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Alyssa Bogetz
Taking up space: Exploring clinical
social workers' attitudes towards and
practice experiences with their
overweight and obese clients

ABSTRACT

This qualitative study provides an in-depth exploration of clinical social workers' experiences with their overweight and obese clients. As the "War on Obesity" rages on, clinical social workers have come to occupy a unique position in understanding and addressing the needs of this population. This study seeks to add to the growing clinical literature on size bias in psychotherapy and intends to explicate the clinician's experience in both establishing and maintaining therapeutic relationships with these clients.

Nine licensed clinical social workers were interviewed about their attitudes towards their overweight and obese clients and their experiences as they worked with them. The findings demonstrated that clinicians' relationships with their clients were marked with great challenge and complexity. Clinicians felt overweight and obesity could be highly problematic to clients psychologically, physically and socially. At the same time, implicit anti-fat attitudes were frequently revealed in clinicians' narratives and may have been unintentionally communicated to clients. An overarching theme was the strong negative countertransference reactions that clinicians experienced in their work with these clients, primarily around weight-related discussions. This research suggests that social work clinicians may benefit from cultural competence training in their work with overweight and obese clients and could benefit from examining their own relationships to their bodies and the ways this relationship enters the therapeutic space.

TAKING UP SPACE: EXPLORING CLINICAL SOCIAL WORKERS' ATTITUDES
TOWARDS AND PRACTICE EXPERIENCES WITH THEIR OVERWEIGHT AND OBESE
CLIENTS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2012

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CHAPTER I

Introduction

Throughout the past fifteen years, there has been increasing media, medical and political attention given to the growing number of Americans identified as overweight or obese. The National Center for Health Statistics reports that an astounding 68 percent of U.S. adults fall into one of these categories (The National Center for Health Statistics, 2010). Obesity has long been termed a “modern epidemic” (Rubenstein, 2005) and recommendations for curtailing it abound. These range from a myriad of diet plans, exercise regimens and weight-loss medications to more extreme measures of surgery that are now being provided to adults and adolescents. The U.S. government is also making efforts to improve the health of Americans and help them lose weight; over half of all U.S. states have legislature restricting food choices and requiring weight screening in schools (Trust for America’s Health, 2011). In the midst of these efforts, however, America’s weight problem has not waned – the prevalence of obesity has steadily increased over the last 20 years (The National Center for Health Statistics, 2010).

As Americans’ waistlines are growing, so are the debates about the causes, consequences and effective solutions to these problems (Bacon, 2008; Connors & Melcher, 1993; Greener, Douglas & Teijlingen, 2010; Rubenstein, 2005; Russell-Mayhew, 2007). All physical and mental health professionals are likely to agree that the achievement of good health is of fundamental importance for every American. Questions, however, have been raised about dominant definitions of health and the ways in which overweight and obesity are framed.

Academicians, researchers, health care professionals and social justice advocates are now questioning America's "War on Obesity" and the nation's emphasis on weight loss (Bacon & Aphramor, 2011; Gaesser, 2002; O'Hara & Gregg, 2006). These authors do not dispute the importance of physiological health, but they contend that the negative health effects of overweight and obesity are grossly exaggerated and that our "War on Obesity" has transformed into a war against fat people – a war that barrages fat people and puts them at even greater risk for poor health (Bacon & Aphramor, 2011; Gaesser, 2002; O'Hara & Gregg, 2006). Indeed, prominent views of obese individuals are that they are unhealthy, lazy, lack self-control and are self-destructive (Greener, Douglas & Teijlingen, 2010; Wadden, Womble, Stunkard & Anderson, 2002). Obese individuals can improve their health irrespective of weight loss (Bacon & Aphramor, 2011; Bacon, Van Loan, Stern & Keim, 2005; Gagnon-Girouard, Begin, Provencher, Tremblay, Bolvin & Lemieux, 2010), yet cultural vigilance about health has turned many overweight and obese people into targets of hatred and blame. As the health crisis mounts and as obesity begins to threaten the nation's economic future (Trust for America's Health, 2011), these negative attitudes may even be seen as justified (Gortmaker, Must, Perrin, Sobol, & Dietz, 1993; Pingitore, 1994; Puhl & Brownell, 2001; Rand & Macgregor, 1990; Roehling, 1999; Rothblum, Brand, & Miller, 1990; Schupp & Renner, 2011).

The vast majority of Americans are overweight or obese. As such, it is likely the psychotherapy population will consist of individuals who may be categorized this way or who categorize themselves this way. With health and weight loss becoming a prominent focus of our nation's attention, the fat body has become a salient aspect of the self that informs how one experiences and is experienced by the world (Tischner & Malson, 2008). Clinical social workers occupy a unique position in understanding and addressing the needs of our overweight and obese

clients. As psychotherapists, we seek to uncover and understand the distinctive psychic lives of our clients; as advocates and change agents, we seek to address harmful cultural attitudes and create changes that lead to growth, justice and well-being.

To engage in effective therapeutic work with our clients, we must have a keen understanding of our attitudes, belief systems and the ways in which they have been shaped by our experiences (Sue, Arredondo & McDavis, 1994). It seems likely that attitudes about weight, the obesity epidemic, and personal experiences with our own bodies may have important affects on the therapeutic process and outcome for our overweight and obese clients. This topic, however, remains relatively unexplored in the literature. My thesis will seek to address this gap by exploring clinical social workers' attitudes towards and practice experiences with their overweight and obese clients. I will specifically explore clinicians' experiences in both establishing and maintaining therapeutic relationships with these clients with the goal of elucidating both the attitudes held towards, and the roles played by clinicians with this population.

CHAPTER 2

Literature Review

This research project will seek to explore clinical social workers' attitudes towards and practice experiences with their overweight and obese clients. Clinical social workers occupy a unique position in addressing the needs of their overweight and obese clients. As the purview is shifting from a focus on the anorexic client to the obese client (Thompson, 1996; Thompson & Smolak, 2001), clinicians' attitudes towards and role with this population must be understood. In the literature to date, only one research project, a doctoral dissertation entitled "Fat in the countertransference: Clinical social workers reactions to fat clients" (Dennis, 2004) has examined this topic. For her dissertation, Dennis (2004) interviewed nine psychodynamically trained social workers and in her findings, discusses the various meanings clinicians associated with the word "fat." She also examined the ways these meanings impacted clinicians' attitudes toward their clients and their suggested treatment recommendations. Her findings revealed that participants held a more negative view of their fat clients than a positive view. Several clinicians saw the fat body as a physical liability and as an indicator of pathology; fat clients were perceived as "out of control," "lazy" and "self-destructive." While some clinicians were able to separate these negative attitudes from their work with clients, others were aware of communicating these biases to clients. Findings from this study will be reviewed later in this chapter, but Dennis concluded that negative attitudes towards fat were common and that fat itself is a highly difficult topic to address with clients (Dennis, 2004).

Only a handful of studies specifically address the topics of overweight and obesity in the social work field and in the literature that does exist, conceptualizations of these issues are varied and unclear (Fabricatore & Wadden, 2003; Lawrence, Hazlett, & Hightower, 2010; Melcher & Bostwick; 1998; Weiss, 1989). Some social workers (Fabricatore & Wadden, 2003; Melcher & Bostwick, 1998; Weiss, 1989) argue that overweight and obesity are not necessarily indicators of poor psychological or physical health and that clinicians must take caution to not assume this connection. Others (Lawrence, Hazlett & Hightower, 2010) however, believe that overweight and obesity are serious health problems and that social workers play a critical role in encouraging their clients to make lifestyle changes that will lead to weight loss. The specific role and function of the clinical social worker, however, has yet to be explored and the ways in which these issues are framed and addressed in treatment is unclear. This study seeks to fill this gap by examining clinical social workers attitudes towards and practice experiences with their overweight and obese clients.

This chapter will provide a framework for this study by reviewing the literature on five prominent perspectives of overweight and obesity. In a manner similar to Dennis (2004), I will explore the ways overweight and obesity are framed that are particularly relevant to the practice of social work – this discussion will include views offered by the psychoanalytic and medical fields, as well as those offered by feminist psychologists, social constructivists and size acceptance activists. I will also review the literature on weight-based stigma, as this may reflect dominant cultural attitudes internalized by clients and the clinicians working with them. First, however, I will review the literature on the history of countertransference and the important role clinicians' personal attitudes and experiences play in treatment. Then, I will examine the literature on weight-based stigma, a topic that is likely to inform our experiences with our

clients. Finally, I will discuss five prominent perspectives on overweight and obesity in order to provide solid groundwork for this analysis.

Countertransference

The concept of countertransference was first introduced to the field by Sigmund Freud (1910) when he famously wrote, “We have become aware of the ‘countertransference’ which arises in him [the physician] as a result of the patient’s influence on his unconscious feelings” (Freud, 1910, p. 144). In this statement, Freud made clear that the therapist cannot remain unaffected by his patients. Given the nature of psychotherapy, patients were bound to evoke certain feelings in their therapists. Freud believed, however, that these feelings originated in therapist’s unconscious and as such, interfered with the analytic process. In several of his early statements, Freud staunchly argued that analysts recognize and overcome these reactions to avoid adulterating the therapy (Freud, 1910).

Many analysts adhered to Freud’s view that countertransference was something to be suppressed and the topic received little attention until the middle of the twentieth century. Paula Heimann (1950), a British psychoanalyst, was one of the first to depart from Freud’s classical view. She proposed the concept be broadened to include the entirety of the therapist’s emotional response to the patient. Heimann argued for the significance and utility of countertransference when she stated, “the analyst’s emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst’s countertransference is an instrument of research into the patient’s unconscious” (Heimann, 1950, p. 81). Explaining further, she believed it was necessary for analysts to maintain “evenly hovering attention” within the clinical encounter in order to attend to their own feelings towards the patient. Disagreeing

with Freud, Heimann suggested that it was explicitly through the clinicians' countertransference reactions that much clinical insight could be gained (Heimann, 1950).

Like Heimann, Donald W. Winnicott (1949) argued that countertransference not only had therapeutic value, but was also inevitable to the therapeutic process. His oft-cited paper, "Hate in the Countertransference" (Winnicott, 1949) was the first to argue for the existence of three separate types of countertransference. Like Freud, Winnicott believed the first type of countertransference reaction interfered with analysis and required deeper exploration. He described the second as "identifications and tendencies belonging to an analyst's personal experiences and personal development which provide the positive setting for his analytic work and make his work different in quality from that of any other analyst" (p. 195). These reactions were rooted in the therapist's history and accounted for the uniqueness of the therapy. Third, he introduced the concept of "objective" countertransference, which he described as, "the analyst's love and hate in reaction to the actual personality and behavior of the patient based on objective observation" (p. 195). Winnicott argued that all three were relevant to the therapeutic process and like Heimann (1950) he believed a productive relationship with the patient could only be achieved by recognizing and working through these reactions (Winnicott, 1949).

Since Winnicott (1949) and Heimann (1950), clinicians have continued to emphasize both the existence and clinical utility of countertransference (Gabbard, 1999; Green, 2006). Positive and negative countertransference reactions continue to be understood as providing important insight about clients as well as the clinicians working with them. Particularly within the context of modern psychodynamic theory and practice, it is well understood that the experiences, beliefs and assumptions clinicians bring from their own history are certain to inform the therapeutic work (Berzoff, 2011). Indeed, clinicians' developmental histories and distinctive

experiences and interactions with the world profoundly impact their capacity to engage empathically with clients.

Cultural forces are also likely to become embedded in the unconscious and enter the intersubjective space between client and clinician. Gutwill (1994) has argued for the existence of a social holding environment and suggests that this provides the basis for many countertransference and transference reactions. He believes that as individuals move through the developmental process, they form a powerful relationship to the “culture parent” (p. 146) that becomes embedded in their psyches. As such, cultural notions about health and beauty are likely to be internalized by both clinician and client and strongly impact the therapeutic process (Gutwill, 1994; Kahn, 2009).

Although the topic of countertransference itself has long been studied, countertransference reactions to overweight and obesity remain relatively unexplored. The significance of this topic, however, is best revealed in Irvin Yalom’s (1989) book, *Love’s Executioner and Other Tales of Psychotherapy*. In the chapter titled “Fat Lady,” Yalom candidly describes his response towards his patient, Betty. He writes,

The day Betty entered my office, the instant I saw her steering her ponderous two-hundred-fifty-pound, five-foot-two-inch frame toward my trim, high-tech office chair, I knew that a great trial of countertransference was in store for me. I have always been repelled by fat women. I find them disgusting: their absurd sideways waddle, their absence of body contour — breasts, laps, buttocks, shoulders, jaw lines, cheekbones, everything, everything I like to see in a woman, obscured in an avalanche of flesh... How dare they impose that body on the rest of us? The origins of these sorry feelings? I had never thought to inquire... So deep do they run that I never considered them prejudice...When I see a fat lady eat, I move down a couple of rungs on the ladder of human understanding. I want to tear the food away; to push her face into the ice cream. Stop stuffing yourself! Haven’t you had enough, for Chrissakes?’ I’d like to wire her jaw shut! (p. 93-95)

While it seems highly unlikely that clinicians practicing today would consciously hold such flagrant attitudes towards overweight and obese patients, research on this topic is neither

clear nor comprehensive. A review of the literature found only three peer-reviewed articles and two doctoral dissertations examining psychotherapists' weight-related countertransference reactions (Adams, 2008; Agell & Rothblum, 1991; Davis-Coelho, Waltz & Coelho, 2000; Dennis, 2004; Young & Powell, 1985). The published literature to date shows no indication that the attitudes of social workers have been assessed with regards to overweight and obese populations (Lawrence, 2010).

As stated previously, only one study, a doctoral dissertation conducted by Dennis (2004) has specifically sought to understand the social worker's experience with this population. For her dissertation, Dennis (2004) interviewed nine psychodynamically trained clinical social workers in the Chicago area. Participants were recruited from the National Association of Social Workers, the Clinical Social Work Alumni Association, the American Group Psychotherapy Association and the Academy for Eating Disorders. Dennis asked participants to answer three questions: (a) what the word "fat" meant to them (b) what their reactions were to those clients they perceived as "fat," and (c) how these reactions manifested in their work. Congruent with members of the size acceptance movement (National Association to Advance Fat Acceptance, 2011), Dennis used the term "fat" in her study, arguing that obesity is only one aspect of fatness and that fatness in and of itself is not inherently problematic. She embraced the sensitive and radical nature of this term by utilizing a free association narrative interview method (Hollway & Jefferson, 2000 as cited by Dennis, 2004) as a platform for this discussion.

Analysis of the data revealed that clinicians ascribed multiple meanings to fat. Fat was commonly viewed as a physical liability, a flaw and an emotional disadvantage. One clinician reported that fat was not necessarily a cause of physical health problems, but all nine considered fat to be an indicator of emotional distress or disorder; the fat client was often perceived as "out

of control,” “unaccomplished,” “self-destructive,” “depressed” or “eating disordered.” One clinician described the fat client’s weight gain as a “sin” (Dennis, 2004).

Positive countertransference reactions were also apparent, with clinicians reporting strong feelings of compassion and affection towards their fat clients. Not surprisingly, clinicians also viewed fat as serving a psychological purpose. Fat was seen as a tool to distance oneself, fend off unwanted sexual interest or appear threatening. Interestingly, several participants also associated fat with the experience of oppression, but none spoke about the impact this understanding had on their clinical work. In general, fat was a physical indicator of disturbance and weight loss was seen as the desirable outcome of therapy – fat was neither good nor neutral (Dennis, 2004).

Dennis concluded that clinical social workers might react to fat clients in a similar way as the general public, holding more negative than positive feelings towards this population (Dennis, 2004). She concluded, however, that clinicians may differ from the general population in their increased ability to understand the potential psychological functions of overeating and fat, and the potential of overeating and fat to be symptoms of psychological disorder or deficit. Some clinicians were aware of their attitudes and could reflect on the role these played in their work. Others, however, were less successful in recognizing the potential of their biases to impact their work. Dennis further concluded that clinicians’ conceptions of fat were narrow in that they showed little acknowledgment of the genetic, physiological, social and economic factors that may contribute to fatness. She was also surprised that clinicians associated fat with the experience of oppression but did not openly discuss how this impacted their own attitudes or informed their work. Given social workers’ appreciation of the biological, psychological, social and environmental influences on individual development and behavior, it is interesting that their

understanding of fatness and the ways in which it was addressed in psychotherapy did not embody a wider variety of factors, as a broader and more integrative approach may have been a more ethical form of treatment.

To date, Dennis' (2004) doctoral dissertation is the only study to explore clinical social workers' attitudes towards and practice experiences with their overweight and obese clients. Within the published literature, only three studies have examined this topic. For the first study, conducted in 1985, Young and Powell sent a case study to 120 mental health clinicians along with a photograph of a middle aged European American woman. The clinicians were asked to evaluate the client's level of pathology, prognosis and comment on their willingness to work with her. Although the image provided to participants was of the same "average weight" woman, one group received digitally altered images that showed her at an overweight weight.

Similar to the findings offered by Dennis (2004), results indicated that clinicians evaluated the overweight client more negatively than the average weight client. The overweight client was also rated higher in anti-social behavior, sexual dysfunction, addiction and inadequate hygiene. Clinicians' ratings did not differ, however, in their outlook on prognosis or on their willingness to work with clients, which many rated as high for both the average and overweight groups. Results also revealed that compared to others, younger women with fewer years of clinical experience rated overweight clients more harshly. In addition, compared to "average weight" participants, overweight participants were less likely to perceive weight as a significant indicator of difference (Young & Powell, 1985).

The second study to explore this topic was conducted in 1991. In this study, Agell and Rothblum (1991) asked 282 psychologists to read and assess a written case history of a client varied only by client weight and height – the client could be classified as obese or non-obese.

Analyses of these data indicated that obese clients were rated as more “embarrassed” and more “physically unattractive” than non-obese clients. Positive judgments towards obese clients were also reported, with clinicians rating them as “softer” and “kinder” than non-obese clients. Unlike the results from Young and Powell (1985), findings from Agell and Rothblum (1991) indicated that clinicians’ judgments did not have a significant impact on the diagnoses they assigned to their clients or on their treatment recommendations.

The most recent study on this topic, conducted by Davis-Coelho, Waltz, and Davis-Coelho (2000), confirmed findings from Young and Powell (1985) that younger and less experienced psychologists were particularly likely to view fat clients negatively. Fat clients were rated as demonstrating less effort in therapy and having a worse prognosis than standard weight clients. Psychologists were also more likely to assign a lower Global Assessment of Functioning (GAF) score and an eating disorder to clients who were overweight, while non-overweight clients were more likely assigned diagnoses of adjustment disorders. These findings point to a critical area of debate in the social work and psychodynamic literature – whether overweight and obesity are indeed manifest of pathological disturbance.

While the studies described above are somewhat limited in scope, they demonstrate that overweight and obesity is another area where biases may be held and that assumptions about fat may be unintentionally communicated to clients. These studies also reveal that negative attitudes and reactions to overweight and obese people may be more common among women and younger mental health professionals than others. However, these findings leave several areas unexplored. First, how do clinical social workers actually make sense of overweight and obesity in the therapeutic encounter? How, if at all, is this relevant to understanding and working with clients? Second, how are issues actually addressed and responded to in treatment with these clients? Are

clinicians able to identify their weight-related attitudes and separate these from those of their clients'? What happens when these clients are struggling with eating issues or body image concerns? What challenges do clinicians experience? What rewards are experienced? Furthermore, how, if at all, do clinical social workers make use of the social justice issue that exists for this population in their work? Social workers are trained to see their clients' experiences as resulting from biological, psychological, social and environmental influences. Thus, more research is needed to determine how this perspective may be held in practice with overweight and obese clients.

Weight Based Prejudice and Discrimination

An exploration of clinical social workers' attitudes towards and practice experiences with their overweight and obese clients must include a discussion of the literature on weight-related stigma, as dominant cultural attitudes are likely to inform our experiences and those of our clients. Weight-based prejudice is now considered the last socially acceptable prejudice (Stunkard and Sorensen, 1993). A number of studies indicate that negative attitudes towards this population are extensively held, both within the general public (Gortmaker, Must, Perrin, Sobol, & Dietz, 1993; Pingitore, 1994; Puhl & Brownell, 2001; Rand & Macgregor, 1990; Roehling, 1999; Rothblum, Brand, & Miller, 1990; Schupp & Renner, 2011) and among health care professionals (Brown, 2006; Puhl & Brownell, 2001; Rothblum, 1992 Teachman & Brownell, 2001; Schwartz, O'Neal Chamblis, Brownell, Blair & Billington, 2003), and that this prejudice is considered deserved and legitimate (Crandall, 1994; Puhl & Brownell, 2001). Crandall (1994) argues that anti-fat attitudes have become increasingly overt and accepted as America's health crisis has grown. He, among others (Tischner & Malson, 2008), believes that the more we are

exposed to messages that overweight and obesity are increasing at epidemic proportions and lead to serious health complications, the greater the likelihood that the body will come to reflect a person's will and morality. Indeed, treatments for overweight and obesity readily imply that if individuals exert enough control over their eating and exercise habits, they will become thin and subsequently, valued and accepted members of society (O'Hara & Gregg, 2006).

As stated previously, an increasing number of studies document the high prevalence of weight-based prejudice and discrimination. A comprehensive review of the literature on this topic revealed that discriminatory attitudes towards overweight and obese populations are held in four significant sectors of life – medical, health, employment and educational settings (Puhl & Brownell, 2001). In medical and health settings, physicians have been found to associate obesity with poor hygiene, noncompliance with treatment recommendations, dishonesty and hostility. Nurses and health care professionals specializing in nutrition have also identified obese persons as indulgent, lacking in willpower, and lazy (Puhl & Brownell, 2001). It is encouraging that health care providers may hold a more positive view of this population than the general public. Still, a number of studies reveal that overweight and obese patients are frequent targets of physicians' degrading remarks (Rand & Macgregor, 1990).

Employers may even be more likely to discriminate against overweight and obese individuals. Compared to those of normal weight, overweight employees are rated by employers as having poorer work habits and more personal and emotional problems (Roehling, 1999). Several studies suggest that overweight and obese people are less likely to be hired and promoted than standard weight employees or to be recommended for positions requiring face-to-face contact (Puhl & Brownell, 2001; Roehling, 1999). Overweight individuals may earn less than their normal weight counterparts (Roehling, 1999), and are more likely to suffer peer rejection,

restricted access to higher education, and limitations in choice of romantic partner (Gortmaker, Must, Perrin, Sobol, & Dietz, 1993).

Unfortunately, it seems weight bias may also be linked with other types of discrimination. In an analysis of The National Survey of Midlife Development in the United States, Puhl, Andreyeva, and Brownell (2008) found the prevalence of interpersonal and institutionally based weight discrimination was comparable to that of racial discrimination. This was only the case for women, however, a finding consistent with existing studies that place women at greater risk for weight-based prejudice (Puhl, Andreyeva & Brownell, 2008; Roehling, 1999). Data analysis also indicated that both men and women were subjected to higher rates of weight-based discrimination than that based on sexual orientation, religion and physical disability. Interestingly, reported rates of employment based weight discrimination (60%) were comparable to those reporting employment based race-based discrimination (53%), and were higher than those reporting discrimination based on gender (40%) – pointing to the many meanings ascribed to the fat body. Younger women were particularly vulnerable to this discrimination.

What the authors do not mention that is relevant to the practice of clinical social work is that the actual physical and psychological impact of weight-based discrimination may be culturally oriented. For instance, compared to Whites, African-Americans of both genders report higher levels of physical, social and mental health functioning at higher weights (Bentley et al., 2011; White, O'Neil, Kolotkin, & Byrne, 2004).

As clinicians, it is important for us to remember that the psychological impact of weight-based discrimination may differ by group identification and to not assume a connection between the two. However, some researchers argue that unlike race and gender-based prejudice, the

stigma of obesity is unique in that overweight and obese populations are not protected by an in-group bias (Crandall, 1994; Wang, Brownell & Wadden, 2004). This may make people particularly vulnerable to the internalization of anti-fat attitudes (Rand & Macgregor, 1990; Teachman et. al., 2003; Tishcher & Malson, 2008; Wang, Brownell & Wadden, 2004) that must be worked through in therapy by both client and clinician. Overweight and obese individuals may feel flawed, unattractive and shameful (Tischner & Malson, 2008), and for many, weight loss alone may eliminate the stigma that often leads to poor self-esteem and social isolation (Rand & Macgregor, 1990).

Taken together, these studies suggest that weight-based discrimination in the United States is pervasive, powerful and occurs in almost all areas of living. While the extent and impact of this bias may differ by age, gender and race, anti-fat attitudes are widespread and are socially sanctioned. Health care professionals are not immune to weight-based prejudice and while they may be more accepting than the general public, their attitudes towards their overweight and obese patients are primarily negative. Although the potential health consequences of overweight and obesity may underlie this negative view, it seems likely that repeated exposure to anti-fat attitudes will strongly influence our clients' self-perceptions. As clinicians, we must examine the ways we have internalized these messages, understand our own attitudes towards our overweight and obese clients and reflect upon the ways these attitudes inform our work. By doing so, we will improve our ability to openly engage with our clients.

Ways of Framing Overweight and Obesity

Conceptualizations of overweight and obesity are complex and heterogeneous. Overweight and obesity may be seen as an indicator of emotional disturbance (Glucksman, 1989;

Slochower, 1989; Weiss, 1989), as a serious medical illness (Centers for Disease Control & Prevention, 2011), as a dire public health issue (U.S. Department of Health and Human Services, 2011), as defiance against oppressive power structures (Brown, 1989; Orbach, 1978a; Orbach 1978b), and as a social construction used for profit gain (Bacon, 2008; Gaesser, 2002). It seems possible that all of these perspectives may be relevant to clinical practice with our overweight and obese clients. However, there is scant published literature to date documenting how social workers understand, address and respond to these issues. As such, the final portion of this chapter will describe five ways overweight and obesity are framed that may parallel the biopsychosocial perspective and encompass the fundamental complexity of the clinical social worker's role.

Overweight and Obesity as Problems in Affect Regulation. Overweight and obesity entered the purview of psychoanalytic thought when theorists first expanded upon Freud's concept of the oral erotogenic zone (Glucksman, 1989). In his early writings, Freud proposed that excessive or deficient oral gratification in infancy resulted in fixations at the oral stage of development. Symptomology at this level of fixation was thought to be evident in activities such as overeating, smoking, and drinking, and overweight and obesity represented such pathology. Several years later, object-relations theorists expanded upon Freud's view to include not only the influence of the feeding experience on fixation at the oral level, but on the role the infant's entire visual, affective and kinesthetic experience with the caregiver played on the development of this pathology (Glucksman, 1989).

At the same time that object-relations theorists suggested the infant's entire experience with the caregiver impacted psychological development, food specifically came to be linked to Donald Winnicott's concept of the transitional object (Glucksman, 1989). According to analysts

of the time, food represented a tangible form of the mother that could be used to soothe psychic distress. For infants whose mothers were intrusive, overprotective, and unable to distinguish their needs from those of their children, food was particularly likely to occupy this role because it offered regulation the mother could not otherwise provide. This view was later expanded to include overweight and obesity as resulting from a major failure in the differentiation process. If food was offered as a substitute for emotional longings in childhood, these individuals were thought to develop difficulties perceiving hunger and satiety cues and distinguishing these from internal affective states (Bruch, 1961).

Since object-relations theorists first made this proposal, the psychodynamic literature has continued to point to overweight and obesity as indicators of pathological functioning. Food consumption, rather than more adaptive forms of affect regulation, has been thought to soothe distressing emotions. It has been argued that overeating may serve to moderate feelings of depression, guilt, anger and anxiety. Some have argued that fatness itself may defend against more genuine feelings of vulnerability and powerlessness (Kaplan & Kaplan, 1957 as cited by Slochower, 1989).

Many psychological interventions for overweight and obesity have fallen from this line of thought and weight reduction is considered one positive outcome of treatment (Moldovan & David, 2011). Some practitioners, however, challenge whether weight reduction should be the measure of success or the focus of treatment. In their article, "The obese client: Myths, facts, assessment and intervention," published in a 1998 volume of *Health & Social Work*, Janet Melcher and Gerald Bostwick specifically contend that direct practitioners should be less concerned about client weight and the explanations for obesity and should instead, turn their attention towards the psychological ramifications of being obese in a society that values thinness.

They suggest that treatment with overweight and obese clients should focus on educating clients about the effects of discrimination on self-image, the emotional problems associated with dieting, and should encourage clients to develop healthy relationships with food that do not lead to obsession over body and weight (Melcher & Bostwick, 1998).

Overweight and Obesity as a Medical Illness. Perhaps the most familiar and publicly instilled conceptualization of overweight and obesity is that it is associated with poor health and premature death. Obesity has been referred to as a “modern epidemic” (Rubenstein, 2005) that is claiming millions of lives and threatening America’s future (Centers for Disease Control & Prevention, 2011). Obesity has been linked to serious and often fatal illnesses such as hypertension, coronary heart disease, certain types of cancers, sleep apnea, stroke and diabetes (US Department of Health and Human Services, 2011). Some researchers argue that obesity will take over tobacco as the leading cause of preventable death in America. As such, overweight and obese people are admonished to lose weight in order to protect and extend their lives (Mokdad, Marks, Stroup & Gerberding, 2004).

Data to support the claims that obesity is a serious health issue often rely on measurements based on the Body Mass Index (BMI). The BMI is a simple weight-to-height ratio that places individuals in one of four weight categories – underweight, normal weight, overweight or obese. A BMI between 25.0 and 29.9 classifies individuals as overweight and a BMI equal to or greater than 30.0 classifies them as obese. The BMI is seen as a reliable measure of health status and as an easily implementable and inexpensive way to identify those most at risk for health problems. It is utilized by the majority of health professionals and is now a standard element of care (Centers for Disease Control & Prevention, 2011).

Some have argued, however, that despite its widespread use, the Body Mass Index (BMI) is a misleading indicator of health. They contend that because the BMI makes no allowance for the relative proportions of bone, muscle and fat in the body, it cannot accurately reflect an individual's health status (Robison, 2003). Other physicians, exercise physiologists and nutritionists argue that the link between overweight, obesity and poor health is also grossly exaggerated and they challenge the primacy of weight loss in curtailing illness in these populations. Instead, they view nutrition and levels of physical activity as more accurate indicators of health and argue that traditional approaches to overweight and obesity – eat less and move more – are largely ineffective in maintaining weight loss over time (Bacon, 2008; Gaesser, 2004; Gaesser, 2000; Robison, 2003). Many agree that because only a small percentage of the population is able to prevent weight regain, diet promotion is ethically irresponsible. Thus, health professionals are encouraged to help all patients, regardless of size, adopt healthy eating and exercise habits and to remove the emphasis on weight loss (Bacon, 2008; Gaesser, 2004; Gaesser, 2000; Robison, 2003; Wing & Hill, 2001). While the accuracy of body weight in predicting health remains a topic of debate, the medical framework positions overweight and obesity as illnesses that can be prevented.

Overweight and Obesity as a Reflection of Unequal Power Structures. A select number of theorists have long considered overweight and obesity a manifestation of unequal power structures. Feminist psychologists were the first to assert that obsessions with body size and weight were a woman's issue that reflected the inherent power differentials between the sexes. They proposed that women's attitudes towards and feelings about their bodies must be understood within the context of Western history, where physical attractiveness is associated with self-worth and economic power is gained through sexuality and relationships with men.

Feminists argue that socialization into this environment cause women to over-identify with their bodies whereby self-esteem is conditioned upon conforming to beauty ideals. While limited in its heteronormativity, early feminist writings argued that male dictated standards of beauty and restriction of women's opportunities intersected to foster an omnipresent control over every aspect of women's lives, including their bodies.

Some feminist writers have argued that because of this, the fat body expressed a woman's competence, power and assertiveness as it enabled her to reject the "ideal" female form (Chernin, 1986; Chernin, 1981; Orbach, 1978a; Orbach, 1978b; Wolf, 1990). Overweight and obesity were thought to defy men's control and to reflect a woman's need for boundaries and protection against restrictive cultural norms. These authors proposed that there was an inherent connection between the oppression of women, fat prejudice and eating disorders, and that all forms of body dissatisfaction were a natural response to unjust social pressures that needed to be challenged (Piran, 1996).

Although feminist psychologists empowered women to think about their bodies in new ways, even they were unable to avoid a paradoxical relationship with fat. In Susie Orbach's, *Fat is a Feminist Issue* (1978a; 1978b), she grapples with a tension between fat as something that is both comforting and undesirable. She suggests that fat is used to express a woman's strength, but may also be used to avoid the anxiety associated with competition and sexuality. Orbach posits that as women access and operate from their intrinsic power, their fat will no longer have to act for them. By telling women that accessing their internal strength will allow them to "give up their fat" she too, normalizes thinness.

Many feminist authors contend that this fundamental value of thinness powerfully reflects the ways women have internalized cultural norms. Many feminists believe that fat may

be particularly threatening for women because it tests the boundaries between individual desires for power and the broader goals of feminism. Women may therefore be caught in a contradictory position – their bodies both a source of control and a site of oppression (Brown, 1989; Russel & Mayhew, 2007).

Still, it is important to note that feminist psychology has been staunchly criticized for its Eurocentricity. The “ideal female form” referred to in these writings is rooted in White patriarchal values and does not necessarily reflect the standards endorsed by all women or all cultures. Indeed, feminist perspectives do not describe the experiences of all women. However, the theory offers a solid framework for identifying the ways in which oppressive cultural forces may be held within the body, an idea that is receiving new attention as the link between obesity and low socioeconomic status becomes clearer (CDC, 2011).

Overweight and Obesity as a Moral Failing. Overweight and obesity are routinely marked as a result of lifestyle choices. Some authors argue, however, that when seen as a consequence of poor eating and exercise habits, all individuals are characterized “at risk” and those who become overweight or obese are seen as failing in their quest for health. Viewed this way, the thin and healthy body becomes a symbol of hard work, discipline and accomplishment (Kwan, 2009, p. 37). Overweight and obese individuals may therefore be perceived as weak, lacking in self-control, and as unwisely ignoring the evidence that fat is bad. Kwan (2009) argues that this sentiment is particularly ubiquitous in Western societies, where access to healthy food and health information is readily available. Certainly, many people are unaware of what constitutes a healthy diet, lack the means to obtain nutritious foods and lack opportunities for physical activity. However, the “pervasive ethos that bodies can be transformed at will [turns the body into] a metaphor for the psyche (Kwan, 2009, p. 37). In this context, fatness becomes an

offense and a moral failing. It is perhaps this perception that legitimizes weight-based prejudice and explains why size discrimination is so widespread.

Overweight and Obesity as an Oppressed Identity. The widespread acceptance of weight-based prejudice and discrimination (Puhl & Brownell, 2001) has led to increasingly more social justice efforts designed to protect this population. Indeed, the fat acceptance movement has existed since 1969 when the National Association to Advance Fat Acceptance was founded (NAAFA, 2010). Supporters of the fat acceptance movement elevate the importance of fat pride, advocate for the rights of fat people and educate the public about body diversity and “Health at Every Size,” a paradigm that removes a focus on weight loss and emphasizes the importance of health behaviors. A number of NAAFA members vociferously disagree with the anti-fat sentiment and argue that health is an attainable goal for fat people and that weight loss is not possible for every individual. They look to research to validate this claim, noting that diseases associated with obesity including hypertension, heart disease and diabetes, can be minimized or reversed through lifestyle changes alone and that people can improve their health while remaining obese (Bacon & Aphramore, 2011; Bacon, Van Loan, Stern & Keim, 2005; Gagnon-Girouard, Begin, Provencher, Tremblay, Bolvin & Lemieux, 2010).

The fat acceptance movement is small, but it may be gaining public interest as fat activists ask the public to rethink definitions of health. NAAFA supporters view health as multi-dimensional, constituting physical, emotional, social and spiritual aspects of well-being (NAAFA, 2010). In addition, they reject use of the terms “overweight” and “obesity” to refute notions of an ideal weight and the pathology of fat. Instead, they embrace and celebrate their identities as “fat” to cast off the shame associated with this body size. Furthermore, they

encourage the public to consider how the medical, diet and fashion industries profit from the “myth” that fat is bad.

The size acceptance movement is also dedicated to eliminating the prevalence of weight-based discrimination. They view the Body Mass Index (BMI) as a means to label, stigmatize and discriminate against fat people rather than as a predictor of health, and they call attention to the challenges fat people face in achieving good health and fitness because of such pervasive discrimination. Supporters of this movement have even argued for weight and height to become protected legal categories in order to moderate the effects of such bias (Puhl & Brownell, 2001).

Summary

The literature reveals that issues of overweight and obesity are constructed in multiple ways. We ascribe overweight and obesity with meanings such as pathology, morality, illness, oppression, identity and power. Clinical social workers are in a unique position to understand the subtleties of the transference and countertransference issues that may arise in work with these clients. Our work requires us to be cognizant of the attitudes we carry and aware of our potential to be triggered by the issues our clients present. We must have honest relationships with ourselves and view our reactions to clients with curiosity and question. In addition, we are trained to view symptoms in context, honor what it means to work across difference and to acknowledge the oppressive forces in the world and in the therapeutic relationship. As social workers, we are not immune to the biases, beliefs and assumptions our culture holds. We must consider what we bring to the therapeutic encounter as we work with our overweight and obese clients. What do we need to know about ourselves to engage in this work? What is our relationship to fat and the “obesity epidemic”? What must we consider about our clients’

experiences? These questions guide this exploratory study with the intent to learn more about social work clinicians and their attitudes and experiences working with their overweight and obese clients.

CHAPTER 3

Methodology

This study was designed to answer the research question: What are clinical social workers' attitudes towards and practice experiences with their overweight and obese clients? As the literature review revealed, overweight and obesity symbolize a complex interaction between intrapsychic, interpersonal and sociocultural issues. Complicated meanings of eating and what constitutes a healthy and attractive body embedded in the social discourse may provide the basis for clinicians' experiences with their overweight and obese clients. Attitudes towards body and weight may remain an invisible but significant element of the therapeutic process. The literature to date, however, is inconclusive about how social workers understand and respond to their overweight and obese clients. As rates of overweight and obesity grow and as America's "war on obesity" mounts, the ways we work with our overweight and obese patients must be considered.

To address this gap in the literature, a qualitative study was conducted using flexible research methods. Semi-structured interviews were conducted to explore clinicians' attitudes towards and practice experiences with their overweight and obese clients. Specifically, clinicians' were asked to reflect upon the ways they understand overweight and obesity in the therapeutic setting, their attitudes towards their overweight and obese clients, how issues are addressed and responded to in treatment with these clients and finally, what challenges and rewards are experienced in their work with these clients. This chapter presents the methods of

research used in this study and will describe working definitions, the sample selection, data collection and data analysis procedures.

Working Definitions

The terms “overweight” and “obese” are utilized in this research and as such, require working definitions. “Overweight” and “obesity” are medical terms that designate weight categories at risk for poor health outcome according to the Body Mass Index (BMI). The BMI is a simple weight to height ratio that is routinely utilized by health care professionals to identify those who may be at risk for health problems based on their weight. Although clinicians may not be aware of each client’s BMI, there may be visual and subjective cues that lead them to believe an individual is overweight or obese. Cultural perceptions are also likely to influence these beliefs. As such, overweight and obesity may be difficult to quantify in the therapeutic setting and beliefs about which clients fall into these categories are likely to differ for each clinician. To be consistent with the language used in the literature described in the previous chapter, the researcher uses these terms throughout the paper in her own language, as quotes from the literature or when used by participants.

Sample Selection

Potential participants were asked to meet several criteria before they took part in the study. All study participants were asked to have a Masters degree in social work, be licensed as clinical social workers and have at least one year of direct practice experience post licensure. Participants were required to have caseloads presently including at least one overweight or obese client or must have terminated with such a client within the past year. Participants will not be

asked to identify client weight status through a quantifiable measure, as perceptions of overweight and obesity are likely to differ for each individual. However, clinicians will be asked to discuss only those clients whose body sizes lie on the continuum from slightly overweight to extremely obese. Use of this weight-based continuum was intended to designate body size as variable, nuanced, and as existing to a matter of degree.

Those interested in participating who lacked licensures in clinical social work, had only a Masters level or Bachelors level degree in social work, or had less than one year of direct practice experience were excluded from the study. Those who lacked clinical experience with at least one overweight or obese client within the past year were also excluded.

Participants were recruited through snowball sampling procedures. The recruitment letter (see Appendix A) was distributed to clinicians and agency staff with whom this researcher was acquainted. Clinicians directly contacted by the researcher included those from the California Chapter of the National Association of Social Workers North Coast Region, the Association of Professionals Treating Eating Disorders (APTED), members of the San Francisco Psychotherapy Research Group and individuals affiliated with two nonprofit clinics specializing in body image and weight-related issues. These clinicians in turn, were asked to send the recruitment letter to their colleagues via email, as well as to any professional list-serves in which they were members. Interested participants were asked to contact the researcher by phone or email for a screening interview (see Appendix B).

Screening interviews were conducted by phone or email based upon clinicians' preferred mode of communication. Individuals not meeting criteria were informed and were kindly thanked for their interest. Interested participants that met study criteria were promptly emailed a copy of the informed consent letter (see Appendix C) for their review prior to attending the

interview. At the final stage of the screening interview, interview dates and times were set up in a manner that was convenient for the respondent and in a location that maximized confidentiality.

Data Collection and Instruments

Procedures to protect the rights and privacy of participants in this study were outlined in a proposal and presented to the Human Subject Review Board (HSRB) at Smith College School for Social Work prior to data collection. Approval of the proposal (see Appendix D) indicated that the study was in concordance with the NASW Code of Ethics and the Federal regulations for the Protection of Human Subjects Research.

Prior to the interview, I introduced myself, provided brief information about my educational background and my interest in the topic, and thanked clinicians for their participation. Participants were reminded that the interview would take approximately 45 minutes of their time and were informed that that they would be asked a series of questions pertaining to their attitudes towards and practice experiences with their overweight and/or obese clients. Participants were also encouraged to provide specific case examples and give descriptions of their work with the clients they referred to. In addition, each participant was given an informed consent document describing their rights as human subjects and any potential risks or benefits of participation (see Appendix C). After reviewing its content, the participant and researcher each signed a copy of the document. Participants were asked to keep one copy for their records and were informed that the researcher would keep the signed copy. Signed copies will be kept in a secured environment separate from the data for three years after the conclusion of the study as mandated by Federal regulations.

Following a discussion of the informed consent document, information about participants' practice settings, client demographics, years of experience in the field and preferred theoretical orientations were collected. Demographic data were also gathered.

Data pertaining to my research question were obtained using a standardized, open-ended interview guide (see Appendix E). Credibility of the interview guide was enhanced through consultation with a licensed clinical social worker in private practice and a post-doctoral psychology intern who specializes in the treatment of body image disturbances related to overweight and obesity. The reviewers were asked to assess the questions for clarity and relevance to practice and their feedback was incorporated. Suggestions from the Human Subjects Review Committee were also incorporated into the interview guide. The final guide is intended to make clear the researcher's interest in exploring clinicians' entire subjective experience with their overweight and obese clients, including the subtleties of transference and countertransference and the ways these issues are framed in treatment.

The interview questions are open-ended to elicit narrative, in-depth responses from participants that describe the meaning of overweight and obesity, personal attitudes towards these issues, and how these attitudes affect practice behaviors and treatment recommendations.

The questions explored the following themes:

How clinicians define and/or understand overweight and obesity in the therapeutic setting

- In your practice, what indicators (visual, perceptual, numerical, etc) lead you to identify a client as overweight or obese?

How clinicians address or respond to overweight and obesity

- In your practice, how do you typically address and/or respond to issues, weight related or otherwise, with your overweight and/or obese clients?

What clinicians' personal attitudes towards overweight and obesity are

- What are your own attitude towards issues of overweight and obesity? Is this an important issue to you personally? Why or why not?

In what ways, if any, do clinicians' attitudes influence their practice behaviors

- In what ways, if at all, does your own attitude influence your work with these clients?
- In your practice, what are the biggest challenges you experience in your work with these clients.
- Given your practice experiences, what do you think is the most important thing to say, or attitude to adopt, in responding to overweight and obese clients.

Data Gathering and Analysis

All interviews were audiotape recorded and manually transcribed by the researcher. Data were analyzed through a grounded theory approach that involved looking for common patterns and themes among participants under the categories described above. After conducting initial readings of the transcripts, I identified prominent ideas in the data and drafted preliminary coding categories. I then conducted additional readings, confirming coding categories and clarifying or adding themes. Concepts that emerged in the process were organized and the frequency with which they were reported were noted. This content/theme analysis, inspired more by exploration and inquiry than confirmation of a hypothesis, also invited unexpected findings. Through this process, certain issues emerged among several respondents that were not specifically and directly targeted in the interview guide. When topics were repeated, this was noted as a pattern, and data were included in the findings. Attempts were made to interpret the meaning behind the themes and to attend to variations in responses.

CHAPTER 4

Findings

The purpose of this study was to explore the meaning of overweight and obesity to the clinical social worker and to investigate clinicians' attitudes towards and practice experiences with their overweight and obese clients. Overweight and obesity represent a complex nexus of biological, psychological and sociocultural issues. As there is a scarcity of research focusing on the clinical social worker's understanding of and experience with overweight and obese clients, this study addresses an important gap in the literature on clinical assessment, intervention and treatment.

This chapter presents data collected from interviews with nine licensed clinical social workers. Demographic information was collected from each participant that assessed their years of clinical experience, gender, age, race, socioeconomic status, theoretical orientation and practice setting. The interview questions were organized around four themes: how clinicians define and/or understand overweight and obesity in the therapeutic setting, how clinicians address and respond to issues with their overweight and obese clients, what clinicians personal attitudes towards overweight and obesity are, and how, if at all, do personal attitudes towards overweight and obesity affect practice behaviors with these clients. Clinicians were asked to incorporate specific case material into their discussions in order to reinforce and clarify statements made.

Demographic Characteristics of Participants

Nine clinical social workers were interviewed for this study. Years of clinical experience post licensure ranged from one to forty years, with an average length of practice of twenty-two years. Seven participants identified as female and two identified as male. Ages ranged from thirty-one to seventy. All nine participants identified as White and three identified as Jewish. All participants considered themselves to be middle to upper-middle class. One participant practiced from a cognitive-behavioral perspective. Eight participants were psychodynamically trained and incorporated a variety of principles from Control-mastery, relational and intersubjective theory. Of the nine participants, one practiced in a community mental health setting, two split their time between community mental health agencies and private practice, and six worked full time in private practice. In general, participants' patient populations primarily consisted of White, middle to upper middle class women ranging in age from their mid-twenties to early fifties. Four participants saw a small number of low-fee clients. One participant's caseload consisted solely of low-fee and/or government assisted clients. Finally, while most clients discussed by participants were White, Asian Pacific Islander and Latina clients were also discussed in the interviews. Eight participants spoke to their experiences with their female clients. Only one included case material from a male client.

Assessing Overweight and Obesity

Occupying Space. All nine participants discussed having an awareness of their client's body sizes. For some participants, clients' weight statuses were observed and reflected upon to generate hypotheses about clients' overall functioning. Others commented that in the act of

sitting with clients, they were aware of the amount of physical space their clients occupied, but were not specifically oriented or attuned to the client's body unless it was a topic of concern introduced by the client.

Visual indicators of obesity were most clearly noted when clients physically struggled to enter participants' offices. Of the nine participants, three spoke about experiences where they felt their clients' mobility and comfort was impaired by their weight. These participants reported having strong reactions to these clients and used these reactions to inform their assessments. Two participants considered assessing clients' Body Mass Indices with very obese clients due to concern about the health consequences of their weight, but this was not routine, nor was it considered as informative to treatment as a detailed assessment of client behavior and history. Most clinicians described working with clients who they identified as slightly or moderately overweight compared to the general population.

Distinguishing Weight from Body Image. A common theme that arose in all of the interviews was participants' inherent sensitivity to and curiosity about their clients' perceptions of their bodies. Not surprisingly, clients' self-perceptions far outweighed any initial assessments made by participants. An important distinction was noted between weight and body image and many felt that the two were not necessarily related. Clients' body image was considered far more important to treatment, as clinicians were aware their own subjectivities largely influenced their weight-related perceptions. Seven participants commented specifically on cases where their perceptions of their clients' bodies differed from those of their clients. Many remarked that oftentimes, clients they may have perceived as having a "weight problem" did not view themselves that way, whereas clients they thought of as "average weight" identified as "overweight" or "fat."

Very often the client will come in and tell me that they are overweight. It's interesting that their self-assessments and my assessments don't always match. So sometimes clients who think they're overweight aren't having issues with food and then there are a few clients that don't identify as being overweight, but visually look like they might be overweight [Pauses]. I follow where the client is, so I wouldn't make that judgment.

Another clinician also commented on the variability and primacy of body image when working with clients. She specifically stated this distinction was helpful in managing her own reactions to fat clients and in not communicating her biases and personal preferences about weight to her clients. As her perception differed from her clients, she actively sought to understand her clients' attitudes and understood these existed within the overall context of clients' lives.

I often explore what's available and if some people want to change something about their weight... And a lot do, but some people don't. They just want to be happy with the way are, which is an entirely different approach, you know? Personal history, the ways in which they've been socialized, the cultural influences on them all matters. In some cultures big is good, so in their culture being thick is great and I'm sitting there thinking "Oh, you need to lose 30 lbs!" [Laughs]. That's not going to do any good!

Identifying Meanings. None of the participants had experiences where clients entered therapy to specifically address overweight or obesity. However, four of the nine commented that the body itself became a frequent topic of discussion in therapy, particularly with female clients, again emphasizing the importance of the client's perspective. These participants commented on the difference between actual weight status and the general concept of "being overweight," which many believed entered therapy regardless of clients' sizes. Obviously, clinicians believed the concept of "being overweight" communicated a more fundamental level of psychic distress that necessitated further inquiry and many spoke about having these experiences during their interviews. One participant commented that regardless of the messages her clients were receiving about their bodies, many used the idea of weight control to cope with painful affect, which she believed this was important to address in therapy.

So I'm going through my clients and I would say almost every one of my woman clients at some point has said "oh, I should lose a little weight" or "oh I feel fat" or "oh, I'm meeting my boyfriend's parents I want to lose five pounds." But you know, I would say every single [pauses]. I am trying to think of one [client] who is completely sort of immune to that, and I can't think of one.

Another participant similarly reflected, "I continue to be surprised by the degree to which women will often say this when they're not hearing any of this crap from anyone in their lives." She went on to say, "their partners think they're beautiful...it's not that people perceive them negatively, and they aren't being discriminated against or treated badly, but they themselves are their biggest critics." The majority of participants reported experiences where weight-related issues were not a primary concern of their overweight and obese clients and participants were careful not to assume this connection. However, every clinician commented that even if the not the focus of treatment, weight-related issues regularly surfaced in their work with these clients around issues of self-esteem and in relating to others.

In general, when assessing overweight and obesity, clinicians made a clear distinction between those clients they considered obese and their other clients. Clinicians were often more reactive to those clients whom they perceived as obese and often felt weight-related issues should be a central focus of therapeutic work. Even so, clinicians followed their clients' lead in whether to address this or not. With their other clients, clinicians did not express the same sense of concern around this topic.

You know, I'm seeing a woman, who is um, very successful, she is, she's not very overweight, she's in her 50s and uh, uh, she feels like she's overweight, but really what's more of a problem for her is uh, drinking, so we've addressed that more, and I haven't really you know. [Pauses] You know, she does do some exercises and we talk about that, her general health, what she's doing for herself, but she's really wanted to address drinking more than anything, so we've been spending a lot of time you know, focusing on that, strategies for her and the other stuff hasn't been so important.

Attitudes Towards Overweight and Obese Clients

Negative Attitudes Towards Clients. All nine participants commented that conceptualizations of their overweight and obese clients were individually-based and varied from client to client. However, these perceptions were primarily negative. Words that surfaced in clinicians' narratives included those such as, "out of control," "eating disordered," "in denial" "disturbed," "depressed," and "impulsive." One participant believed her obese client was "dependent" and connected this to what she felt was the client's "addiction" to food. Another commented, "there were times where I honestly wanted to tackle [the overeating], because that was my, like I wanted to fix it a little bit, if she could just get herself under control, but she was out of control in many ways." Two clinicians described their overweight clients as "resistant" and "avoidant," which specifically came up around discussions about their weight. In general, an overall sense of clients as self-destructive and unable to care for themselves was often communicated in participants' narratives. This perspective, however, was coupled with an understanding that clients had complex and often traumatic histories that brought them into therapy.

She's very disadvantaged. She's disadvantaged on a lot of fronts. You know she comes from an abusive family, and was in a not good marriage and was economically disadvantaged and because of the size she's become, and she's not that intelligent, you know, literally. Uh, I think she's not taken seriously enough by the medical profession. She's taken a number of drugs, this and that, but no one addresses the weight with her, and I think it's unfortunate.

Positive Attitudes Towards Clients. Positive feelings were also expressed towards overweight and obese clients. Feelings of sympathy and protectiveness regularly surfaced in participants' narratives. One clinician described her overweight client as "intelligent" and "sophisticated." Another described her client as "very motivated." In general, clinicians expressed much concern for their clients. One participant described being both surprised and

pleased by the progress her client was making in therapy, despite coming in for treatment only once every two weeks.

The interesting thing about her too was that the person who referred her to me said she only wants to come every other week, that's all she can afford, and I don't work that way, so if you want to see her, fine. And I don't like to see people every other week, but especially in this economy, you have to more and more. So I thought okay, and I was kind of pessimistic because every other week, my experience is much more diverted, and more frustrating and you just don't see the same kind of progress, but she just proved me wrong, she was like, just moving right along, and it was very satisfying and it sort of surprised me. It didn't feel like we had the same kind of intensity you would have, but it had its continuity, so it went really well.

Conceptualizations of Overweight and Obesity

As a Lifestyle Choice. A reoccurring theme in the interviews was that of the health consequences of overweight and obesity and the idea that such consequences could be prevented through changes in lifestyle. Health concerns were often raised by the clients themselves, sometimes by the social work clinician, and other times by family members or doctors outside of the therapeutic relationship. Three participants described clients who had come to therapy feeling anxious about their physician's warnings to lose weight. Much uncertainty was expressed, however, in ways of thinking about weight and health. Four participants believed that clients were seldom successful in maintaining weight loss. Two commented specifically on the negative effects of dieting and prolonged restrictive weight control. At the same time, all nine expressed concerns about the health ramifications of overweight and obesity, especially when clients already had health problems that clinicians felt were weight-related.

I'm more concerned about the health aspect because I have [the client's] lab reports and her glucose level. She's on Metformin and I talk about the consequences of this, what she's gonna do about losing this [weight]. She's got all these excuses, you know, 'I can't exercise,' and I've offered to refer her to a dietician, but she hasn't taken me up on this. But yah, I address it... She's in denial about the consequences this is having on her health. Her triglycerides are off the chart, her LDL's are high, her glucose is way over 100, so I talk about it from a health standpoint, I talk about the health consequences of diabetes, if

you don't do something about this and she's already got a little bit of nerve stuff in her feet, she's got the consequences of being overweight, the foot pain and stuff, so I don't participate in the denial at all, but am I making any headway? Probably not. In terms of her losing weight, she's 5'7, she should weigh 140 pounds. That's a lot to lose, almost 35 pounds.

As noted previously, most participants believed their clients were overweight or obese because they were overeating and inactive. As such, several participants talked about incorporating behavioral interventions into their work, such as encouraging healthy eating habits and regular exercise. Two participants talked about making referrals to nutritionists and three explored options such as Overeaters Anonymous and Weight Watchers if clients expressed interest in these programs. In general, dieting and weight loss efforts were not immediately encouraged or endorsed, however. Instead, clinicians framed these discussions in the context of their client's overall health and self-care behaviors.

While several participants gave their clients advice encouraging healthier eating and exercise habits, five specifically expressed interest in understanding the feelings and thoughts clients associated with their bodies, the purposes food served and the illusions clients associated with weight loss. Given that eight participants had training in psychodynamic theory, it is not surprising that many encouraged clients to explore the roots of their symptoms, relationships to their bodies and what these relationships meant to them, rather than simply focusing on symptom reduction.

If people come to me with the attitude that they want to lose weight, that's not a project I'm going to jump into, not that I'm against people trying to get healthy or feel better, but I try to get them to frame things as healthy as opposed to lose weight or "I want a different body." I'm much more interested in helping them figure out why they feel the way they do about their body and what is the actual problem... others' perceptions of them, or ways they attack their own bodies, or use food in destructive ways, but the weight itself is not something I participate with people in defining as a problem.

As a Form of Self-Regulation. Given participants' training and background, it is not surprising that clinicians believed weight and food served psychological purposes. There was a general consensus among participants that clients "used food" to soothe distressing emotions. Eight participants' narratives specifically reflected this belief, where clinicians felt clients overate in response to anxiety, stress and other unpleasant emotions. As stated previously, one participant felt her client developed an "addiction to food," and related her experience of working with this client to that of working with her drug using clients. She felt, however, that working with clients who were "addicted" to food was much more challenging because food was unavoidable and was such an integral way of connecting with others. Others similarly commented that because food was always available, it was a particularly quick and reliable remedy to clients' distress.

As a Form of Protection. Another reoccurring theme in participants' narratives was the idea of weight as serving a protective role. Terms such as 'shield,' 'armor,' and 'defense' commonly surfaced in conversations about clients. Fat was generally considered a way to maintain distance from others. Several participants commented on the protective function weight served for their clients, either to defend against deeper feelings of vulnerability or fear or to protect themselves from relationships. Most talked about using weight as tool to desexualize oneself, but one commented that for some of her overweight female clients, weight made them feel more "sexualized" and "on display." She spoke about her clients' feelings of discomfort with this visibility and noted that occasionally this attention led to body dissatisfaction that motivated weight loss efforts.

For some people, weight can feel protective that makes them less sexual and for other people weight makes them feel more sexual and more sexualized like big hips and big breasts. But you're on display in ways that you feel vulnerable and you wish that would go away....like stop noticing my body.

As a Way of Maintaining Connection. Another theme that arose in clinicians' narratives was the role of fat in maintaining attachments to caregivers. Two participants spoke about fat as a way of maintaining filial loyalty. Both clinicians believed the fat body related to separation guilt in that the fat itself thwarted clients' efforts to achieve autonomy and well-being. Another clinician believed her client communicated her anger towards her mother through her fat.

Her mother was, I think, was horrified that she was so fat, and I think it was sort like a gesture of "screw you! I'm gonna be fat!" and "you've never done enough for me," and "you like my brother better" and all that kind of stuff.

You know, it's complicated and she's got enormous guilt towards her parents...she's the youngest of seven from the Bronx and her family, they were very very upset with her moving out here, and it's sort of like I can move to get my own life, but I can't really let myself have everything I want here, which is getting married, having a husband and children because of guilt towards them. And I said weight is an obstacle to this [pauses]. She's very self-depriving and I think that's a compensation to her family of origin and her weight is a way of uh, you know, it supports this defense, that the kind of guy she wants to go home with is not gonna give her the chance when she looks like this.

In general, participants believed the body could act as a "container" for complex emotions and relationships. Three participants felt this was especially true for patients with significant trauma histories, where the body could be a "threat" or a place of "refuge."

I was working with someone who was sexually abused by a good friend of her parents for several years and the weight was a way she could feel somewhat protected...she was a big woman, she was tall and the weight enabled her to keep her a little bit more shielded from people that might abuse her. She did lose the weight actually, ultimately she got married she got married to a guy and ultimately they got divorced and it was not a terrible relationship and it enabled her to achieve a feeling of safety...and he wasn't bad to her. But the good thing about the relationship is that she felt safe and she lost a lot of weight and she wasn't fat at all when I last saw her.

Interestingly, only one participant talked about fat as serving a positive role in relationships. She felt this was in part due to cultural messages that were shifting towards greater acceptance of body diversity and the idea of “big as beautiful.”

...there are a lot of young women I'm finding who are overweight who I'm finding are fine with it, which you know, is sort of refreshing. So that there's that latter thing is kinda cool; that these young women are going, “hey, this is me, this is my body.” So there's that whole celebration of the very full figured woman being desirable, and that you don't have to look like Kate Moss.

As a Barrier to Relationships. All participants described overweight and obesity as presenting problems in interpersonal relationships. Several described weight as a barrier to having successful relationships, particularly for women and fatness itself as being “off-putting” and “isolating.” Overweight and obesity was most often described in terms of affecting one's overall level of attractiveness. These feelings were often reflected in clients' comments themselves and in the statements made by participants. One participant spoke about a client's investment in losing weight in order improve her desirability.

She wanted to be more attractive to men, I think...and she dated a lot of unavailable men before she finally got into a really good relationship. [Pauses]. She's been with someone now for a year and I think they're going to get married and it's really nice, but um, I think she felt unattractive, she felt unloved...like no one really cared about her.

Another participant commented on her own feelings that weight was an obstacle to a client looking her best and therefore being in relationship.

[The client's got] a lot [of weight] to lose, almost 35 pounds. I address it from a standpoint of it's getting in the way of the kind of men you want to meet. It's you know, but you know, they're so conscious about how people look! They're not gonna go for this. And she's got a gorgeous face, she's really a pretty woman and uh, you know, it's not easy.

One male participant made a more general comment about the role of weight and body in relationships, noting that it was indeed, something he felt was important to people's self-evaluations and the evaluations others made of them.

I tend to feel concerned about how much we emphasize those sorts of issues in our society. I feel concerned about people having shame about that, like internalizing a sense of shame about that because of the cultural messages and things like that [Pauses]. Those are the sorts of things that stand out...just concern for the way it affects people.

Concerns about the messages we get in our culture; the messages that are reinforced in our relationships, interactions, those sorts of things. I don't know where it starts, but it's there in the way we relate to people...and all those messages and cues get reinforced. I think everyone wants to feel desirable and attractive and our society has a fairly narrow view what leads to that.

As a Social Problem. Almost every participant's narrative reflected some reference to societal prejudice and discrimination directed towards overweight and obese people. There seemed to be a general understanding among clinicians that fat phobia has become increasingly more accepted and widespread. Only two female participants, however, specifically talked about the ways they incorporated this knowledge into their work. They believed that fat-phobia, coupled with a cultural obsession with thinness, often informed their female clients' relationships to their bodies and spoke with clients about the ways they may have internalized these messages. One participant reflected on his feelings that while bringing culture into clients' narratives could be helpful, he wondered if it risked disconnecting clients from their experiences.

I'll sometimes take a stance that's critical of the cultural messages, you know, I might make a statement that demonstrates that I think the way that our culture addresses those things is problematic or harmful. I don't like to get too caught up in those sorts of things, because that compromises the neutrality or could take the patient away from their own material...if I start railing on culture and how bankrupt it is, then the patient has lost my empathy and I'm on a tirade or soapbox criticizing culture; so I might make a comment that shows that it's a concern, that there are environmental factors that contribute to those feelings the person's having, but I still want to stay with the person's feelings and individual meanings the person has, and the feelings that means for the particular individual.

Although most clinicians recognized the existence and potential harm of an anti-fat sentiment, none specifically commented on the ways this understanding informed their work with their obese clients. As stated previously, there was a general consensus that overweight and obesity were problematic and necessitated change, particularly for obese clients. Clinicians'

approach with clients was helping them to consider what changes they could make to improve their health habits.

Only two participants, however, talked about society as being a possible focus of intervention. One participant felt overweight and obesity were constructed as “social problems” and “diseases that are perpetuated in people’s minds.” To her, it was important to help her clients consider the ways they have internalized messages that weight is under an individual’s control and encouraged her clients to reframe cultural messages that so often contributed to their body dissatisfaction. While she felt the role of culture was important to address, she also believed she could be most helpful to her clients by encouraging them to reflect on the ways cultural messages have shaped their attitudes towards themselves. Reflecting on how she integrates these perspectives, the participant remarked,

Of course, there are physical issues too, but the problem we can work on together is the loathing they feel towards themselves and that that kind of attitude towards themselves is one of the most damaging things that’s happening in their lives and we can address that attitude...helping people show kindness and compassion for themselves. The others issues, I mean of course they’re still there, this society is very fat phobic and all of those things are true, but if there’s not that loathing and hatred that they feel towards themselves, the other stuff is going to be much more manageable...and if their goal is to lose to weight it will be much less fraught if they’re doing so when its not tinged with hatred and moralism and a sense that they are failing.

The other participant commented on her belief that overweight and obesity was more a reflection of clients’ socioeconomic standing. She believed many of her clients were overweight or obese not because they were inactive or overeating, but because they did not have access or the resources to obtain nutritious foods. As a clinician in the community-mental health setting, she felt her clients were “just struggling to survive.” She commented, “these are people working to just stay out of the hospital, maintain their housing, ultimately get some kind of job...people who are struggling with basic survival in our society so it’s a matter of, ‘I don’t understand these

letters from SSI, how can you help me they're saying they're cutting my benefits off, Section 8 is threatening to evict me'...it's 'what can I get on the plate to feed myself at the end of the day.'” She felt changes to public policy were necessary to successfully address obesity, which she felt was problematic and was linked to high levels of stress and poverty. She felt that obesity could be best prevented by eliminating the social and economic disparities that so often led to this outcome.

Intersecting Dynamics

Perhaps one of the most common themes that arose in participants' interviews was the attention they gave to their work with clients around weight-related issues specifically. Clinicians seemed to have strong reactions to weight-based conversations with clients and these attitudes often dominated participants' narratives. Feelings most commonly experienced by participants included those of frustration, sadness, anxiety, helplessness and feeling responsible for clients. One participant who believed it was important to maintain neutrality around weight described an impasse she frequently found herself in with her overweight clients in discussions about weight.

I've had the experience with several people of almost at some point arguing with me, 'well, the problem is my body size. If I just change my body size I'd feel differently about myself.' And it can become a very circular argument, so that I think is a big challenge, when it becomes fixated on, and on there's not really an exploration or interest in the other aspects of the self or what's the fantasy about what would be different with a different body size.

This participant went on to speak about a powerful interaction she had with another client who regularly used her therapy to describe the difficulties she had losing weight. Unable to achieve this goal, this became a source of her feeling bad about herself and feeling like a failure. In the interview, the clinician commented that this added an additional element to their work that

made it difficult to feel helpful to her as her psychotherapist. While she felt she could sympathize with her client around this struggle, she found it difficult to reach any resolution with her, noting that this became a “repetitive and not very productive theme of [their] work together.” Another participant similarly described feeling ineffective around this issue. This felt particularly significant in the face of the social pressures encountered by her clients.

They can feel great in your office, they can feel accepted, they can feel like they understand more about themselves, how they think about themselves, how they look, how they're eating and they go out and within minutes or days they're right back to where they were, to feeling that they're horrible, you know, they're weak willed, they're too fat, that no one's gonna love them, or that their life is pointless...And it's just such a long-haul to get someone free of this; it just takes a very long time”

In most cases, participants did not actively encourage weight loss for their fat clients, though three believed this was necessary to prevent health problems. Among the three who considered this important, two described feeling guilty and responsible for not helping clients achieve this goal. One participant specifically spoke about her desire to “fix” her fat clients. Another hoped her clients would lose weight and wondered if she failed clients by not helping them do so.

You know, there's a couple of women that are very overweight and I feel bad, you know, I would like them to be able to take it on. I have one woman who is very very defended in general, and she is...it has come up that she has struggled with weight for many many years and she's really, you know, quite overweight. She has, you know, uh, when she brings it up, I'll address it with her, you know, but she's really cut down on coming and I feel bad. I mean I think that, or I wish that she were able to address it more because it's just so bad for her health, and I think it actually may interfere with her career because there's a lot of um, prejudice in our society against overweight people, particularly, I think more against overweight women, I think it may get in the way of advancing in her career, so I just wish that were more that I could have done or could do to help her address it.

Five participants discussed the challenges of holding the tension between an understanding of what it means to be overweight or obese in society alongside their theoretical knowledge, and how to integrate these views in the treatment setting. Many found it difficult to

work with their clients' internal experiences alongside powerful external pressures. In describing his work with a young female client, one clinician remarked,

I have a patient who's a professional musician so she's very concerned about her image and in particular her weight and navigating her image versus her sense of her true self, um, is a challenge for her. [Pauses]. This feeling that she has to compromise who she is or be someone else in order to get where she needs or where she wants to go in that industry. And she talks a lot about the stereotypes and things like that that exist in this industry. It's sort of like a game, and you have to play by the rules of the game. It doesn't mean it's right or good in her opinion, but you sort of have to play along, but in the way that she talks about it and thinks about it, it portrays that she doesn't feel that who she is good enough, or that she can just be herself and be successful in that industry. And it's challenging for me because on the one hand it seems like there may be a pathogenic belief associated to that, but on the other hand, there's also, well, some truth to that, that you do have to look a certain way to some degree."

Other participants commented that their own relationships to their bodies added an even greater level of complexity to the work around this topic. One participant commented that while she makes great efforts not to communicate her attitudes to her clients, this was sometimes difficult to avoid.

I think sometimes I have that urge, that somewhat irrational feeling that well, if they lost weight, life would be better for them, which I think what a lot of people who are trying to lose weight think, "if I lost weight, I'd have a job, or be happier or have a boyfriend," but I think sometimes I fall into that. Like, wow, she'd be really pretty if she lost 20 pounds, but of course I try not to let that slip out.

Another participant similarly felt that there was "always the dilemma" of whether she should comment on clients' weight loss and applaud their appearances if they achieved a weight loss goal. She wanted to support her clients' efforts for self-care, but expressed concerns about the messages she may be communicating to her clients.

There's part of me that can relate to that. Like oh yah, I sometimes feel that way too [that I have to lose weight] but when I see it them, I think, why? Why are you torturing yourself, why are you punishing yourself? You look great. Why are you suffering over this perceived uh, flaw? And then other times I see it more analytically, it does seem very related to anxiety and when people get anxious, they control their weight and that helps contain it and that's something they can control.

Another participant described what she believed to be the “inescapable” nature of body dissatisfaction, especially for women. She was aware of the potential for this to impact her clinical work, and commented on her belief that these messages could be easily communicated to clients.

I always think about my own countertransference because it’s such a slippery slope, you know...even agreeing with someone that they’re overweight, like yes, you really are, or yes, and what do you want to do about it? I mean, that could be my countertransference, like I think they’re unhealthy, or that they told me their doctor says that they’re unhealthy, and the tendency is to agree with the doctor, and that probably would be a mistake, you know.

She went on to comment on her belief that concerns about the fat body were unavoidable for women and were just a part of the “load that women have to carry in this society.”

I really don’t think anyone’s immune. And I have one friend that always follows her clients into the room because she’s very self-conscious about her behind and she doesn’t want clients looking at her butt! [Laughs] And I think it’s a little nuts myself, but you know, that’s what she does...because when she was little, someone made a comment that she’s really really pretty, but you know, her butt’s too big. I think it’s just inescapable, no matter what weight you are, no matter how beautiful you are.

CHAPTER 5

Discussion

This qualitative study examined the experience of clinical social workers in their therapeutic relationships with their overweight and obese clients. Overweight and obesity can be viewed through multiple frameworks and several were explored in the review of the literature. Semi-structured interviews were conducted with nine licensed clinical social workers and data were analyzed through a content-theme approach. Results indicate that clinicians' attitudes towards and experiences with their overweight and obese clients are multifaceted and depend largely on the unique subjectivities of clients and the clinicians working with them. However, several patterns were revealed in participants' narratives and these will be described in detail in a subsequent section of this chapter. One prominent theme was that clinicians' attitudes towards overweight and obese clients were primarily negative – clients were often perceived as “out of control,” “impulsive,” “in denial,” and as unable to care for themselves. Similar to the general population, participants also viewed overweight and obesity as an anomaly and as highly problematic for clients. Another prominent finding was clinicians' general acceptance of the belief that overweight and obesity are linked to overeating and that weight loss may be achieved through changes in eating habits. In addition, there was a general acknowledgement that overweight and obesity is a widespread problem that impacts clients in myriad ways. Almost every participant believed overweight and obesity were linked to poor physical health outcomes. In general, the fat body was also an indicator of psychic distress; many saw food as providing an

essential self-regulatory function and saw fat as serving a protective role. Perhaps the most striking finding of this study was that clinicians' experiences with their overweight and obese clients were marked with great challenge and complexity. This became particularly apparent around discussions about weight-related issues. At times, these struggles were related to problems their clients presented and other times, they seemed to arise out of clinicians' personal body experiences and exposure to cultural attitudes about health and beauty.

My Own Subjectivity Explored

The findings from this study cannot be separated from the experiences of the participants interviewed and therefore cannot be generalized to the population of licensed clinical social workers. Indeed, my own subjectivity similarly informs this project as it has influenced my research questions, my reactions to participants' responses, and the process of data analysis. As data were acquired and filtered through my lens, I believe it is necessary to describe how my own interest in this topic developed.

My interest in this study stems from a combination of personal experience and a diverse background in the fields of medicine and psychology. Prior to entering graduate school for social work, I spent several years working with a University-based research team that assessed and designed programs to support medical professionals' counseling behaviors with their patients. My work specifically explored physicians' attitudes and behaviors counseling patients about sensitive topics such as safe sexual practices, substance use and intimate partner violence. Counseling on overweight and obesity were also included in this research, as both were framed as potential health problems that were challenging and delicate topics to broach with patients. For one of my research projects, I interviewed physicians about their counseling experiences with their overweight and obese patients and used these findings to create an intervention to

assist physicians in helping their patients engage in healthier habits. As the intervention was based upon the theory of Motivational Interviewing (Miller & Rollnick, 2002), I began to recognize the importance of a client-directed approach. At the same time, I also came to believe that with enough effort, will-power and access to the right resources, individuals could control their weight. Although there is some research that refutes this belief (Bacon, 2008; Gaesser, 2002; Robison, 2003), this attitude informs my experience today and is one I continue to remain mindful of in my work with those overweight and obese clients struggling with their weight.

Indeed, my own relationship to food and fat during this time was complex and I had a long history of body dissatisfaction, frustrations with dieting and a “fear of fat” that felt particularly threatening as a white woman in our society. This necessitated much deeper personal exploration. With my own anger and guilt unveiled, I began to see a strong link between body dissatisfaction, obesity prevention and the development of eating disorders. It was here that I formally began my journey towards clinical social work – my desire to explore the mind, understand the nuances of individual experience and to effect change on a social level.

In the four years prior to attending Smith College, I worked with a nonprofit organization that encouraged women to develop loving relationships to their bodies. As I worked on these programs, my network of colleagues expanded and I began to get acquainted with the concept of “Health-at-Every-Size,” fat pride and the fat acceptance movement. Over time, I was introduced to women who proudly proclaimed they were “fat” and loved their bodies, and met therapists who challenged the thin-ideal and questioned the politics behind the woman’s “normative discontent” of her body. I was struck by these women’s experiences, the freedom with which many walked through the world, and the courage they had to fight against attitudes that I myself had felt stifled by for so many years. Through these experiences, I learned that my personal

struggles with body dissatisfaction could not be generalized to everyone. Not all women allowed their bodies to speak for them – the fat body was not necessarily linked with dissatisfaction and overeating was not necessarily linked with fat. Over time, I met many individuals who were not overeating, but were fat and were satisfied with their bodies, others who were not overeating, but were fat and dissatisfied, and fat people who were dissatisfied with their bodies and were overeating. These experiences culminated in a complex arrangement of feelings of curiosity, enthusiasm and skepticism. It is these feelings that have grounded and inspired this research project.

Review of Findings

Analysis of the data revealed several themes underlying the experiences of clinical social workers with their overweight and obese clients. By virtue of their training, licensed clinical social workers seek to understand the “whole person” in the context of their biological, psychological and social worlds. As such, overweight and obesity may provide one of several pieces of information about clients’ lived experiences that must be considered as operating alongside other forces in clients’ lives. The data presented above indicate that bodies – both the client's and clinician's – do inform the therapeutic encounter and that the extent to which this occurs varies from one client to the next. As a whole, participants were keenly interested in their clients’ subjective experiences and used this as the primary source of understanding clients, their psychological difficulties and their treatment needs. Every participant approached clients’ concerns with curiosity, openness and an inherent understanding of the nuances of individual experience. Client safety and trust was of primary importance and clinicians felt approaching clients from a place of acceptance and neutrality was critical for safety to be established. Not

surprisingly, every participant made a strong effort to understand and empathize with their clients' experiences, which were highly varied and unique.

There was a general consensus among clinicians that clients did not enter therapy to specifically address overweight and obesity and that neither were direct targets of therapeutic intervention. Nevertheless, findings reveal that clinicians held many attitudes towards those clients they identified as overweight or obese. While both positive and negative attitudes were conveyed in participants' narratives, clinicians primarily viewed their clients negatively. Some participants described their overweight and obese clients as "a mess," "out of control," "eating disordered," "impulsive," and "in denial." Obese clients were seen as self-destructive, physically and socially impaired and limited in what they could achieve. The similarity to which these reflect stereotypes in society, indicate that clinicians may harbor judgments and biases against fat people, particularly towards those who are obese.

In understanding these findings, however, it must be said that almost every participant worked with their clients for several years and that these conclusions were based upon a thorough understanding of each client's background and presenting problems. Thus, while it is possible prejudice towards fat people played a role in these reactions, no conclusions can be drawn from this study. Negative feelings reported may or may not have had a relationship to the client's size and many of the experiences clinicians reported may have occurred whether the client was fat or thin. Indeed, one limitation of this study is that it did not compare clinicians' attitudes towards their obese and nonobese clients. This is an important area for future research as it could reveal much about clinicians' attitudes towards their fat clients. The findings from this study, however, lead me to believe that the therapeutic relationship may moderate the effect of any weight-related stigma, as weight itself was not a primary factor in developing an overall

understanding of clients.

As exploration of this topic was a primary intention of this project, it may be useful to look at the existing literature to clarify whether size bias is present in the therapeutic relationship. In their study, Young and Powell (1985) compared attitudes towards obese and nonobese clients by providing mental health professionals with a case study and photograph of a client digitally altered to represent different degrees of obesity. Findings revealed that obese clients were judged to have significantly higher rates of psychological distress and more severe symptoms than nonobese clients. This suggests that clinician bias may have played a part. However, Dennis (2004) and Agell and Rothblum (1991) found that while clinicians may hold negative attitudes about fat people in general, these did not significantly affect diagnosis or treatment recommendations with fat clients. Indeed, this finding seems more consistent with the present study. Certainly, some overweight and obese people do suffer from eating disorders, depression and impulsivity and it is likely they enter therapy to address these issues. Not all overweight and obese people do, however, and clinicians must take caution to not assume this connection. As revealed in the analysis, many participants were mindful of this. Perhaps a more important question that clinicians should ask with clients is how much of a client's suffering is directly related to the experience of being fat in this society? Weight-based discrimination in the United States is pervasive, socially-sanctioned and occurs in almost all areas of living (Puhl & Brownell, 2001; Roehling, 1999). Repeated and unrelenting exposure to anti-fat attitudes is likely to impair one's psychological health. Helping clients see the contribution of societal prejudice to their suffering is not only consistent with social work values, but may relieve clients from self-blame.

As described in the previous chapter, participants experienced their work with their overweight and obese clients as highly challenging and complex, particularly around weight

related issues. Clinicians' narratives indicate that psychological, social, and biological perspectives towards overweight and obesity were difficult to hold and tease apart in treatment. Clearly, clinicians viewed overweight and obesity as highly problematic. Whether this represents bias or fact is difficult to determine given the controversy surrounding weight and health. However, findings from this study parallel those of Dennis (2004) who found that the fat body was not viewed with neutrality – the thinner body was perceived as healthier and more desirable. That clinicians' attitudes reflected those of the general population is perhaps not surprising given that thinness is elevated and celebrated in Western culture (Kwan, 2009). What is surprising, however, is that only two clinicians seemed to recognize these reactions and the affect they could have on client care. Out of the nine participants, the clinician practicing full-time in the community mental health setting seemed most cognizant of her biases. She specifically commented that as a white woman from a middle-class background, the meaning she makes of her body and the importance she ascribes to maintaining a thin frame often differed from that of her clients, many of whom valued a larger appearance. She was aware that her ideas about health and attractiveness did not always parallel those of her clients and was careful not to project her own body anxieties onto them. As the analysis above revealed, however, almost every other female participant struggled to separate their own weight-related beliefs from those of their clients. This is most clearly revealed in the six statements that follow, three of which were included in the previous chapter.

I address it from a standpoint of it's getting in the way of the kind of men you want to meet. It's you know, but you know, they're so conscious about how people look! They're not gonna go for this. And she's got a gorgeous face, she's really a pretty woman.

I worked with one woman who was really driven and she lost the weight, she went to Weight Watchers, she lost the weight, she kept it off as long as I saw her... she probably lost 50 lbs, and it almost wasn't part of the therapy. When she came in she was just a

mess emotionally, been rejected by this boyfriend in the Midwest and moved back out here and she kinda knew she had to lose weight – this wasn't really discussed. She was overweight by at least 50 lbs – looked terrible. On her own, lost the weight for as long as I saw her [Pauses]. She got remarried um, her life did get better and better and she kept [the weight] off for three years.

She was someone who had lost her mother at a young age, had a somewhat cold, withholding stepmother...She's almost 40 now, she was 36 when I first started seeing her. She had never been in therapy, she had never dealt with a lot of these issues so it seemed to go very nicely that as we started working together, um, the weight kind of came off, it was really nice.

You know, there's a couple of women that are very overweight and I feel bad, you know, I would like them to be able to take it on...I wish that she were able to address it more because it's just so bad for her health, and I think it actually may interfere with her career because there's a lot of um, prejudice in our society against overweight people, particularly, I think more against overweight women. I think it may get in the way of advancing in her career, so I just wish that were more that I could have done or could do to help her address it.

I had one woman briefly who was very very obese – just a mess – but she also smoked pot twenty-four seven... and I approached her about her weight and she just really was in denial. She says, “You know I can dance, I can do anything else anyone else can do,” and you know, I challenged her on that, and I said, you know my concern is that you're okay, you may not be feeling the aches and pains now, but there are consequences of this down the road.

I think [obesity] is one of the hardest things to fix you know. Drug addiction is almost easier. For alcohol addiction, you get the person to commit to a program they can actually, if they're really committed, they can change their social circle, they can avoid going to the place where they maybe bought drugs, they may have to change friends sometimes, they can avoid bars...but you can't avoid food.

These statements might provide some useful insight into why clinicians felt weight was a difficult topic to broach with clients and why fat itself was seen as a barrier to the relationship. Certainly, there are several reasons why this may have been the case, but what is most clearly revealed above are clinicians' own feelings of anxiety, fear, guilt and helplessness in working with clients around these issues. This may be indicative of a client's defensive functioning (i.e. projective identification), but it could also evidence countertransference reactions stemming from clinicians' own personal experiences and exposure to cultural messages. Underlying

conflicts around the body, attitudes that fat is pathological, unhealthy, repelling, and undesirable and beliefs that weight is solely under the individual's control could have easily been communicated to clients. It seems possible this may have led to some of the challenges and impasses clinicians described. What were clinicians' well-intentioned goals for their clients? What did clients themselves hope to achieve? What messages may have been communicated through these interactions? What is clearly missing from this study is the perspective of the client. Although it is likely clinicians were supporting their clients in their desires to lose weight, it may be useful for clinicians to consider how dominant cultural attitudes about the body and health may be reinforced through such interactions. The therapeutic relationship is indeed an important one. Remaining neutral about the validity of clients' wishes to lose or not lose weight, while helping them explore the realities of these options, may very well be the difficult but essential task of the clinical social worker with these clients.

Perhaps an even more important question is why compared to the male participants, so many female participants struggled in their work around this issue? The helplessness, lack of progress, sadness and confusion so many female clinicians described having in their work with clients was startling to this researcher. Laura Brown (1989) may offer a useful perspective in understanding this. She proposed that this guilt and the combined desire to protect clients reflects clinicians' own conflicts between the wish to rid themselves of oppression and the wish to align with cultural ideals. Internalized anti-fat attitudes may be so ingrained that they remain an invisible but powerful element in the therapeutic relationship. Perhaps this explains one participant's comment that discussions about weight were a "repetitive and not very productive theme" of her work and why another felt body dissatisfaction was "inescapable" for women. Must clinicians accept this dilemma? Is this the message we wish to convey to our clients? It

seems that as long as the anti-fat sentiment remains accepted and unexamined, clinicians will unwittingly participate in shaming clients and in reinforcing oppressive cultural attitudes.

It is also critical to note, however, that clinicians may have seen overweight and obesity as so problematic due to the fact that eight of the nine had training in psychodynamic theory. Similar to the perspectives of Glucksman (1989) and Slochower (1989), most participants believed clients used weight as a defense or for protection. Indeed, bias may have played a role in this and could have easily added to the challenges clinicians faced in their work. However, as discussed in the literature review, psychodynamic theory itself speaks of fat as an aberration – a way to conceal one’s “true self” and protect oneself from being fully known in a relationship. As many participants described, some of their clients feared relational need and were unable to use the therapist as a soothing other. As such, clinicians’ attitudes may have stemmed from a strong understanding of traditional analytic views towards fat.

As this analysis revealed, clinical social workers also believed strongly that overweight and obesity were preventable and resulted from poor lifestyle choices. Although most clinicians did not directly encourage weight loss, these efforts were generally not discouraged either. As clinicians operating from the biopsychosocial perspective, we should be aware of the ways the body and mind sustain themselves through physiological processes. It is notable that participants in this study were not familiar with the futility of dieting, the biological determinants of body size or the concepts of “set-point” or “natural weight” (i.e. the weight range a person is genetically programmed to maintain). It seems possible, however, that the research questions were limited by the scope of material they could elicit. Asking clinicians about their beliefs about the efficacy of dieting may have led to these results. However, as these terms (“set-point” or “natural weight”) are most commonly referred to in the literature on eating disorders, it is

likely participants were not familiar with this language, as I did not specifically interview specialists in the treatment of these issues. As this study indicates, weight-related issues frequently surface across all specialties of practice. As such, clinical social workers should be aware of the biological realities of the body. Social work programs should include training on physiology, nutrition and biochemical processes to insure that students enter the field with this knowledge. Furthermore, as therapy shifts more towards helping clients learn how to regulate their affect and other internal states, the brain-body-mind connection may become particularly essential to the treatment process.

This analysis revealed that clinical social workers have much to understand about fat, health and how their relationships to their own bodies inform their work. That being said, clinicians are well attuned to their clients' stories and view each client as an individual with strengths, a distinctive history and a venerable perspective. Clinicians are careful to not make assumptions about their clients, are aware of their own subjectivities in informing their perceptions about clients' bodies, and approach each client from a stance of curiosity and openness. Nevertheless, these data reveal that as social workers, we are not immune to cultural perceptions and ways of thinking.

As discussed in the literature review and confirmed by this analysis, overweight and obesity can be framed in myriad ways – it may be seen as a physical health concern, an eating disorder, a barrier to relationships, a source of protection or a source of oppression. Conclusions from this study cannot be drawn, as each client and clinician brings with them a unique history and experience that is gradually revealed and transforms over time. Our task with our clients, therefore, is to understand our own relationship to fat, understand what it means to us and

examine what it means to our clients. We must explore how we use these meanings in our work and consider how we may wish to do so in the future.

Limitations of the Study

There are several limitations to this study. This was a small, exploratory study, intended to identify themes from narrative data. While the small sample size (N=9) allowed for in-depth and rich material about clinicians' experiences with their overweight and obese clients, findings cannot be generalized to the wider population. With access to more time and resources, the study would have benefitted from more participants. Another principal limitation of this study is that the sample consisted of all white, heterosexual participants, seven of whom were women. Future research should gather information from a more diverse sample, as attitudes and responses to overweight and obese clients are likely to differ based on individual history. The fact that participants self-selected to be in this study also limits the validity of the findings. Most participants who joined the study had interest in body image issues and described a personal history with weight-related struggles or body dissatisfaction.

Another limitation to this study is the bias I hold in this particular subject area. As someone with a complex relationship to my body and experience in both eating disorder and obesity prevention, my own questions around how to work with clients has been consistent throughout this research project. The link that I believe exists between size oppression, body dissatisfaction, obesity and eating disorders has indeed, been conscious through this process. That said, I worked to keep my personal biases separate from every stage of the research process.

Given the opportunity to do this research again or with access to more resources, I would interview a greater number of participants. I would also include a more diverse sample and interview clinicians in wider range of practice settings, perhaps by using a stratified sampling

procedure. As differences emerged in the attitudes and practice experiences between those in private practice and those in community mental health settings, this seems particularly important to address in future research. In addition, exploring clinicians' attitudes and practice experiences with clients was a lofty task, as both encompass a wide range of factors. Having completed this research project, I believe two separate studies on each topic would have proven more useful. These data revealed that while some clinicians are aware of their negative attitudes towards fat people in general, they were unlikely to consciously hold such biases towards their clients. Indeed, the therapeutic relationship may even moderate the effects of any bias. Nevertheless, as clinical social workers, we must be aware of the attitudes, assumptions and beliefs we carry with us because as this analysis revealed, they may be communicated to our clients. Future research should assess clinicians' attitudes through a quantitative component in order to maximize study validity and reliability. The anti-fat attitudes questionnaire (Crandall, 1994) may be one such avenue to do this.

Conclusion

As America's "War on Obesity" continues to mount, questions about weight and what it means to be healthy will continue to emerge. The fat body has become a salient aspect of identity that is relentlessly targeted in society. Clinical social workers occupy an important and challenging position in understanding and addressing the needs of these individuals. As psychotherapists, we seek to create a therapeutic alliance, understand our clients' subjective realities, and acknowledge the oppressive forces at play in the world and in the therapeutic work. As allies and advocates, we seek to give a voice to those most vulnerable, amend injustice and create opportunities for change on both individual and systemic levels. Overweight and obesity

represent a complex nexus of issues concerning physical health, psychological health, normative standards of beauty and social oppression. What sense do we make of these multiple factors? How do we integrate these understandings into our work? What is our tolerance for fat? And finally, how is our own relationship to fat communicated to our clients? We must examine our answers to these questions while remembering that weight is, at its core, paradoxical – at the same time it may destroy and subjugate the self, it can affirm and protect the self. We must recognize this paradox as we engage in therapeutic work and help clients articulate how they use their bodies to both punish and replete themselves. We must examine our own beliefs and understand the ways these collide and intersect with our clients'. We must make use of the information provided to us in our relationships with our clients and always remain curious about what is uncovered.

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Appendix A

Recruitment Letter

Dear Clinical Social Worker,

My name is Alyssa Bogetz and I am writing to you as a Masters student from the Smith College School for Social Work to request your assistance in research that I am conducting for my Masters thesis.

The purpose of this research project is to explore the nature of clinical social workers' attitudes towards and practice experiences with their overweight and/or obese patients. Government statistics report that 68% of American adults are overweight or obese. As such, we are likely to see many patients in our practices whom we classify that way or who classify themselves that way. Awareness of our own attitudes about these issues and reflection on the ways they impact our work may help us develop better therapeutic relationships with our overweight and/or obese patients.

I am hoping you are interested in contributing to the field's understanding of overweight and obesity by participating in a one-on-one 45-minute interview with me. This is a qualitative study and all interviews will be audio-recorded. The interview itself will consist of only five questions in order to allow plenty of space for free association and elaboration of ideas. Qualitative research is often utilized in clinical social work because it is useful for understanding complex human interactions that are difficult to quantify.

My research method is designed to maintain strict confidentiality as consistent with Federal regulations. Identifying information will not be linked to any study materials. If you are a clinical social worker with at least one year of practice experience post-licensure and are currently working with at least one client whom you visually identify as lying on a continuum from "slightly overweight to extremely obese" -- or have terminated with such a client in the last year -- please consider contacting me at the email address or phone number listed below. I look forward to the experience as something that will be mutually beneficial and will contribute to our ability to empathically engage with our patients.

Thank you very much for your interest and consideration.

Sincerely,

Alyssa Bogetz □

Smith College School for Social Work

(personal information deleted by Laura H. Wyman, 11/30/12)

Appendix B

Screening Interview

Thank you for your interest in participating in my research project. As you may already know, this study has strict inclusion criteria. I will need to ask a few questions to confirm that you are an eligible participant.

1. Are you a licensed clinical social worker?
2. Do you have at least one year of practice experience post licensure?
3. Are you currently engaged in clinical practice with one or more patients whom you visually identify as falling somewhere on a continuum from slightly overweight to extremely obese?
4. If your current caseload does not include at least one overweight or obese patient, have you terminated with such a patient within the past year?

Does Not Meet Study Criteria

Unfortunately, you have not met study criteria. I thank you very much for your interest in this project and hope you will find this work useful to your practice.

Meets Study Criteria

You have met study criteria. Do you have any questions about my project?

I would like to mail you a hard copy of the informed consent letter so you can learn more about this project and what your participation will entail. Can you please tell me the address you would like me to send the informed consent to?

What's the best time for us to meet? Ideally, our interview would take place within the next 2 weeks.

You may choose not to participate upon receiving the informed consent letter. If you're no longer interested in the study, please inform me by phone at **(personal information deleted by Laura H. Wyman, 11/30/12)** as soon as possible.

Appendix C

Informed Consent

Dear Participant,

My name is Alyssa Bogetz and I am a Master's level graduate student at Smith College School for Social Work. I am conducting research for my thesis project, which will explore the nature of clinical social workers' practice experiences with their overweight and obese clients. Clinical social workers are likely to work with a number of patients whom they might describe as "overweight" or "obese." Your participation has been requested because you have experience working with these clients. This study is being conducted as part of the requirements for my Master's degree and may also be used in future presentations and publications on this topic.

If you choose to participate in this study, you will sit with me for a one-on-one audiotaped interview that will last approximately 45 minutes. As a part of the interview, I will ask you to answer a few demographic questions. Research questions will investigate your attitudes towards your overweight and obese patients and how you address and/or respond to these issues in your practices. t

As a participant, it is understood that you are a licensed clinical social worker with at least one year of clinical practice experience post-licensure. It is also understood that you are currently working with at least one client whom you visually identify as lying somewhere on a continuum from slightly overweight to extremely obese. It is also understood that if are not currently working with such a client, you have terminated with one in the past year. I will transcribe all interviews. If an additional transcriber is needed, however, he or she will be asked to sign a confidentiality pledge.

There are no major risks to participating in this study. However, it is possible your participation may trigger uncomfortable or difficult feelings related to your own body or your experience working with your clients. As a participant, you may refuse to answer any question. You may also withdraw from the study at any time prior to April 1, 2012. Should you choose to withdraw your participation, all materials related to you will be immediately destroyed. There will be no financial benefit for participating in this study. However, it will provide an opportunity for you to reflect on your attitudes and reactions to your overweight and obese clients. You may also gain a new perspective in developing therapeutic relationships with these clients. Your contributions will provide information that may be useful in furthering the knowledge of clinical practice with this population and may add to social work education and training programs.

If you choose to participate in this study, strict confidentiality will be maintained as consistent with Federal regulations and mandates of the social work profession. The audiotaped interview will be assigned a number for identification and you will not be asked to identify your name while the tape is running. You will not be asked to identify your clients at any time during the research process. Any identifying information that is inadvertently recorded will not appear in the transcriptions. All transcriptions related to your interview will be linked to the assigned number. My research advisor will be the only person with access to the data. However, as

mentioned previously, the data will not include any identifiable information. In the final report and in potential future publications or presentations, the data will be presented as a whole. All electronic data will be protected and notes, tapes, transcripts and additional study materials will be kept in a secure and locked location for a period of three years as required by Federal guidelines. Should my need for study materials extend beyond the three-year period, all materials will continue to be kept in a secure location. All materials will be destroyed when no longer needed.

Your participation in this study is completely voluntary. You are free to refuse to answer any specific questions and you may withdraw from the study at any time before or during the interview. You may also withdraw from the study after the interview. The final withdrawal date will be April 1, 2012 when the report will be written. Should you choose to withdraw, all materials pertaining to you will be immediately destroyed.

If you have any additional questions about the study or wish to withdraw, please feel free to contact me at the address below. If you have any concerns about your rights as a participant or any aspect of this study, I encourage you to contact me at **(personal information deleted by Laura H. Wyman, 11/30/12)** or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. You may also contact me by email at alyssasfprg@gmail.com.

Enclosed you will find an additional copy of this letter as well as a stamped and addressed envelope. Please mail me one signed copy of the consent letter. You may keep the other copy for your records.

Alyssa Bogetz
(personal information deleted by Laura H. Wyman, 11/30/12)

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Participant's Signature: _____ Date: _____

Researcher's Signature: _____ Date: _____

Please keep a copy of this form for your records. If you have any questions or wish to withdraw your consent, please contact Alyssa at **(personal information deleted by Laura H. Wyman, 11/30/12)**. Thank you for taking the time to participate in this research project. Your help is immensely appreciated.

Appendix D

Human Subjects Review Committee Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 12, 2012
Alyssa Bogetz

Dear Alyssa,

You did a lovely and professional job with your response letter and a very thoughtful job in your changes. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your research.

Sincerely,

A handwritten signature in black ink, appearing to read 'David L. Burton', with a long horizontal flourish extending to the right.

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee
CC: Diana Fuery, Research Advisor

Appendix E

Interview Guide

I would like to start by thanking you for your interest in this study and for taking the time to speak with me today. This interview will take approximately 45 minutes. In the time that we have, I will ask you to answer a series of five questions regarding your attitudes towards and practice experiences with your overweight and/or obese clients. I want to remind you that participation in this study is voluntary, and that you may refuse to answer any question at any time. You may also withdraw from the study at any point during this interview should you wish to do so. As noted on your consent form, all study materials related to your participation will be kept in a secure location. If you withdraw your participation all study materials related to you will immediately be destroyed.

Before we begin, do you have any questions for me about this project and your rights as a participant in this study?

First, I would like to ask you a few questions about yourself, your practice setting and your patient population.

- How many years have you practiced clinical social work?
- What is your current practice setting? What are the demographics of your patient population? (i.e. gender, race, ethnicity, age, socioeconomic status, sexual orientation)
- What theoretical frame(s) do you practice from?
- What is your age?
- How do you choose to identify to your:
race and/or ethnicity
gender
socioeconomic status

Now, I would like to ask you a few questions about your practice experiences with your overweight or obese clients. Please take a few moments to think about one or several of these clients.

In your practice, what indicators (visual, perceptual, numerical, etc) lead you to identify a client as overweight or obese?

In your practice, how do you typically address and/or respond to issues, weight related or otherwise, with your overweight and/or obese clients?

What are your own attitudes towards issues of overweight and obesity? Is this an important issue to you personally? Why or why not? In what ways, if at all, does your own attitude influence your work with these clients?

In your practice, what are the biggest challenges you experience in your work with these clients around issues of weight and/or body size?

Given your practice experiences, what do you think is the most important thing to say, or attitude to adopt, in responding to overweight and obese clients struggling with weight and body concerns?

We have reached the end of the interview. Thank you very much for taking the time to participate in my research project. Your support is greatly appreciated. Please feel free to contact me at **(personal information deleted by Laura H. Wyman, 11/30/12)** should you have any questions, comments or concerns about your participation in this study.