "not willing to accept her personal freedom and the responsibility that comes along with it."

Diagnosis Skills Vary

Data appears to indicate that some participants may not be able to provide reliable results when assigning diagnosis. A participant stated, "I am not at a point where I could comfortably diagnose a person" and another stated that "Not knowledgeable in terminology and conditions to make an educated guess." Some diagnoses given by participants were not DSM IV-TR diagnosis, such as, "neurotic disorder, codependency and suicidal" indicating a lack of knowledge of diagnostic categories, as these are not

categories in the DSM IV-TR. Some responses indicated that students understood the categories but not the time required to make a proper diagnosis; “I would say depression or major depressive disorder, after reviewing the time frame and other factors 3 months is not long enough, so anxiety disorder” and “unsure of the timeline for MDD (6 mo or 3 mo?).” The DSM IV-TR indicates that for both depression and anxiety disorder the client must be affected for a period of two weeks. However, most students properly assigned a mood disorder (major depressive disorder, anxiety disorder and major depressive episode) to both client types.

V. DISCUSSION

The purpose of the study was to examine the extent of bias that graduate students in counseling programs hold against overweight persons. The investigation was performed using an indirect approach of asking the following questions: How useful do you feel therapeutic interventions will be with the client? Explain briefly why you feel this way. In your opinion what is the prognosis for this client? How willing are you to work with this client? What types of symptoms does this client display? What diagnosis would you give this client? In your opinion what types of social support may be available to this client? What are some of the barriers or challenges that this client may experience in counseling?

Data was gathered at Auburn University and University of West Georgia. Fifty-nine graduate students in counseling responded to the open-ended questionnaire. Each student responded to the same case history and an overweight or normal weight photograph as the stimulus condition. The photographs were of the same normal weight model adapted using Adobe Photoshop to make her appear overweight in one photograph. Data was analyzed using a phenomenological method (Moustakas, 1994) and verbatim transcripts of the data were created to analyze the data according to this method. Triangulation, peer debriefing, negative cases, and referential adequacy were employed

to ensure credibility of the study (Lincoln & Guba, 1985). Upon the completion of data analysis of the consolidated data, one general and six specific themes emerged.

Overall, the findings in this study largely correspond with previous research in that the findings in this study confirm existing knowledge and understanding of helping professionals' perceptions of clients who are overweight. The major thematic findings of the current study can be summarized as follows: (a) The participants perceived that therapeutic interventions are helpful to clients whether they are normal weight or overweight and their prognosis is equally good; (b) The participants also perceived that both clients have social support that might help improve their current psychological, emotional conditions; (c) Nevertheless, the participants appeared to have implicit bias against the client who is overweight. This was evident in student's language usage when providing prognosis for the client who is overweight; (d) Covert bias became evident when it turned out that the participants prescribed more psychological symptoms for the client who is overweight; and finally (e) more barriers against effective counseling were identified for the client who is overweight.

This study found that participants feel that therapeutic interventions are helpful and useful for both the client in overweight condition and the client in normal weight condition. This finding is consistent with Young and Powell's (1985) findings that mental health professionals felt that therapeutic interventions with clients who are overweight would be helpful to both overweight and normal weight clients. Further, Young and Powell found that weight status did not affect mental health professionals desire to work with a client. In the current study a similar result was found, however qualitative responses indicated that counselors-in-training used more qualified language when

referring to the overweight client. For example, “I am willing [to work with her] as long as she is willing.” The counselor in training demonstrates her willingness, but qualifies it, by making it contingent on the client’s participation. Indicating that there is some possibility that the counseling student feels that the client is not fully committed. This perhaps indicates a bias toward overweight persons indicating that the student feels that overweight persons aren’t committed to change. Further this speaks to implicit bias, in that counselors-in-training do not appear to feel explicit bias to the extent that they believe that overweight clients are beyond help.

This study also found that participants felt that long-term prognosis is good for both overweight and normal weight clients. Young and Powell (1985) had similar results in their study. They found that there were scant differences in practitioners’ view of client’s prognosis based on weight status. The current study also found that participants feel that social support is equally available to both types of clients although the types of support available to the clients differ. Participants in the current study perceived less spousal support for the client who is overweight. This finding differs slightly to that of Rogge et al. (2004) who found that many overweight persons experience difficulty in gaining social support, and in particular in establishing successful and lasting relationships with significant others. Counselors-in-training appear to feel that clients, regardless of weight status, are able to gain social support, especially when the client is in counseling.

The current study found that overweight persons have a number of outlets for social support and that counselors-in-training feel that positive therapeutic outcomes are possible for person who are overweight. These findings contrast to many existing studies

on bias that helping professionals have towards clients who are overweight. A number of studies found that helping professionals have bias toward overweight persons (Amici, 2003; Davis-Coelho, et al. 2000; Hassel & Lynn, 2003; Loewy, 1994) and assigned less favorable prognoses to clients who were overweight. Amici (2003) found that overweight clients were assigned more pathology and negative characteristics (such as lack of motivation and difficulty in personal relationships) than were clients of normal weight by mental health professionals. Hassell and Lynn (2003) found Christian and non-Christian mental health professionals judged overweight clients with more pathology and negative characteristics. Further studies indicate that there is bias against overweight patients by their physicians and health care workers (Fabricatore, et al., 2005; Rogge, et al., 2004; Schwartz, et al., 2003; Teachmann & Brownell, 2001; Weise, et al., 1992). All of these studies were conducted with experienced mental health professionals, and the difference in experience levels may account for the differences in their results and the results of the current study. Further, there may be a more positive attitude generally for those who are outside the norm that allows graduate students to perceive more positive outcomes. Nevertheless, this would be an excellent area for continued research.

Although the participants' overall perceptions towards clients who are normal weight and clients who are overweight were equally positive, differences in their perceptions that imply their implicit bias towards the client who is overweight emerged as well. Implicit bias is defined as covert or subconscious thoughts which are unknown or unexpressed by an individual (Brownell, 2005). In this study, implicit bias of participants became clear through the use of conditional qualifiers given to the client who is overweight. This is demonstrated in statements that use phrases that place conditions on

otherwise positive statements about the overweight client's prognosis, helpfulness of therapeutic interventions, and in participants' willingness to work with the client. For example, counselors-in-training described that the overweight client must work hard, and/or take responsibility to benefit from psychotherapeutic interventions.

Further demonstration of this bias is indicated in the participants' assumptions that self-esteem issues are character traits in overweight clients. Self-esteem was mentioned as an issue for overweight clients in the first question discussing personal characteristics of the clients. In the overweight condition, participants talked more about the client having low self-esteem and as needing to be empowered, and as needing to take responsibility for her condition and recovery. No such statements were made about the normal weight client. With the normal weight client there was more discussion of self-esteem as a target variable for intervention as reported by a participant: "Client has low self esteem and needs to have her value reinforced." This indicates that participants feel that self-esteem issues are transitory or amenable to therapy in a normal weight client. Self-esteem issues in the client of normal weight are a fleeting issue that requires little intervention on the part of the counselor. Conversely the overweight client's self-esteem issues are a permanent condition and not readily changeable character trait requiring both professional intervention by the counselor and hard work and dedication on the part of the client. This difference in perception uncovers an implicit bias demonstrated by counselors-in-training as they assign a more negative view toward overweight persons.

This finding of implicit bias is heavily supported in the literature, particularly in the literature of health care provider perceptions of overweight patients (Fabricatore, et al., 2005; Rogge, et al., 2004; Schwartz, et al., 2003; Teachman & Brownell, 2001;

Weise, et al., 1992). Foster and colleagues (2003) found that physicians embrace negative opinions of overweight patients, but that they demonstrated less overt bias and more implied bias. Participants in their 2003 study were not willing to endorse statements that overweight persons are awkward, unattractive and ugly, but they did endorse statements that indicated that overweight patients were less motivated and had more psychological issues. The Implicit Attitude Test (Greenwald, 1998) was designed to measure such bias. Teachman and Brownell (2001) gave the test to health care providers, and found that they had moderate implicit bias against overweight patients. Schwartz et al. (2003) found that health care professionals' explicit attitudes toward overweight persons were modest while implicit negative attitudes were vigorous. There have obviously been shifts in recent years that prohibit expressions of overt bias; however subtle bias appears to remain among care providers and among counselors-in-training.

Those implicit biases became even more evident when examining psychological symptoms identified by participants. In the present study, participants identified more psychological symptoms for the overweight client than for the client of normal weight. Further, the types of pathology identified varied in type and frequency. The three additional symptoms assigned to the overweight client were anti-social behavior, hypochondrias, and addiction. Intolerance of change was listed as a symptom for the client who is overweight while incoherent speech was listed as a symptom for the client of normal weight. The participants identified less self-injurious actions for the overweight client than for the client who is normal weight. On the other hand, they appear to see the overweight client as being more agitated, emotional, suspicious, impulsive, intolerant of change, and as demonstrating inappropriate behavior than the normal weight client.

In general there was more explanation given for the diagnoses specified to the normal weight client indicating perhaps more caution or seeking possible consultation when assigning diagnosis to normal weight clients. Statements such as "well, it could be bipolar, I would need more information" are representative of most statements toward the normal client whereas for the overweight client, diagnoses were plainly stated: "depression and major depressive episode and anxiety disorder" indicating less ambivalence in giving diagnosis to the overweight client allowing less room for error. This discriminative approach demonstrates an implicit bias toward overweight persons, as they are perceived as having more clear pathology than the client of normal weight. Such findings as this largely correspond with previous research in the area. Davis (1998) found that the client's weight did have an effect on the clinical judgments and treatment planning of therapists. Further she found that psychologists have a far more negative view of overweight clients. Hassell and Lynn (2003) and Amici (2003) found that mental health professionals assigned more pathology and negative attributes than that of a normal weight client.

Results of the present study in diagnosis were also very similar to the study conducted and used as a model for this study (Young & Powell, 1985). They found that mental health professionals rated overweight clients more negatively and had higher ratings in addiction, anti-social behavior, inadequate hygiene and sexual dysfunction. The present study had a similar trend in that overweight clients were rated more negatively particularly in the area of self-esteem, with counselors-in-training discussing the intransigent nature of low self-esteem in overweight clients. However, the areas chosen as pathology have changed. Young and Powell (1985) also found that mental health

professionals gave more severe pathology and assigned more negative symptoms to the overweight client. In their study they also found that the greatest differences in symptoms were in self-injurious behaviors and emotional behaviors. Unlike their study, however, participants in the Young and Powell (1985) study rated normal weight clients as having less suicidal ideation. This finding was reversed in the current study. This raises questions about why this reversal is possible. Perhaps changes in the twenty-three years since the original study in cultural perceptions of overweight persons can account for this shift in perceptions. Perhaps the inexperience of counselor-in-training accounts for this difference.

One of the surprising themes found in this study is that there is a wide range of clinical skill among counseling students, and there is also a varying level of confidence in those skills. Participants in this study expressed and demonstrated a lack of knowledge about diagnostic categories and a lack of confidence in their ability to properly apply diagnostic categories. Exactly half of the participants in this study (n = 28) had not taken the diagnosis and/or psychopathology courses required in the CACREP standards and in both programs that provided participants. The diagnostic categories in the DSM IV-TR are required as part of all counselor training, and appear to be taught and utilized in varying degrees in counseling programs. Given that only half of the participating students have taken diagnosis and/or psychopathology courses, results of the findings in the area of diagnosis need to be interpreted with caution.

This study, like the previous studies (Amici, 2003; Davis-Coelho, et al. 2000; Hassel & Lynn, 2003; Loewy, 1994; Young & Powell, 1985), found that young female therapists surveyed tended to assign more pathology and negative qualities such as low

self-esteem and lack of motivation to overweight clients, than did participants who were older and/or male. This trend has held true from the earliest study in this area (Young & Powell, 1985) to this study. This is an important finding for counselor educators in understanding the perceptions of their students in that young female students are more likely to have bias toward overweight clients, and most students in counseling programs are women under thirty.

Lastly, participants' discriminative perceptions towards the client who is overweight appeared when they recognized that there were more barriers to effective counseling for the client who is overweight compared to the client who is normal weight. The overweight client is seen as being limited by feelings of inferiority and inadequacy, self-defeating beliefs, and unwillingness to accept her personal freedom and the responsibility that comes with it. Such findings in this study resounded in the literature. The idea raised in the current study that overweight clients are seen as feeling inferior and have less personal responsibility relates to Angell and Rothblum's study (1991) that found that mental health professionals found overweight clients to be softer and kinder and therefore more vulnerable. Likewise, Davis (1998) found that psychologists predicted client effort was lower in overweight clients. As in the present study, this speaks to the perception that overweight persons need to work harder and take more responsibility.

Counselors-in-training have implicit bias toward overweight persons. We see this in their use of qualified language when describing the overweight clients and in their concept of the overweight client's therapeutic issues. This is further demonstrated in the perception that overweight clients have more pathology and the pathology differs from that of the normal weight client. Counseling students feel that overweight clients have

more barriers to positive counseling outcomes. Counselors-in training have a balanced perspective however in that they feel counseling will be helpful to both types of clients and want to work with both client types. Finally, counselors-in-training perceive that social support is available to both types of clients, but feel that spousal support is less for the overweight client.

Implications for Counselor Educators and Counselors

This study has a number of implications for practice, the most salient of which is providing information to counselor educators so that counseling students can become more aware of their own bias. Implicit bias, as was discovered in this study, is insidious and often goes undetected in oneself. It is imperative, therefore, that counseling professors include activities and curriculum to generate awareness of bias, implicit and explicit, to produce counselors aware of their own bias. Another very important implication for practice is that this issue requires discussion among counseling professionals, particularly in counselor education programs. Diversity training must not be limited to race, gender, language, ethnicity, culture, and sexual orientation; it must be expanded to include weight status as well. The data in this study reveals that there are misunderstandings about the lived experiences of overweight persons in our culture by counseling students. All other research indicates that overweight persons are discriminated against in their families and at work. This study showed that counseling students felt the same social supports were available to persons who are overweight. This is a I view that requires challenge. This discrepancy in understanding must be addressed

in the classroom. The counseling profession has not even begun to look at weight as a factor in training counselors; it is time to do so.

More focus needs to be given to the following areas. It is clear that counseling students must understand the particular circumstances in which overweight persons find themselves and how this affects their psychological functioning to effectively work with overweight persons. The data in this research suggests that counseling students have implicit bias toward persons who are overweight, that they appear to feel that persons who are overweight are unwilling to change, have some resistance to working hard, have some difficulty in following through on commitments, and are overly dependent on others. These beliefs about a client on the part of a counselor would greatly change the course of the treatment plan. These beliefs about a client, if untrue, would be harmful to a client and need to be addressed for what they are, bias on the part of the counselor. Therefore it is necessary to encourage students to actively educate themselves about the population by reading, and attending relevant educational opportunities such as workshops, forums, and conferences.

Further, counselor-training programs must focus on the inclusion of weight bias as a topic in the program and in courses. This will allow counselors-in-training to realize implicit bias that they might have towards clients who are overweight and help them understand the issues and concerns that the client group has such as a lack of protective factors such as in-group identity that other groups have. This knowledge will allow students to develop skills to well serve the client population. In counseling practice, it is critical to provide an opportunity for counselors to examine their overt and covert bias to become effective and ethical counselors.

Limitations of the Study

There are several limitations of this study. Some were seen prior to the collection of research and some were discovered during the research process. One limitation discovered in the course of the research is the diverse diagnostic skills of the student participants. This diversity in skill appears to limit the application of this research. One of the early assumptions of this study was participants would most likely give the overweight client more severe pathology. The evident diversity in clinical skill would need to be explored further to confirm the findings of this study, and requires that one interpret the findings of this study with caution.

Another limitation of this study is researcher bias. As in all qualitative study, the researcher's opinions can influence the outcomes of the study. In this case great care was taken to seek outside assistance in both research design and coding categories. Further, rigorous procedures to address credibility were used, in particular bracketing. However, researcher bias is inevitable in a study such as this, because the very nature of qualitative data is subjective.

The participants in this study are representative of many counseling programs in that they are primarily young women in a school counseling program. These participants, however, cannot adequately represent all counseling students everywhere. As a result caution must be used when applying this research as it may not be representative of the larger population as men and persons of color and community counseling students are not well represented in this sample. The generalizability of this study is therefore limited.

When designing this study there was a concern about selection bias. All but two students in all the classes surveyed participated in the study. Both of the declining

potential participants knew the researcher personally and were familiar with the research premise. Their participation would have added bias to the study. Further one must use caution in generalizing the results of this study, as it is a small sample size.

Implications for Future Research

This study was structured to be descriptive of counselors-in-training perceptions of overweight clients. As no known study has previously been done with counseling students to ascertain their perceptions of overweight clients there have been no exact points of comparison when analyzing the data and comparing it with extant literature. As this study was modeled after Young and Powell's (1985) study, the findings are quite similar in the two studies (as outlined earlier in this chapter). What the current study adds to the literature is foundational research on the perceptions of counseling students toward clients who are overweight. This study gives counselor educators a snap shot of counseling student's attitudes toward overweight persons.

The focus for counselor educators is pedagogy and as such, how to best assist students in increasing awareness, knowledge and skills when working with persons who have weight related issues. Certainly, understanding the skills needed in the profession is one part of the pedagogical puzzle, and the other piece is understanding where the students are in their development and providing an environment and materials that will help students put the pieces together. The value of understanding the perceptions and attitudes of students in developing successful counselor training modalities cannot be overstated.

As this is a relatively new area of study, there are many directions that future research in the area of weight bias can take. There are several questions generated by this study. Further research on the implicit bias of counseling students is needed to confirm the results of this study and to expand some of the findings. Research which focuses on how to best teach students about weight bias and its effects on clients would be helpful to counselor educators. To properly train counselors one must understand the nuances of the lived experiences of persons who are overweight, the messages given to overweight persons, and how these experiences may affect overweight persons in multiple areas such as employment, education and access to quality healthcare. The fact that weight bias exists has been established in the literature (though more can be done on this front as well); however, what is lacking is an understanding of the implicit and covert nature of this bias, and qualitative research is one way to get at nuanced responses. Research is needed which focuses on how to best teach these concepts to students.

As counselors we often use strengths based approaches when working with clients. There is a great need to understand strengths that overweight persons may have, and in training counselors to look for positive qualities in overweight clients with whom they work.

There is a need in future research to understand weight bias more fully, particularly by gender, age, race, ethnicity, religious background, years of clinical experience and the like. Several studies found that there are differences in gender and age, but more research is needed to fully understand this trend. This is particularly important in counselor education as many counselors-in-training are predominately

young women, and in early research young women have been shown to display more weight bias.

Conclusion

In conclusion it is important to state again that implicit weight bias exists among counselors-in-training. The question for further consideration by counselor educators is how to best give knowledge to students, how to help students gain awareness of their own bias, and how to help students develop skills to appropriately address clients who are overweight. The first step in this process is to develop a knowledge base about weight bias and the experiences of overweight persons in our culture so that counselor educators can include issues related to weight in their training of students. There needs to be much more research in this area in the field of counseling and it needs to happen with haste. The weight epidemic in our country is growing; counselors need to be ready to do their part in therapy, advocacy and training. Moreover, activities and modalities to help students and educators become aware of their own biases are important for implementing change in the ways counselors interact with clients who are overweight. And finally it is crucial to develop a set of skills that are appropriate for working with persons who are overweight. There is a great deal to do in the field of weight bias; as counselors, we must take the lead on this issue if we are to continue our lead in diversity issues.

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APPENDICES

APPENDIX A

WEIGHT CHARTS

Weight Chart for Women

Weight in pounds, based on ages 25-59 with the lowest mortality rate
(indoor clothing weighing 3 pounds and shoes with 1” heels)

Height	Small Frame	Medium Frame	Large Frame
4’10”	102-111	109-121	118-131
4’11”	103-113	111-123	120-134
5’0”	104-115	113-126	122-137
5’1”	106-118	115-129	125-140
5’2”	108-121	118-132	128-143
5’3”	111-124	121-135	131-147
5’4”	114-127	124-138	134-151
5’5”	117-130	127-141	137-155
5’6”	120-133	130-144	140-159
5’7”	123-136	133-147	143-163
5’8”	126-139	136-150	146-167
5’9”	129-142	139-153	149-170
5’10”	132-145	142-156	152-173
5’11”	135-148	145-159	155-176
6’0”	138-151	148-162	158-179

Weight Chart for Men

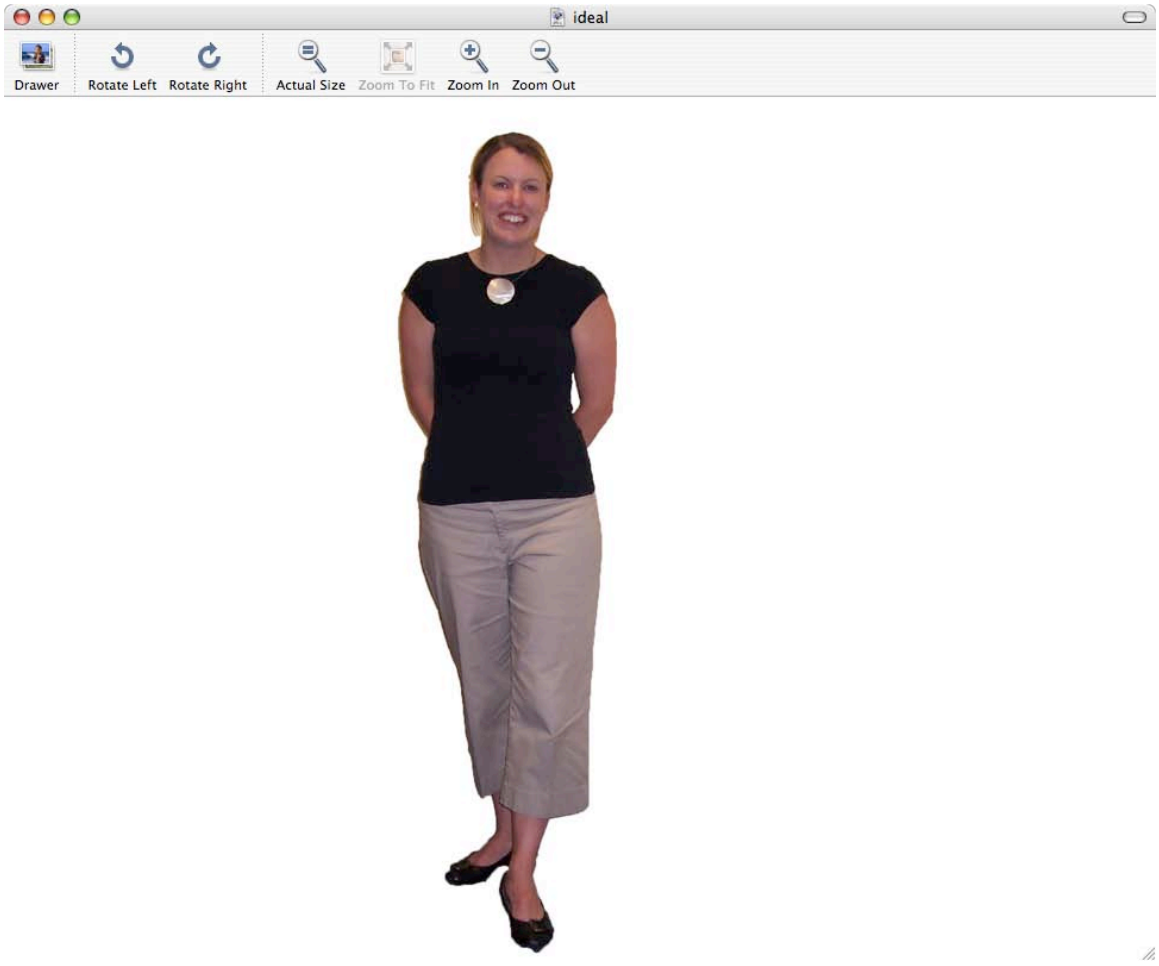
Weight in pounds, based on ages 25-59 with the lowest mortality rate
(indoor clothing weighing 5 pounds and shoes with 1” heels)

Height	Small Frame	Medium Frame	Large Frame
5’2”	128-134	131-141	138-150
5’3”	130-136	133-143	140-153
5’4”	132-138	135-145	142-156
5’5”	134-140	137-148	144-160
5’6”	136-142	139-151	146-164
5’7”	138-145	142-154	149-168
5’8”	140-148	145-157	152-172
5’9”	142-151	148-160	155-176
5’10”	144-154	151-163	158-180
5’11”	146-157	154-166	161-184
6’0”	149-160	157-170	164-188
6’1”	152-164	160-174	168-192
6’2”	155-168	164-178	172-197
6’3”	158-172	167-182	176-202
6’4”	162-176	171-187	181-207

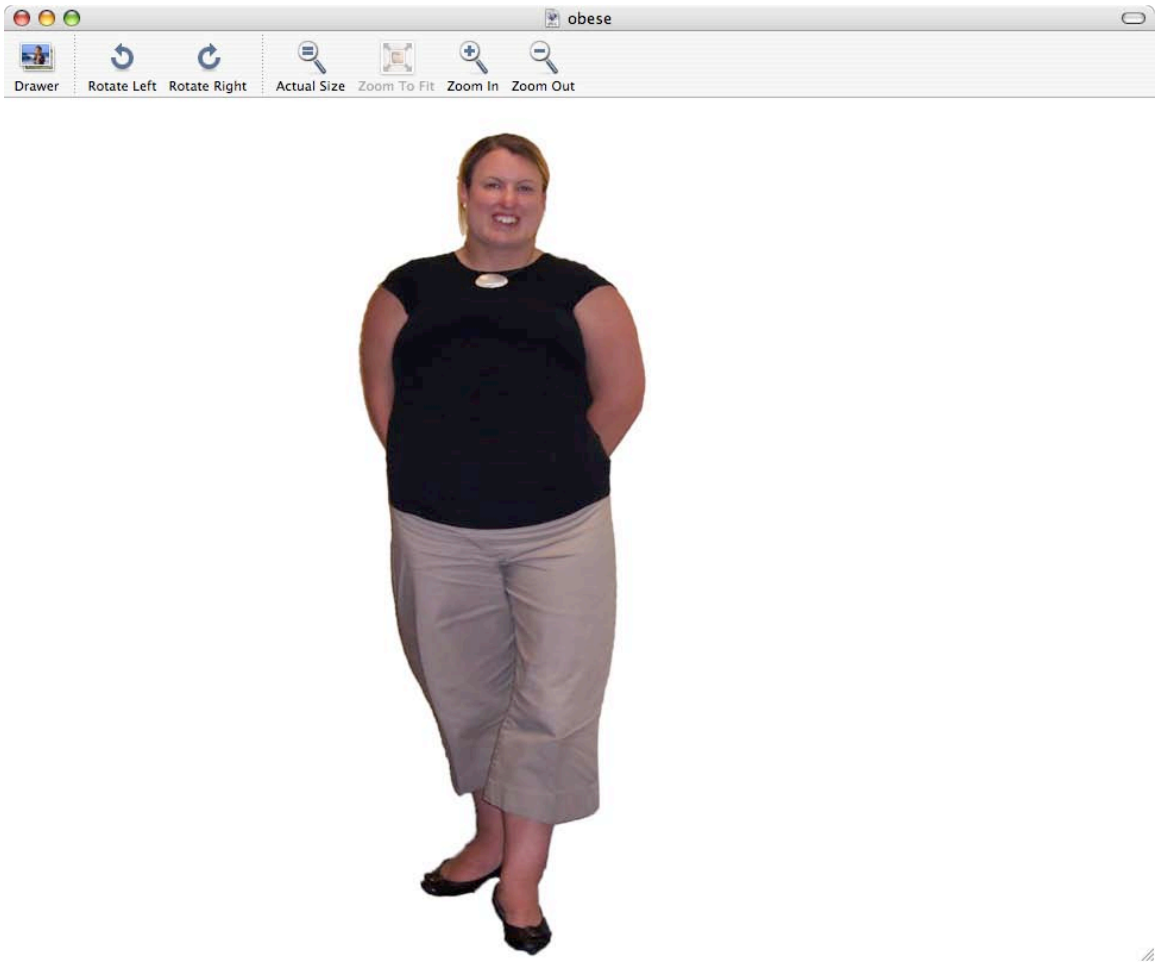
*Ideal Weights according to the Metropolitan Life Insurance Company tables (1983)

APPENDIX B

PHOTOS OF CLIENT



Normal weight


obese
Drawer
Rotate Left
Rotate Right
Actual Size
Zoom To Fit
Zoom In
Zoom Out

Overweight

APPENDIX C

CASE STUDY

Case Study

The client is a 25-year-old White married woman, the mother of two children. She stated that she became very depressed about three months ago following her husband's recovery from pneumonia and resumption of his activities, one of which involved his spending several evenings away from home during the week. Since that time, she has become increasingly nervous and irritable. She has been particularly angry and aggressive with her family, stating that she doesn't believe that they ever really cared for her. She has become fearful of "going to pieces" and has been preoccupied and forgetful. She began to feel superfluous as a wife and mother and began thinking that her family would be better off without her. This culminated in a suicide attempt with sleeping pills prior to her phoning in for help.

The client is the eldest of three children. Her father died when she was about six years of age, after which time her mother obtained a job as a sales clerk in a store. Two years later, her mother married a man who was a wholesale distributor with an office supply company. The client intensely disliked her stepfather, who was extremely strict with the children. Regular family meetings were held at which each of the children had to stand up and recite their current misdeeds. Their mother or stepfather would then punish them. The client always resented the fact that her mother sided with the stepfather against the children in any disputes. The client states that she felt very sad in her early life. She also described herself as always having been a worrier and as one who made "mountains out of molehills."

The client and her husband were in high school together and married after graduation. Her husband completed college and subsequently became head engineer in

charge of training and program development with a large company. She feels they have made an adequate adjustment in the marriage. However, the client feels that her husband has been devoting less time to her for the past year or so.

At the initial outpatient interview the client was found to be of average intelligence and was quite insightful. Her mood was dejected and she continued to have some suicidal ideation but not intent, and she showed evidence of weight loss and sleep disturbance. She was trembling visibly at first, her contact was low, and when she spoke, her voice was quiet and shaking.

APPENDIX D

PARTICIPANT INFORMATION

Participant Information:

This study is designed to assess the clinical case conceptualization skills of counselors-in-training. You will be asked to provide brief demographic data prior to reading a case study and examining a photograph of the client. You will be asked to answer seven (7) questions about the client in the case study.

CIRCLE ONE:

1. Degree sought: Masters Doctoral Ed.S

2. Area of study: School Counseling Community Counseling
Counselor Education Rehabilitation Counseling
Other: _____

3. Gender: Female Male

4. Age: under 24 25-30 31-34 35-40 41-44 45-50
51 and above

5. Ethnicity: Caucasian African American Pacific Islander
Native American Asian American Hispanic
Latino/Latina Other:_____

6. Have you taken a course in diagnosis or psychopathology? Yes No

7. Clinical Experience in counseling and related areas:

None Internship 1-5 years 5-10 years 10+ years

APPENDIX E

INSTRUMENT

Instrument

Please examine the attached case study and photograph and answer the following questions about the client. (Use the back of the pages if you need additional space.)

1. How useful do you feel therapeutic interventions will be with this client? Explain briefly why you feel this way?
2. In your opinion what is the prognosis (long term outcome) for this client?
3. How willing are you to work with this client?
4. What types of symptoms does this client display? (Circle all that apply)

Addiction	Agitation	Antisocial Behavior
Disorientation	Egocentrism	Emotional Behavior
Hypochondrias	Impaired Judgment	Impulsive Behavior
Inadequate Hygiene	Inappropriate Behavior	Incoherent speech
Intolerance of Change	Obsessive-Compulsive behavior	Reminiscence
Self-Injurious behavior	Sexual dysfunction	Stereotyped behavior
Suspiciousness	Thought disorder	

5. Given the above listed symptoms; what diagnosis would you give this client?
6. In your opinion, what types of social support may be available to this client?
7. What are some barriers or challenges that this client may experience in counseling?

APPENDIX F

VERBATIM TRANSCRIPTS

Question 1:

How useful do you feel therapeutic interventions will be with this client? Explain briefly why you feel this way.

Overweight Survey Group	Normal Weight Survey Group
1. I think there is a lot of potential for the client to benefit from therapeutic intervention. She still seems confused about her purpose and place in life and although has already made a suicide attempt w/sleeping pills (as opposed to "blowing her brains out") She called for help after doing so, which seems to state that she has not c written off life. Therapy that would allow her to address past wounds and to perceive her reality in a healthy context-orientated manner, I think could be affective. She seems to only be comfortable when she feels people NEED her (ill husband, kids, etc.) She is the oldest child which may play a role in this role of "NEED" being central to her self-concept of worth.	31. Useful- the circumstances she is describing would be very appropriate to explore a therapeutic relationship.
2. I feel therapeutic intervention would be helpful to this client. She expressed feelings of fear, sadness and anger.	32. They would be helpful because client is intelligent and insightful- she is able to verbalize and look at situation.
3. Very useful- she has some issues from her past that she doesn't seem to have dealt with.	33. I believe they will be useful clearly she has anger from childhood that she has not let go of- I think in a safe and supportive environment she will be able to let go of some of that anger.
4. Very. Client need to have someone to talk to who is non-judgmental. The client needs to be in a safe place where she feels acceptance.	34. I believe that therapeutic interventions would be very helpful to help the client sort through her feelings and probable misconceptions about family dynamics, as well as her own place and value within her environment.
5. Medication. Anti-depressants.	35. I think an intervention would be very useful. Solution- focus and counseling may help her learn how to cope and change her current situation.
6. Very. She really would benefit from changing her negative thought patterns and exploring her unresolved issues from her childhood possibly even assertiveness to express concerns with family to member of family.	36. I see intervention useful for this client. She is seeking help despite suicidal ideation and because she reached out in the midst of an attempt.
7. Therapeutic interventions would be effective with this client. The client seems to have settled into life, which can become mundane and overwhelming (is this it?) to wives and mothers. It would also be helpful if her husband would agree to joint martial counseling as well to strengthen their relationship.	37.

8. Relatively effective: The client has a moderate level of insight and seems relatively able to self-disclose. She has become cognizant of the ways in which her cognitions and behaviors are leading to her unhappiness. Note: Client will likely have to work on issues related to dependency on others; particularly her husband.	38. I think imperative. She has been coping with many aversions for a long time. She has proven to have and utilize coping skills. She has come to an impasse that the skills she has are no longer working. She seems to want help, and ready to receive them.
9. Useful because as stated in the case study the client was found to be of average intelligence and quite insightful. She knows that she is experiencing is not a true example of her characteristics and she had already phoned in to ask for help in the past.	39. I think this client can be helped by a variety of therapeutic interventions. She is of average intelligence and very insightful/ self aware, so she should be able to gain further insight.
10. Very useful. I think letting her talk about what's going on in her life and why she feels the way she does will help her.	40. I think that an intervention would be very helpful. I feel that she really needs someone to sit down and listen to her talk about her issues.
11. Very useful. Therapy can help this client find the true underlying issues that are causing her unhappiness. Through counseling, she can possibly remedy her ills.	41. Quite useful, but not in the immediate future. There are several areas that need to be identified, discussed, and worked over a period of time. This is not an unneeded- late fix situation as there are several aspects involved.
12. Very good. Her sudden emotional change shows she has the capacity to choose the emotive state she experiences. Her suicide attempt definitely is a call for help, and she needs professional help to work through what is causing her issues.	42. I think therapeutic interventions would be very helpful with this client. It seems she ahs been through a lot in her life and need to learn some coping skills. Through the use of these skills she will be able to deal with her husband's medical problems and her own personal feelings about them.
13. I think that therapeutic interventions will be helpful to this client because with them the client can become more empowered and start to let go of her irrational beliefs.	43. Very useful. It is evident that her childhood has played a role in her feelings about herself. Her suicide attempt also warrants special attention.
14. I think this be very useful being the fact she is having a hard time with her family and childhood.	44. I think therapeutic interventions would be very useful to this client on dealing w/her issues about her husband not taking the time with her.
15. It seems to me like the client would benefit from therapeutic interventions. She seems to be dealing with issues of her role in the home environment. With not having anything to "worry" about the client seems to have lost her identity. She would probably benefit from individual and family counseling.	45. I feel they would be extremely useful to get at the clients root of her problems. Also, techniques would be helpful for the client to deal with past issues, so that she can have a healthy relationship with her family. Free-association and subjective/objective interventions would be beneficial with this client.
16. Therapeutic intervention is needed for this client. The client has shown characteristics that are risk factors to her safety. A threat or thoughts of suicide should be taken seriously and given priority attention.	46. Very helpful. She has already attempted suicide, so immediate interventions would need to be made. She is intelligent and insightful so she would be able to grasp concepts. Also, she is seeking help, therefore has already made a mind set to change.

17. Since she is intelligent and insightful, I feel she will cooperate and be willing to change. It sounds like she knows she has problems that need to be resolved.	47. Moderately so- I'm concerned about the suicidal ideation, her beliefs her family "never really cared for her." Her early onset of depression like symptoms and presenting affect (trembling voice, etc.)
18. I feel that therapeutic interventions will be useful for this client because she needs to reevaluate her thinking process. She is depressed, lonely, low self-esteem, and some other problems that need to be addressed.	48. Very useful as client could gear insight into her distress and help alleviate feelings of suicide.
19. I think intervention will be useful because: 1.) She sought counseling. So she is open to change. 2.) She is aware of her presenting problems as "problems." 3.) She does not have any apparent difficult-to-treat disorders s/a bipolar, schizophrenia, etc.	49. I feel they will be useful to her in her current situation b/c she obviously wants help and has sought out which indicates she is likely to work in therapy and outside (home interventions.)
20. I feel therapeutic interventions will be useful for this client. I think it is possible for the client to change her thoughts and behaviors. It also seems she has some unresolved issues of her childhood, which may be helpful for her to deal with.	50. I feel that therapeutic interventions will be extremely useful w/this client. I feel this way because the case identified the client as being insightful and of average intelligence and being able to have insight into one's self makes the probability of the success of interventions rise.
21. There seem to be a lot of unresolved conflict that the client has internalized over the years. I think therapeutic interventions would be of great value.	51. Therapeutic interventions may be very useful with this client.
22. Intervention might be helpful if the client can effectively deal with issues related to her childhood that are effecting current functioning. She seems to have a lot of built up anger from the death of her father. She is seeking attention from her husband possibly due to the lack thereof that she received from her father.	52. I think she could defiantly benefit from therapeutic interventions. She has on-going unsettled issues from losing her father/ opp. Sex parent at 6 yo. When the "eidipal" stage is ending and superego and moral char. Are solidified. She was forced into a rigid, punishing home where she worried, exaggerated, felt sad, and resented her mother for "abandoning" her. She married young and her husband dev. His career well and "she adjusted" but having him home sick showed how life could be w/o abandonment.
23. I think interventions have a good chance of success. The client is willing to talk about the issues surrounding her depression, she has intelligence and insight which are helpful in counseling situations she should be able to set goals in conjunction with the counselor and seems to desire help.	53. I believe therapeutic interventions would be helpful. The therapist found the client to be of average intelligence and to be insightful. There were not any instances of psychotic features.
24. Based on the fact that she has asked for help and is following up with attending the initial outpatient interventions I would day that interventions may prove very useful. Depression is quite common. While the client is dealing with not only depression but also a	54. I think they would be useful in increasing her self-awareness and in helping her learn coping skills.

possible personality disorder enlaced to attachment. It also seems that is willing to work on her issues. Further information would be needed to attest to her diagnostic needs. Therapy for depression would be wanted.	
25. Very useful- it seems as though she has been experience periods of anxiety and low-self esteem for a long period- she may have been repressing these feelings for a period but the stress brought on by her husband's illness/injury may have triggered episodes of anxiety and depression. She would do well to continue in therapy to work on these issues and explore.	55. I feel that interventions will be useful with this client because she shows signs of wanting help and of having some degree of knowledge of where she is and where she would like to be. Interventions may also prevent the client from committing suicide and should be implicated.
26. I believe therapeutic interventions will be greatly useful to this client. The client seems willing to come to counseling and understands there is a problem. Her intellectual functioning and insight are high which is beneficial to the counseling prognosis.	56. Depending on the type of interventions used, her success will vary. I would note that she has very little in terms of a social support network.
27. I think that T. interventions would be useful because she has taken the step to seek help, is open to therapy and appears to be insightful of herself. Possibly cog/behavior therapy.	
28. Very useful. The client seems to be open to exploring her situation which gives her and the therapist the ability to intervene and make changes in her life.	
29. Useful- needs outside assistance interventions for self-esteem issues.	
30. I think it will be very useful. She could take time to examine her life including her past and hot to may affect her not (esp. in relationships._ She appears to be dealing w/feelings of neglect which should be examined more in depth.	

Question 2:

In your opinion what is the prognosis (long term outcome) for this client?

Overweight Survey Group	Normal weight Survey Group
1. If she does not begin to feel confident and self-centered in her worth and place in life she will continue to feel worthless and in the way, which could eventually lead to more suicide attempts and possible success. She needs to become less dependent on the perceptions of others in determining who she is and how she lives her life.	31. The prognosis would be good-she could possibly need medication- if only temporarily for the depression and sleeplessness- but w/therapy could the prognosis would be good. The medication would need to be carefully considered due to suicide attempt.
2. I feel her prognosis is good due to her seeking help.	32. Good with time.
3. Good- when she addresses her issues.	33. She may be in therapy for a while, but I think she can "feel" better.
4. Depression. Generalized anxiety disorder.	34. I believe that she will be able to function very well once she understands her life in context and learns where and how to find support when she needs it.
5. Depression with medication should stabilize the diagnosis.	35. Depression and mood disorder- treatment lasting several months.
6. Good.	36. Long term treatment 3+ years. Longer the intervention/therapy better for long term positive outcomes. Years of maladaptive behavior will take length and depth to undo/rebuild.
7. Bright, she might always return to this state when disturbing situations arise. Therefore, she should continue to see a therapist whom understands her past.	37.
8. Based on the limited info provided, I suspect that she has a somewhat good likelihood of resuming normal functioning in the long-term. I don't see definite evidence of a personality disorder, psychosis, or mood disorder (though bipolar could be a possibility if I had more info.)	38. She will be able to function again on a productive level. But she does need a good combination of pharmaceutical, behavior, and cognitive therapy.
9. Learn how not to worry as much and learn and feel that she is loved, needed, and appreciated. Not everyone that she loves, like her mother, will decide against her.	39. She can probably get some skills to deal w/her depression and low-self esteem and will probably require intermittent counseling when she gets going again.
10. Once she learns how to del with her feelings I think she will be ok.	40. I feel that with some counseling and possibly medication she can get over her suicidal ideation.
11. I feel that she can possibly overcome her self –esteem issues by talking through her past and present.	41. I believe that the prognosis of a more optimistic outcome towards self and others is obtainable, given the competency of the counselor involved, and a period of time to reflect and "work on" her problem areas.

12. She needs to learn better coping skills. She will be given more support from her family and husband, but must develop a life that is not co-dependent on others to make her happy.	42. Regain self-confidence and control in difficult situations. Establish family support systems.
13. She will need more sessions but eventually will be okay.	43. Prognosis is good. Client is obviously dealing with depression. I believe however, that therapy would need to be ongoing.
14. My prognosis is that she has yet to resolve her childhood issues and with her husband resent changes has cause her to become depressed.	44. I think she could recover or be able to stabilize her mood.
15. Not equipped to make an educated guess.	45. In my opinion this client must get treated or she will continue to attempt suicide. I feel she is suffering from depression, which stems from her childhood, and also has anxiety about her husband dying or leaving her, like her childhood was.
16. This client is dealing with several issues of neglect as a child, neglect form a spouse, and most importantly self-defeating emotions. She needs to have on-going counseling.	46. Become better self-aware and more confident. Also develop coping skills for depression, also ease depression.
17. She will go through therapy and gain some insight to her conflict. I think she will turn out fine after she has worked through her problems with her husband.	47. I feel she needs regular individual sessions to discuss her family history and early “sadness” her past suicidal attempt and why she feels “no one ever cared about her.” I would also want to examine the angry and aggressive feelings the client is having toward family members.
18. I think the long term outcome for this client would be pretty good. I think if she could learn to love herself and not to be so dependent on her husband that she would be much happier. The client may also need to look into some anti-depressant/ anxiety medicine to help pull her out of her depression.	48. Depression, long-term prognosis appears to be good as client seemed to have good pre-morbid features.
19. Good. I think that through counseling, she can isolate the majority of her incongruence, set goals to become more self-actualized and eventually work towards a better life.	49. The prognosis appears to be good for this client.
20. I think with therapeutic intervention, the prognosis of the client is very good. I feel she can overcome her negative thoughts and behaviors.	50. I believe that with the proper therapy and interventions this client can find new ways of thinking and new, more positive behaviors to engage in.
21. Once her issues are revealed, I believe the client can have a successful recovery and resume a normal, healthy and satisfying life.	51.

22. It is likely that she will continue to be depressed, which may ultimately lead her husband to end the relationship. This may cause her to become more depressed and may lead her to attempt suicide. If she is able to face her anger and need for attention /paternal love, this prognosis would be unlikely.	52. Prognosis is good if she works with it. Homework and reflection will be important.
23. Long term prognosis is good for this client to work through these issues. The changes of success would be enhanced with medical evaluation and family counseling.	53. It depends. If her husband is involved and supportive and if she continues therapy then I think things will be fine. Well, if she has a strong support group any close friend or family would help.
24. I'm not sure I could answer that based on the initial information. I recognize some good signs in that she personally phoned for help after her suicide attempt and that while she shows suicidal ideation she is not meaningfully expressing intent.	54. I think that with therapy she will be able to have more control over her depression b/c therapy will teach her methods to express her emotions and provide an outlet for her.
25. Positive with continued therapy and possibly psycho-pharmaceutical intervention.	55. With so little information it is hard to give an opinion about the prognosis. I can say that because she is seeking help relatively early (3 months) and is aware that there is a problem I would lean towards the prognosis being good. She also has a family that if they are supportive should help w/outcome.
26. I believe the client will be well suited with individual and group therapy and possible medication compliance.	56. Fair.
27. With effort put in from client to work through her depression and anxiety, I would give a good prognosis.	
28. She will probably be on depression/anxiety drugs in conjunction w/prolonged therapy. She should be able to live a normal life.	
29. Depression. Maybe PTSD depending on level of abuse she suffered as a child.	
30. I think the prognosis is good if she is cooperative. She is insightful which is a plus.	

Question 3

How willing are you to work with this client?

Overweight Survey Group	Normal Weight Survey Group
1. Very willing. I believe she could benefit from therapy.	31. Very willing.
2. I would be willing to work with this client.	32.
3. Very.	33. I would be willing to work with this client.
4. Very willing.	34. I would be especially interested as a parent educator because of all of the family dynamics involved. I'm not sure there's a client I wouldn't work with. People intrigue me, and I enjoy spending time w/a diversity of people.
5. Very willing.	35. Yes.
6. Very willing.	36. Would love to work w/her!
7. Very willing.	37.
8. Scale of 0-10=7. I have some fears related to her suicidal attempts.	38. Very. I have worked with similar patients, of course with some diversity. Individual and/or group in my opinion would be fine.
9. Therapy sessions on ways to control anxiety demonstration activities (role play) that would show areas of her family's loves that would not work without her being there. Involve her husband and kids in therapy so they could be her support at home.	39. Very.
10. Yes.	40. I would work with this client if I were qualified to give her all the help she needs.
11. I would be willing to talk to and work with the client.	41. At this point I would refer this client to a more experienced counselor- one who has worked with clients having similar concerns in the recent past.
12. Very.	42. I would be very willing to work with this client.
13. Somewhat.	43. I would be very wiling to work with this client primarily because she is not previously mentally ill.
14. I would be very willing to work with her.	44. I am not too willing to work with her while she is having suicidal ideations.
15. With the proper development of a relationship I would be very willing to work with the client.	45. I would be very willing to work with this client.
16. I would begin working with the client by getting her verbal account of how she feels and what is going on in her life. From that point on I would take a person centered approach with her and lead her to uncovering for herself how she can improve her current life situation.	46. Very willing. Open to change. A little hesitant w/her suicidal thoughts and actions though.
17. I would be willing but I'd rather work with children.	47. I would be fairly willing to work w/ this client.

18. I would be willing to work with this client because I think she has the potential to get better considering she is insightful and average intelligence.	48. Willing to work with the client.
19. Very.	49. I would be willing to work with her.
20. Very willing.	50. I would be very willing to work with this client.
21. I would be more than willing to work with this client and assisting in her healing.	51. I would be willing to work w/this client.
22. Very willing.	52. Very.
23. I would be willing to work with her, however I would want her to be evaluated medically as well. Physiological issues could evoke similar behaviors.	53. I would be willing to help her on her path and journey put of depression.
24. I am very willing to work with this client.	54. Very willing.
25. On a scale of 1-10 around 8.	55. I would be very willing to work with this client.
26. Very willing.	56. Very.
27. Pretty wiling (4 of 5).	
28. Willing as long as she is willing.	
29. Fine.	
30. One-on-one face to face interaction once a wk. Taking a look @ her feelings and where they may stem from.	

Question 4:

What types of symptoms does this client display?

Normal Weight n=26

Addiction	17 Agitation	1 Antisocial Behavior
4 Disorientation	2 Egocentrism	22 Emotional Behavior
Hypochondrias	10 Impaired Judgment	5 Impulsive Behavior
Inadequate Hygiene	3 Inappropriate Behavior	3 Incoherent speech
5 Intolerance of Change	1 Obsessive-Compulsive behavior	2 Reminiscence
23 Self-Injurious behavior	Sexual dysfunction	Stereotyped behavior
5 Suspiciousness	7 Thought disorder	

Anxiety
Overweight n=30

1 Addiction	26 Agitation	2 Antisocial Behavior
2 Disorientation	2 Egocentrism	25 Emotional Behavior
2 Hypochondrias	13 Impaired Judgment	10 Impulsive Behavior
Inadequate Hygiene	8 Inappropriate Behavior	Incoherent speech
9 Intolerance of Change	2 Obsessive-Compulsive behavior	7 Reminiscence
21 Self-Injurious behavior	Sexual dysfunction	Stereotyped behavior
11 Suspiciousness	12 Thought disorder	

Question 5:

Given the above listed symptoms; what diagnosis would you give this client?

Overweight Survey Group	Normal Weight Survey Group
1. The client's self-concept is wrapped up in the way in which others relate to her; especially in relation to their dependence on her. She does not have a strong sense of self and seems incapable of existing independently of others; yet does not seem to be able to believe that others actually do care for her. She appears to have an almost crippling fear of abandonment, probably stemming from the early loss of her father.	31. Probably depression?
2. ?	32. Depression.
3. Depression	33. I would not diagnosis as I am not qualified to do so- since I don't have a DSM IV in front of me it will be hard to even make a stab at it… but off the top of my head… dsthymia perhaps?
4. Depression, Generalized Anxiety Disorder	34. I would say she is depressed. If one of her children is a baby she could suffer from post-partum depression.
5. Depression and maybe displaced	35. Depression and mood disorder.
6. Depression	36. Major depressive disorder.
7. Depression, Anxiety	37. Depression/anxiety disorder. Evaluate medically—especially for sleep disorder and or other medical conditions.
8. I-Major depressive disorder, single atypical episode (severe) II-None III-None IV –Moderate V-60-65	38. Major Depression—single episode.

9. She is a very agitated by worry and the thought of not being needed. The worry consumes her thoughts and therefore causes impaired judgment. Also, the impaired judgment leads to suspiciousness about her family, for example, if they truly need and love her. Lastly, these all lead to emotional behavior of depression and self injurious behaviors of suicidal thoughts and attempts.	39. Depression and Anxiety.
10. Depression?	40. I would say that she is depressed and possibly has a mood disorder or something to that extent.
11.	41. I think the client has low self-esteem at this point and needs to have her value reinforced both verbally and by physical attention. Her childhood traumas concerning admissions of short comings may have been the base, and when added to her husband's absence after she aided in his recovery.
12. Neurotic Disorders, co-dependency and suicidal.	42. Depression due to husband's medical condition and dealing status. Withdrawal.
13. Major depressive episode and anxiety disorder based on the information given.	43. Client has depression.
14. So far I would think about diagnosing her w/depression MOD, after reviewing the time frame and other factors. 3 months is not long enough… Anxiety disorder.	44. I would diagnosis her with a mood disorder.
15. Not knowledgeable in terminology and conditions to make an educated guess.	45. I would diagnosis this client w/severe depression and anxiety. I would diagnose her as highly suicidal as well. Would say she is in so much pain due to the abuse and neglect of her parents she is trying to relieve her pain by killing herself.
16. I am not at a point where I could completely diagnosis a person.	46. Depression and Anxiety and low self-esteem.
17. Depression/Anxiety	47. I feel I don't have enough information, but I would be looking at depression or bi-polar. Probably more so bipolar based on the depressive symptoms, fearful of "going to pieces, suicidal ideation, anger/aggression, nervous, ect.
18. Depression (severe.)	48. Major depressive episode.
19. Anxiety disorder (GAD) and clinical depression.	49. OCPD.
20. Depression. Anxiety.	50. I would probably diagnose this client w/major depressive disorder if she met all of the criteria, but definitely a mood disorder.
21. Clinical Depression.	51. I would diagnose the client as depressed.
22. Slight Depressed-depression. Anxious-anxiety.	52. Depression w/anxiety or Bipolar I.
23. Depression.	53. None.

24. The only one I would give without exploring her claims (her husband's lack of attention/lack of caring for her husband and children) would be depression and a possible anxiety disorder. Given mere information she may also have a personality disorder.	54. Depression w/suicidal ideations.
25. Depression with anxiety.	55. Without criteria I am unsure of the timeline for major depressive disorder (6 months or 3 months) I would lean towards major depressive disorder thought. I would also look into some medical studies as well to ensure there are no hormonal or thyroid like issues.
26. I would diagnosis major depressive disorder	56. Adjustment Disorder.
27. Major depression and adjustment disorder.	
28. Depression and anxiety disorder.	
29. Already indicated.	
30. Depression (maybe, or at least episodes) MDE.	

Question 6:

In your opinion, what types of social support may be available to this client?

Overweight Survey Group	**Normal Weight Group**
1. She doesn't seem to have an social outlets outside of her family. Her mother and siblings may be available along w/her husband but there was no mention of work and she seems to feel ostracized from her kids and husband. So I don't know. There is no mention of close friends.	31. Groups- maybe even getting involved in community groups and special interest groups.
2. Possibly her husband but did not mention any other support.	32. Candidate for family therapy with husband.
3. Restructuring thoughts/thought processing to a more positive thought.	33. I believe it might be helpful for her to join a psychotherapeutic group and perhaps work part-time or volunteer to help her start to identify herself in broader terms- and improve self esteem.
4. Client may have a close friend or family member she can depend on for support.	34. Therapy, mom's groups, religious groups, possibly extended family, friends, neighbors, hopefully her husband.
5. Group therapy	35. None w/in immediate family- perhaps friends or siblings.
6. Hobby/club (ie: scrapbook…) women/mom groups, siblings support, church, friends, volunteer work.	36. Groups for depression.
7. Ongoing group discussing stresses of being all to everyone. Couple support group.	37. Group therapy.

8. Possibly her husband, she didn't mention any friends.	38. Religious, social groups, individual psychotherapy group, medication management.
9. Having her family aware of her situation and feelings. Give the family ways to help her at home.	39. Her siblings, perhaps friends she needs to do things for herself- exercise, perhaps at a community gym. Join a book club, socialize.
10.	40.
11.	41. Support group for children of controlling parents. Marriage counseling to aid the husband see his importance of spending more time w/the family. Professional counseling to understand the suicidal attempt and dejected mood and then work thru them.
12. Her Husbands, but there is no mention of any other adults. Social support is lacking.	42. Family support system. Group counseling.
13. Family and friends and maybe a support group type of therapy.	43. She could become involved in the community or in activities linked with her children's school.
14. Maybe group counseling that caters to wives or women who have issues dealing w/anxiety.	44. Her husband could be her social support.
15. Family counseling would be in the best interest of the client.	45. Counseling; support groups for individuals who were abused. Also, maybe a group for addiction to pills.
16. I would be curious to know what role friend may have in her life and I would also look into some community networks and help lines that are available.	46. Group counseling, individual counseling.
17. Couple counseling, Friends/others who are going through the same thing (group counseling.)	47. Community mental health centers. Perhaps religious support groups.
18. Maybe a mother's club or friends that she could hang out with to take a break from her family. Also maybe she could spend some time with her brothers or sisters.	48. Family, church, friends
19. Husband and family.	49. Her husband and children
20. Group therapy with other women who have attempted suicide, self-esteem group exercise or some other physical activities to help with stress.	50. Her family (husband and kids) may be a form of social support and hopefully through therapy she can be introduced to different outlets for social supports.
21. Family support- husband, children (to a certain extent) community groups, friends and acquaintances.	51. Ways to meet other individuals- volunteer, work, join a club. Group counseling.
22. Other women, Mother, other siblings, her children.	52. Group classes- seminar on interest- like scrapbooking or book club- be around people that validate her and are not likely to abandonment. Homework- self app. Activities.
23. Counseling groups with similar issues. Spiritual encouragement or training.	53. Possibly siblings; maybe husband.
24. Family support- (depending on if claims are unsubstantiated about her husband and children) Husband, children, siblings (to deal with early trauma.	54. Her husband and children seem to be her primary social support.

Friends- (not mentioned where she has a structured support group in this area.) Group therapy- and/or group organization (targeting menial women or women in general?)	
25. Children of Abuse support group. Spouse seems supportive (still together and no mention of a spilt.) Friends, Siblings (possibly.)	55. She has her children and her partner to help her.
26. From the case study it seems the client does not have much of a social support network w/which to help with her inabilities at this time.	56. Community Outreach programs (childcare?) group counseling.
27. Group therapy, any friends or siblings, any religious org. she might belong to.	
28. Church, friends (especially those who are unaware of her situation) If they were aware; maybe they could help.	
29. Women's group. Maybe counseling w/spouse, individual counseling.	
30. Siblings? Friends, support group.	

Question 7:

What are some barriers or challenges that this client may experience in counseling?

Overweight Survey Group	Normal Weight Survey Group
1. Lack of self-efficacy, lack of trust in the therapist's desire for commitment to her growth, inability to accept personal responsibilities for her life's direction.	31.
2.	32. Client tends to be a worrier- reading more into situations. Sad childhood.
3. Resolving old feelings and what might lie behind them. It seems she ahs repressed a lot for a long time.	33. Trust.
4. Continued worry which leads to anxiety. Lack of support from her husband or mother. Lack of understanding from her children.	34. The client hasn't had a healthy family modeled for her, and so it will be a challenge to help her gain this insight. Her depression will need to be dealt with before meaningful change can occur.
5. May not respond to a male counselor b/c of past w/step father.	35. Building trust w/counselor disclosing personal information about self and past, no support systems in place at the home, further suicide attempts.
6. I can't really think of any barriers unless couples counseling is suggested and her husband is unable/unwilling to attend due to work or extra "activities."	36. Realistic perception of other's views of her. Trust.

7. 1.) She nor her counselor can control the husband's behavior. Yet, her state of mind is contingent on the support that she feels from him. 2.) Can this client be happy? Some need to be unhappy and this client may be one of those.	37. May think that her circumstances are unique and reject group insight and experience.
8. Suicidal ideation and attempts, very low-self esteem (not her weight!) assertiveness training probably necessary feelings of unreasonable responsibility: Oldest child, mother, wife.	38. Status Quo- family belief of "public punishment" or shame, suicide as an option, truth- about husband's behaviors.
9. Overcoming her past and believing that she is loved and that the love her family has for her cannot be replaced. Always worrying all the time will take time to change this behavior.	39. She seems to have low self-esteem and that may make it more difficult for her to work on her depression symptoms. Not sure if her husband would be supportive, or her children either. She may need some anxiety medications. She also needs to explore the messages she got as a child and how they play into her adult life.
10. Not feeling trust with others.	40. I feel that she may not be open to talk about deeper issues. I think it would be important to talk about past issues with her father dying mother working and getting remarried and it mot not be something she is willing to do. Then once it is time to terminate the sessions I think that could another issue that could cause problems.
11. Coming to grips with and accepting herself.	41. And/or husband. Complete blame may be placed on her parents rather than her reactions to the past- (how she over- came these problems) Her husband may deny there is a problem now or may refuse to receive counseling (for help with the therapy). Client may attend a few sessions claim she is "cured" and not return for more/deeper assistance.
12. Not willing to accept her person, freedom and the responsibility that comes along with it.	42. Reluctance in discussing her childhood and suicidal behavior. She may have problems opening up b/c she feel know one cares for her.
13. Maybe an impasse or a stuck point when dealing with her childhood.	43. She may have some difficulty letting go of her past 'demons' and because of her dejected mood may lack the motivation (despite being insightful) to change her negative thinking.
14. Not really sure. I'm kind of focused on her dealing w/childhood issues and how that is overlapping w/her family.	44. She may not want to expose some of the things she is feeling. She may be in denial about things so having to confront issues is something she may not be comfortable with.
15. Not wanting change or to deal with issues.	45. May be very resistant to therapy due to her trust issues. May have difficulty bringing up childhood experiences, such as her father's death and the abuse she experienced.

16. She may not be trusting of people and she may not feel comfortable talking about her personal history in the beginning of a counseling session.	46. Opening up about childhood experiences, having low self esteem. Feeling as though she's being judged by therapist, feeling unable to open up in general, that she isn't normal for being in counseling and how family may judge.
17. Conflicts w/husband, feeling inadequate, dealing w/feelings of inferiority, calming down, dealing w/past experiences.	47. Mental health stigma, cost of treatment
18. She may experience denial of feeling like she is not good wife/mother. She may be irritable and easily agitated due to the depression and sleep disorder. She also may experience some anxiety about going to sessions and getting out of the house or trying to make new friends.	48. Being a woman, feminist therapy may be beneficial.
19. Dealing with her childhood memories and the way they have affected her. It may be difficult to sort through difficult memories. Taking responsibility for her attitude about her family, not blaming it on her husband's absence. Dealing with depression and anxiety and reasons of those.	49. 1.) Subsiding her suicidal behavior 2.) letting go of her worry 3.)Acknowledging her angry and aggressive behaviors are reminiscent of her step father's behavior.
20. If she seeks counseling, it could help her, but not necessarily improve her marriage.	50. The client may become frustrated at the rate of change, things may not go fast enough for her. She also may face a challenge at realizing that she can only change herself, not her husband. There are also other barriers, emotional ones, that could be met along the way.
21. Willing to confront those who have hurt her in the past, mom and stepfather, in particular, if still living.	51. Self- resistance. Not fully participating in the counseling process w/ interventions and HW.
22. Overcoming anger. Self-esteem issues. Fear of rejection. Father not present.	52. Resistance, transference, projection.
23. One barrier stems from her childhood experiences with her mother and stepfather. Trust might be difficult to establish. Being asked to talk about her life might be reminiscent of the childhood recitations. Given her lack of confidence at this time, she might want the counselor to be the authority and solve her problems. Another barrier to counseling could be the gender of the counselor.	53. Lack of social support from family. She needs to build up her confidence in herself.
24. If me counselor is a man, she might struggle given her past issues with her stepfather and current issues with her husband. There may be residual resenting towards a female, given her experience with her mom not advocating for her.	54. Childhood experiences. Coming to terms with her depression.

25. When depressed, many clients are resistant to apply therapeutic techniques and look for excuses why various approaches would be ineffective and also may represent characteristic of denial esp. as it effects the influence of her young life and her mothers role in her current state.	55. Her husband may not be as supportive as she would like. She may also experience some problems from her mother and step father.
26. Lack of support network. Confrontation in therapy might not be well received.	56. Small support network, troubled childhood, marriage/family problems (support of spouse).
27. Self-defeating beliefs/ low self-esteem; lack of support from family.	
28. Facing her past; admitting the things in life that have hurt her, as well as confronting those issues.	
29. Relapse thoughts of suicide behaviors, only recurring support from counselor and no one else. Communicating real issues, admitting/taking responsibilities for planning for her own life.	
30. Neg. self-esteem- may think counselor doesn't care about her or that client is hopeless. Desire/need for affection/to be liked.	

APPENDIX G

DATA ANALYSIS FLOW CHART

Data Analysis Flow Chart

APPENDIX H

THEMATIC CODING TABLE

Thematic Coding Table