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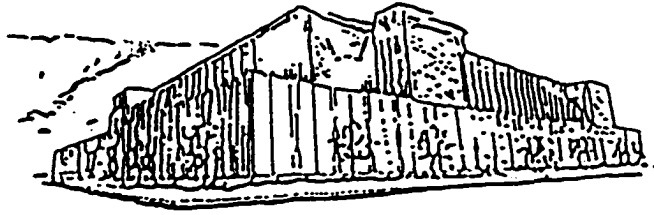
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FAT BIAS AMONG PSYCHOLOGISTS: IMPACT OF CLIENT WEIGHT  
ON CLINICAL JUDGMENTS AND TREATMENT PLANNING

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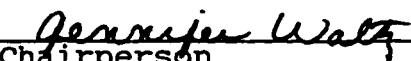
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Psychology

Fat bias among psychologists: Impact of client weight on clinical judgments and treatment planning (103 pp.)

Chair: Jennifer Waltz, Ph.D. *gw*

Bias and discrimination against fat people is common in Western society, and psychologists are not immune to the prejudices of the culture in which they live. The present study was designed to examine the influence of client weight on psychologists' clinical judgments and treatment planning. Participants were selected randomly from four divisions of the American Psychological Association, and were mailed a self-description and photograph of a client. Photographs depicted the same Caucasian woman, appearing either fat or non-fat. Client weight significantly influenced participants' provisional diagnoses, treatment goals, estimations of client effort, and predicted prognosis; findings were in the direction of more negative views of the fat client. Younger, female, and less experienced psychologists exhibited more bias against the fat client. Suggestions for intervention are proposed.



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Fat bias among psychologists: Impact of client weight  
on clinical judgments and treatment planning

Bias against fat people<sup>1</sup> has been described as one of the few "acceptable" prejudices in Western culture today (Schoenfielder & Weiser, 1983). Both the experiences of fat people and the empirical literature document this pervasive form of prejudice. In empirical research, this bias is commonly expressed in negative evaluations of fat people and the attribution of negative characteristics to fat people (Galper & Weiss, 1975; Klesges, Klem, Hanson, Eck, Ernst, O'Laughlin, Garrot, & Rife, 1990; Larkin & Pines, 1979; Maddox & Leiderman, 1969; Staffieri, 1967). A concomitant discrimination against fat people has also been empirically documented, including employment and educational discrimination (Crandall, 1991; Crandall, 1995; Larkin & Pines, 1979; Klesges, et al., 1990). Although many writers focus on women's experiences of fat bias (Brown, 1989; Brown & Rothblum, 1989; Chernin, 1981), both sexes are vulnerable to experiencing bias and discrimination based on their weight (Rothblum, Brand, Miller, & Oetjen, 1990). As members of this culture, mental health professionals

1. Footnote: Use of the term "fat" is consistent with current researchers and activists who write about fat oppression. See discussion of this on page 5.

are not immune to its prejudices. Research has demonstrated that a variety of client characteristics can influence a clinician's psychological evaluation, therapeutic interaction, and treatment recommendations (Ford & Sbordonne, 1980; Hobfoll & Penner, 1978; Loring & Powell, 1988; Strickland, Jenkins, Myers, & Adams, 1988). However, only one published study has examined the impact of client weight on clinicians' perceptions of clients (Young & Powell, 1985). These researchers found that fat clients were perceived as having a higher degree of various types of psychopathology than non-fat clients. However, it is unclear what influence, if any, these biased perceptions have on the psychotherapeutic treatment of fat clients. Given the potential impact of this bias on the psychotherapy of fat people and, thus, on the lives of fat clients, it is critical that this question be examined empirically. The present study is designed to address this by assessing psychologists' clinical perceptions and treatment recommendations for fat and non-fat hypothetical clients.

#### Fat Oppression

Fat oppression is hatred and discrimination of fat women, solely because of their body size.

It is the stigmatization of being fat, the terror of being fat, the rationale for a thousand diets

and an equal number of compulsive exercise programs.

It is the equation of fat with being out-of-control, with laziness, with deeply-rooted psychopathology, with ugliness (Brown & Rothblum, 1989, p 1).

More generally, fat oppression has been defined as "the fear and hatred of fat people, particularly women, and the concomitant presence of oppressive and discriminatory practices aimed toward fat people..." (Brown, 1989, p 19). As noted above, research has clearly demonstrated that negative perceptions of fat people and discrimination against fat people are both common in the United States (Breytspraak, McGee, Conger, Whatley, Moore, 1977; Crandall, 1991; Crandall, 1995; Galper & Weiss, 1975; Klesges, et al., 1990; Staffieri, 1967). However, the equation of fatness with "badness" is not consistent across cultures (Beller, 1977; Crandall & Martinez, 1996; Furnham & Baguma, 1994), and has not always been the case in Western culture (Beller, 1977; Chernin, 1981; Seid, 1989). As recently as the early 1900's, women often overate purposefully in order to gain weight because, "...their bodies seemed more beautiful to them when they were fat" (Chernin, 1981, p. 86). Fat people were viewed as cheerful, well-adjusted, productive, and prosperous; however, a variety of developments in the fields of medicine, psychology, culture, and fashion began to alter

this view toward the one held today (Beller, 1977; Seid, 1989).

Research has demonstrated that the "ideal" female form has consistently decreased in weight since the late 1950's, apparently plateauing in the late 1980's at 13 - 19% below the expected weight of women given their age and height (Garner, Garfinkel, Schwartz, & Thompson, 1980; Wiseman, Gray, Mosimann, & Ahrens, 1992). This finding cannot be attributed to a general decrease in women's average weight during this time, since the weight of the average woman under age thirty actually increased during this period (Garner, Garfinkel, Schwartz, & Thompson, 1980). Alarming, researchers conclude that the plateau in the late 1980's is simply the result of a "floor effect" in ideal weight; that is, a further decrease would be almost impossible and decidedly dangerous (Wiseman, Gray, Mosimann, & Ahrens, 1992). Women who reach this ideal already meet a primary criteria for Anorexia Nervosa as defined in DSM-IV, i.e., body beliefs in current Western culture that 1) fat is bad and 2) the ideal weight for women is below that considered "normal," can lead millions of women to self-hatred and self-starvation, particularly those women who are far from the ideal. weight less than 85% of that expected (American Psychiatric Association, 1994). The converging beliefs in current Western culture that 1) fat is bad and 2) the ideal

weight for women is below that considered "normal," can lead millions of women to self-hatred and self-starvation, particularly those women who are far from the ideal.

### Use of the term "fat"

Although in lay use in the United States the term "fat" is considered to be a negative descriptor with an insulting connotation, use of the term "fat" in this paper is consistent with current researchers and activists who write about fat oppression. It is believed by writers on fat oppression that to use a word other than "fat" implies that there is something about fatness to be concealed or avoided. Other, more traditional terminology has been rejected by these authors for several reasons. "Obese" is a medical term, and "being fat is a physical characteristic, not a disease" (Goodman, 1989, p. 12; Barron & Lear, 1989). The term "overweight" is not used because it assumes that there exists an objective, ideal weight which some people are "over" (Bennet & Gurin, 1982).

Beyond these theoretical problems with the current popular terminology, a problem of operationalization is also present in research on fatness. Numerous terms have been used to describe various weight categories in this literature, including "mildly overweight," "moderately overweight," "overweight," "obese," "severely obese," "morbidly obese," and even "super-obese." This would not be

problematic if these terms fell into discrete categories and were used consistently. However, researchers have used different terms to refer to the same weight category, have used the same term to refer to differing weight categories, or have neglected to define their terminology at all. Thus, for the theoretical and empirical reasons described above, the term "fat" will be used in the present study. When two different degrees of fatness are considered within a study, these will be labeled "fat" and "very fat," for differentiation. For purposes of discussion, Brown (1989) suggests that a good operationalized definition of a non-fat person is someone who can buy their clothing size off the rack in any store.

#### Bias and discrimination

Although the Latin word "obesus" means "well-fed" (Mustajoki, 1987), this positive connotation of fatness is no longer present in Western culture. Findings of bias against fat people are consistent across respondent age groups (Lawson, 1980; Stager & Burke, 1982), socioeconomic levels (Maddox, Back & Liederman, 1968), ethnic groups (Crandall & Biernat, 1990; Maddox, Back & Liederman, 1968), respondent weight status (Crandall, 1994; Crandall & Biernat, 1990), and sex (Goodman, Richardson, Dornbusch, & Hastorf, 1963; Lawson, 1980; Lerner, 1973; Lerner, Karabenick, & Meisels, 1975; Stager & Burke, 1982).

Many early studies demonstrated the prevalence of bias against fat children by other children and adults. Children as young as six describe silhouettes of a fat child as "lazy," "dirty," "stupid," ugly," "cheats," and "lies" (Staffieri, 1967). When shown black and white line drawings of a non-fat child, a fat child, and children with various handicaps, including missing hands and facial disfigurements, fat children are rated as the least likable by both children and adults (Goodman, Dornbusch, Richardson, & Hastorf, 1963; Maddox, Back, & Liederman, 1968; Richardson, Goodman, Hastorf & Dornbusch, 1961).

That many adults in the general population hold a bias against fat people has also been demonstrated in a variety of studies. In one study, subjects presented with pictures of the faces of fat people rated them as significantly less likable and less attractive than faces of non-fat people (Galper & Weiss, 1975). Research which has compared adult subjects' attitudes toward ex-convicts, ex-mental patients, and fat people found no significant differences between subjects' ratings of these three groups, although there was a trend toward more negative attitudes toward fat people than toward both ex-convicts and ex-mental patients (Homant & Kennedy, 1982).

People in the medical profession also evidence a bias against fat people. Physicians tend to view fat as unaesthetic and an indication of lack of personal control



(Maddox & Liederman, 1969). Researchers found that medical students viewing a fat patient on videotape rated her as less well educated, less likable, less seductive, more emotional, and more defensive than the non-fat target. They also saw her as less in need of help and less likely to benefit from counseling, but viewed her as more likely to have continuing problems if she did not receive help (Breytspraak, McGee, Conger, Whatley, & Moore, 1977).

Along with bias against fat people, concomitant discrimination also exists. This discrimination functions on many levels, including cultural, interpersonal, educational, and employment discrimination. Cultural artifacts in Western culture are clearly constructed with the thin person in mind: narrow seats in buses, airplanes, trains, and theaters are all designed to accommodate the non-fat frame. Restaurant booths, hotel beds, telephone booths, and conventional furniture can also pose difficulties for fat people. This physical construction serves to deny fat people full participation in our culture (English, 1993). Although there is currently a legal mandate to make public settings such as these more accessible for people in wheelchairs, fat people are required to pay extra money for comfortable accommodations when it is possible, endure physical, emotional, and social discomfort when it is not, or simply avoid social situations that non-fat people take for granted.

As a natural extension of the interpersonal bias described above, studies have also found that interpersonal discrimination exists against fat people. Two studies found that school children both expressed a desire to keep a greater personal space distance from fat children than from non-fat children, and actually did keep a greater distance from fat children during their interactions with them (Lerner, 1973; Lerner, Karabenick, & Meisels, 1975). In a study on helping behavior, Rodin and Slochower (1974) found that fat people were less likely to be helped by strangers than non-fat people. Another study demonstrated that landlords were significantly less likely to rent an apartment to a fat renter than a non-fat renter (Karris, 1977). Finally, Crandall and Thompson (under review) found that expressing anti-fat attitudes ("I would definitely not pick the fat guy. I don't think fat people make good counselors. I know I wouldn't go to a fat guy. Personally I just don't like fat people") leads to few or no negative interpersonal consequences for the speaker.

The disparate socioeconomic levels between fat and non-fat people has frequently been noted (Sobal & Stunkard, 1989; Sonne-Holm & Sorensen, 1986). One possible explanation for this is educational discrimination against fat people. Several studies have demonstrated that there is a lower incidence of fat students at colleges and universities than their presence in the general population and public high

schools would lead one to expect (Canning & Mayer, 1966; Crandall, 1995; Pargman, 1969), and despite no difference in desire to attend college, objective admission criteria, ability to succeed once admitted, or socioeconomic status (Canning & Mayer, 1966; Crandall, 1995).

After these findings were initially demonstrated, Canning and Mayer (1966) hypothesized that this was the result of bias/discrimination, either on the part of the admission committee who interviewed the applicant, or on the part of the applicant's guidance counselor. The idea that fat bias may play a role in the admission process when an applicant's weight is known is supported by research by Crandall and Thompson (under review). In two studies on the effect of derogatory anti-outgroup speech, Crandall and Thompson examined the ratings given to psychology graduate school applicants by undergraduates who were simulating an admissions committee. Applicants consisted of a non-fat white male, a non-fat white female, a non-fat black male, and a fat white male. All applicants had equivalent qualifications. In both studies, the fat white male was rated the lowest on having the necessary intelligence, qualifications, personality, and predicted success in graduate school. The fat white male also received significantly lower admittance rates than could be expected by chance.

The role of finances in the lower numbers of fat students in higher education has been examined in several studies by Crandall (1991, 1995). These studies have demonstrated that fat female college students rely more on jobs, savings, or financial aid to pay for college, while non-fat female students rely more on family support. An initial similar finding for fat male college students has not been replicated. These findings remained significant even when parents' educational level, parents' income, ethnic status, family size, and number of children attending college were factored out. One plausible explanation for this effect, according to Crandall, is that parents' familiarity with common stereotypes of fat people could lead them to believe that their fat children are not well suited to higher education, thus leading to familial discrimination.

Research has also demonstrated that fat people are likely to experience employment-related discrimination. Regardless of objective qualifications, fat targets are viewed as less qualified than non-fat targets (Klesges, et al., 1990), and are less likely to be recommended for hiring (Klesges, et al., 1990; Larkin & Pines, 1979). Studies have found that fat targets are rated more negatively than non-fat targets on personality characteristics relevant to job performance, including industriousness, organization, decisiveness, ambition, and self-discipline (Larkin & Pines,

1979). Regarding other factors related to job performance, fat targets are again rated more negatively. For example, fat targets are viewed as "mentally lazy," less competent, less successful, less productive, less likely to get along with others, needing more direction, prompting, and supervision, taking less pride in their work, and taking more non-medical absences than non-fat targets (Klesges, et al., 1990; Larkin & Pines, 1979). Very fat people also report experiencing more types of weight-related job discrimination than fat or non-fat people, including being hired contingent on weight loss, denied promotions, raises, or benefits because of their weight, or being fired or pressured to resign due to their weight (Rothblum, et al., 1990).

Prejudice against the fat may be one of the few "acceptable" prejudices today (Schoenfielder & Weiser, 1983). One possible reason relates to the specific stigmatizing nature of being fat. Rejection of an individual with a stigmatizing condition that is perceived to be controllable is judged as more reasonable and less prejudiced than rejection of an individual with an uncontrollable stigma (Rodin, Price, Sanchez, & McElligot, 1989). Other research has shown that fat is a stigmatizing condition for which others believe that the fat person is responsible (Crandall, 1994; Crandall & Martinez, 1996; Weiner, Perry, & Magnussen, 1988). Thus, fat oppression may

be viewed as justifiable based on cultural beliefs regarding the controllability of body weight; however, the belief that fat people are responsible for being fat is contradicted by a large body of research demonstrating that on average, fat adults do not eat different amounts or have significantly different eating styles than non-fat adults (Garrow, 1974; Kissileff, Jordan, & Levitz, 1978; Rosenthal & Marx, 1978; Stunkard, Coll, Lundquist, & Myers, 1980). DeJong (1980) found that when fatness is attributed to an uncontrollable factor, such as a thyroid condition, fat individuals are liked rather than derogated. Finally, Crandall (1994) demonstrated that changing subjects' beliefs about the controllability of fatness led to a reduction in bias against fat people.

In sum, numerous research studies have demonstrated that fat people are likely to be the recipients of bias and discrimination on a variety of fronts, solely because of their body size. As one set of authors concluded, "These data suggest a strong prejudice against fat people, and a readiness to discriminate against them" (Crandall & Thompson, under review, p. 24).

#### Mental Health of Fat People

Historically, the psychological and psychiatric communities have assumed that fatness was the result of emotional disturbance (Mustajoki, 1987). Early theorizing

identified numerous intrapsychic "causes" of fatness. The assumption that fat people as a group are psychologically disordered grew out of experiences with fat clients undergoing psychoanalytic treatment; however, the problems with making general assumptions from clinical populations are obvious. Nonetheless, most research which has found differences in the psychological functioning of fat and non-fat people has used "patient" populations, either of mental health clinics or medical facilities where weight loss is sought. Further, these studies frequently use subjective measures of psychological functioning or non-blind raters, and often lack control groups (Coates & Thoresen, 1980, cited in Klesges, Haddock, Stein, Klesges, Eck, & Hanson, 1992; Rodin, Schank, & Striegel-Moore, 1989).

Fortunately, well-designed research utilizing the general population has also examined the psychological functioning of fat versus non-fat people. This research has consistently found either no significant differences between fat and non-fat adults and children (Hayes & Ross, 1986; Kittel, Rustin, Draimaiz, deBacker & Kornitzer, 1978; Quaade, 1955, cited in McReynolds, 1982; Segers & Mertens, 1974; Wadden, Foster, Brownell, & Finley, 1984), or higher levels of positive functioning among fat subjects (Crisp & McGuinness, 1976; Kittel, et al., 1978; Stewart & Brooke, 1983, cited in Stunkard, 1983). In the one study where differences were found with fat participants showing more

psychological difficulty, it was in the area of "appearance self-esteem" (Crocker, Cornwell, & Major, 1993).

Some research has suggested that identification with the stereotypes of fat people and bias against fat people may have a stronger impact on self-esteem than actual weight status. Stager and Burke (1982) found that identification with the "fat child" stereotype was related to lower self-esteem in children, regardless of actual weight. Crandall and Biernat (1990) found that although self-esteem and being fat were not significantly correlated among female college students, fat female college students who held a strong negative attitude toward fatness did have a lower self-esteem. These studies suggest that while being fat itself is not directly related to self-esteem, holding negative, stereotypical beliefs about fat people, and identifying yourself as a fat person, may lead to lowered self-esteem.

The finding that, on average, the mental health of fat people is no worse than that of non-fat people has been consistent across a variety of non-client populations, operationalized definitions of fat, and measures of psychological functioning. Thus, a reviewer of this literature concludes, "...the evidence indicates that obesity is not associated with a low level of adjustment or particular personality pattern among nonpatient student and worker populations" (McReynolds, 1982, p. 53). However, clinicians are not immune to the biases of the culture in



which they live. In spite of this robust evidence, many clinicians still subscribe to the belief that fatness is associated with psychopathology (Young & Powell, 1985).

#### Impact of client factors on mental health professionals

A mental health professional's perception of a client can have a direct and substantial impact on a client's life; the therapist may base decisions about the client's level of disturbance, their primary problems, what type of therapy to recommend, and even appropriateness for treatment on their perception of the individual (Cripps, 1973; Jones, 1982; Loring & Powell, 1988; Mayo, 1974; Perlick & Atkins, 1984; Strickland, et al., 1988). Although these decisions are usually not based solely on the clinician's superficial perception of the client, this perception inevitably influences the clinician's judgments. Many client factors may be appropriate to take into consideration during clinical evaluations and treatment decisions, such as age, ethnicity, and sex; however, an ethical problem exists when therapists' assumptions about these factors bias their clinical judgments or negatively impact treatment. Following is a brief review of research examining the influence of client characteristics on therapist perceptions, including ethnicity, sex, age, and attractiveness.

The impact of client ethnicity on clinicians' judgments has been documented in numerous studies. Ethnicity has been found to influence clinicians' diagnostic evaluations (Lane, 1968; Li-Repac, 1980; Wampold, Casas, & Atkinson, 1981), the therapeutic modality chosen (Cripps, 1973; Krebs, 1971; Mayo, 1974), evaluation of client symptoms (Jenkins-Hall & Sacco, 1991; Jones, 1982; Ridley, 1986), perceived level of disturbance (Jones, 1982; Strickland, et al., 1988), appropriateness for therapy (Strickland, et al., 1988), and likelihood of successful therapy (Strickland, et al., 1988). Research has also demonstrated an interaction of client ethnicity with clinician ethnicity (Jones, 1982; Ridley, 1986; Strickland, et al., 1988), highlighting the fact that client influences on clinicians' judgments do not occur in an interpersonal vacuum.

The sex of a client can also have an impact on clinicians' judgments. In the now-classic study by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970), it was demonstrated that sex-role stereotypes influenced clinician's judgments of mental health. Stereotypically masculine characteristics were identified by clinicians as describing a mentally healthy man, and stereotypically feminine characteristics were identified as describing a mentally healthy woman; however, the stereotypically masculine characteristics which were used to describe a mentally healthy man were also identified as

describing a mentally healthy adult (gender unspecified). These differential views of mental health create what is referred to as the "double standard of health" for women. That is, women must choose between being a mentally healthy adult, and thus an unhealthy woman, or a mentally healthy woman, and thus, an unhealthy adult.

Client sex also has also been demonstrated to influence diagnosis. In a study examining both race and sex, Loring and Powell (1988) presented psychiatrists with case studies of actual clients being treated for undifferentiated schizophrenia with a dependent personality disorder, and asked them to make diagnostic judgments, describing the client as either a White man, White woman, Black man, or Black woman. When described as a White man, 56% of the respondents correctly diagnosed undifferentiated schizophrenia; when described as a Black man, White woman, or Black woman, the proportion of psychiatrists choosing this diagnosis ranged from 21% to 23%. Among respondents who did not diagnose undifferentiated schizophrenia, male respondents were biased toward giving a diagnosis of recurrent depressive disorder to female clients, regardless of race. In addition, male psychiatrists were more likely to diagnose White females with Histrionic Personality Disorder, although there was little evidence for such a diagnosis. Female respondents were more likely to diagnose White

females as having a brief reactive psychosis, regardless of their own race.

The age of a client can influence diagnosis, treatment recommendations, and estimates of prognosis. Two different sets of researchers presented clinicians with either a written case study or an audiotaped interview with a depressed client, and varied the reported age of the client. In both studies, more diagnoses of organicity or dementia were attributed to older clients and more depression to middle-aged clients (Perlick & Atkins, 1984; Settin, 1982). Of course, this finding could be attributed to clinicians' knowledge of the differential base rates of these disorders among different age groups; dementia is more common among older adults (over age 75) than younger, and the highest incidence of major depressive disorder is among adults in the 25 to 44 year old age group (American Psychiatric Association, 1994). However, research has shown that other treatment variables are also affected solely by the age of the client. Using methodology similar to that of Perlick and Atkins (1984) and Setting (1982), two other research teams found that mental health professionals recommended drugs more frequently than psychotherapy to treat depression in older persons, as opposed to younger ones (Ford & Sbordonne, 1980; Rodin & Langer, 1980). Mental health professionals have also been shown to give poorer prognoses to older

hypothetical patients (Dye, 1978; Ford & Sbordonne, 1980; Ray, Mckinney, & Ford, 1987; Settin, 1982).

Perhaps most relevant to the current study, physical attractiveness has also been shown to influence clinicians' judgments; a client's level of conventional attractiveness can influence ratings of mental health, treatment recommendations, and clinicians' willingness to work with the client. The effect of client attractiveness on mental health professionals gained empirical attention after Schofield proposed the now well-known "YAVIS syndrome;" that is, that clinicians prefer clients who are "youthful, attractive, verbal, intelligent, and successful" (p. 133; Schofield, 1964). Since that time, numerous studies have examined the impact of client attractiveness on mental health professionals.

Hobfoll and Penner (1978) found that graduate students in clinical psychology rated physically attractive stimulus persons as having a significantly better self-concept than less attractive stimulus persons. Barocas and Vance (1974) found that mental health professionals estimated more favorable prognosis for a conventionally attractive client than a conventionally unattractive client. In another study (S. Cochran, personal communication, June 14, 1995), a self-description of a prospective female client was distributed to therapists; attached to the self-description was either a picture of a very conventionally attractive woman, a less

conventionally attractive woman, or a conventionally unattractive woman. Therapists tended to accept the self-diagnosis of the very attractive woman, but only did so for the least attractive woman when she stated that her problem was sexual in nature. Clinicians tended to recommend long-term individual psychotherapy for the conventionally attractive woman, and recommend group therapy for the conventionally unattractive woman. Also, clinicians tended to invite referral of the more conventionally attractive woman, and suggest that the less conventionally attractive women be referred elsewhere.

#### Present study

With an estimated 34 million fat adults and 12.4 million very fat adults in the United States (Van Itallie, 1985), mental health professionals will inevitably be involved in the treatment of a fat person at some point in their career. Unfortunately, these mental health professionals have been raised within a culture where fat bias and discrimination are the norm. Thus, they are likely to hold the implicit beliefs that "thinness = happiness" and "fatness = unhappiness" and these beliefs are likely to be transmitted to their clients in many overt and subtle ways. One common example of an unconscious transmission of values occurs when the client walks into the therapist's office and says, "I lost five pounds this week," whereupon the

clinician smiles and congratulates them. The valuing of thinness has an impact on the clinician's perception of the client, and on the client's perception of him/herself. Although clinicians are becoming increasingly aware of the potential impact of other values on the therapeutic process, as an "acceptable bias," fat oppression is all but unconsidered.

Despite the large number of people involved, and the number of dollars spent in therapists' offices each year for weight-related treatment, there has been only one study examining the impact of client weight on clinicians. Young and Powell (1985) examined whether clients' weight affects mental health professionals' clinical judgments. Researchers used the same photograph of a Caucasian, "middle-aged" woman, computer-altered to appear three different weights. This photograph was presented to mental health professionals employed in the metropolitan Washington, D.C., area. "Mental health professional" was defined as a person involved in the direct provision of counseling and therapy (respondents included people who described themselves as holding one of the following job titles: mental health counselor, rehabilitation counselor, substance abuse counselor, psychiatric social worker, family therapist, counseling psychologist, psychiatric nurse, psychiatric aide, psychologist, and psychiatrist). Respondents were also

presented with a case history of the "client," which was identical across weight conditions.

These researchers found no significant difference in clinicians' interest in working with the client, prediction that treatment would be useful, or prediction of a favorable prognosis. However, significant differences were found in the level of symptomatology attributed to the client when they appeared very fat versus fat, and when the client appeared very fat versus non-fat. Mental health professionals rated the very fat client significantly higher than the fat client on the following symptoms: agitation, emotional behavior, impaired judgment, inadequate hygiene, inappropriate behavior, obsessive-compulsive behavior, self-injurious behavior, and stereotyped behavior. Significant differences on these same symptoms were found between the ratings of the very fat and the non-fat client; in addition, the very fat client was rated significantly higher than the non-fat client on the following symptoms: egocentrism, hypochondriasis, intolerance for change, and suspiciousness.

In this same study, therapist factors were found to interact with client weight. Older mental health workers were less likely to differentiate between targets according to weight than younger mental health workers. Female mental health workers were more likely to ascribe negative symptoms to fat and very fat targets than were males. Fat clinicians were less likely to ascribe negative symptoms to fat and



very fat targets than were non-fat clinicians. However, all participants described very fat targets as possessing more negative symptoms than non-fat targets. The authors conclude, "these findings confirm that obese women will receive negative judgments [by mental health workers] for characteristics that have no clear relationship to obesity" (Young & Powell, 1985; p 241).

Although the above study demonstrates that mental health practitioners tend to ascribe greater psychopathology to fat clients than to non-fat clients, it does not indicate what impact these perceptions may have on the psychotherapeutic treatment of fat clients. It is easy to imagine individual examples where a therapist's fat bias impacts a client's treatment. For example, a fat woman is given a powerful message when she enters therapy to discuss how her family has always rejected her because she is fat, and as part of her treatment is referred to a weight loss clinic. An even more dramatic example may involve a man who is being evaluated for custody litigation, and the therapist's implicit belief that fat people are psychologically maladjusted influences the therapist's recommendation to the court.

Despite the ease of generating hypothetical examples, the empirical question remains: does a biased perception of fat clients systematically influence clinicians' judgments and treatment recommendations? Although Young and Powell

demonstrated that fat clients may be perceived as more maladjusted, it is unclear whether this differential perception influences the more subtle considerations a mental health professional encounters when beginning treatment with a new client. The treatment modality recommended, diagnoses considered, estimates of client effort and motivation, and treatment goals are all examples of factors which directly influence psychological treatment. Theoretically, it is possible that these factors are not influenced by client weight or by the attribution of greater psychopathology to fat clients. If this is the case, although the differential perception demonstrated by Young and Powell (1985) may be problematic in and of itself as a form of bias, it would not necessarily have an impact on the services that fat clients receive. However, it is clearly possible that this differential perception does have a direct impact on the psychological treatment of fat clients, and thus, an impact on their lives. This finding would have important implications for the training of mental health practitioners, as earlier findings of biased treatment based on ethnicity and gender have had. Thus, the question of what influence, if any, mental health professionals' biased perceptions have on the psychological treatment of fat clients must be examined. The present study is designed to address this question by examining the impact of client weight on mental health professionals' treatment

recommendations, perception of client factors relevant to treatment (such as motivation and effort), provisional diagnoses, and treatment goals.

An expected finding that mental health practitioners will predict equivalent treatment prognoses for the fat and non-fat client is based on previous research which yielded this finding (Young & Powell, 1985). Since the same study also found that mental health professionals attribute significantly greater psychopathology to fat clients, the authors conclude that the finding of no difference with regard to prognosis reflected clinicians' faith in the efficacy of treatment, rather than equivalent client characteristics. However, this question requires further exploration. It is hypothesized that when asked specifically about client factors that affect prognosis, mental health professionals' biased perceptions of fat clients will appear. Thus, it is expected that therapists will attribute a lower level of motivation to change and a lower level of effort toward treatment goals for the fat than non-fat client, and will also predict a longer duration of treatment required for a successful outcome with the fat client.

One experience reported anecdotally by fat people who have been in psychotherapy is a perception that the therapist endorses an implicit or explicit treatment goal of weight loss, or considers the client's weight to be a

clinically relevant "problem," independent of whether the client identifies his or her weight as a clinical issue (R. Wood, personal communication, August 22, 1995). This is often expressed through the therapist's initiation of topics such as "exploring your relationship with food," or introducing discussion of nutrition, exercise, or eating patterns when there has been no indication from the client that these are areas of concern. Although a concern for the health of one's clients is commendable, this focus on exercise and/or eating habits may be an expression of bias when the therapist is making the assumption that because a client is fat they are not exercising or eating properly, and when these areas are not assessed similarly for one's non-fat clients. Although many therapists may justify initiating discussion of a fat client's weight as concern for their health, few therapists would initiate discussion of a (non-fat) client's smoking habit or cholesterol level if the client did not indicate that these were clinically relevant issues.

Thus, a secondary purpose of the present study is to examine the influence of client-generated treatment goals on the therapists' clinical perceptions and treatment recommendations. The primary questions to be addressed are: 1) do therapists automatically endorse weight loss as a treatment goal for fat clients, and 2) how are therapists influenced by treatment goals generated by the client? If a

fat client indicates that one of their treatment goals is "self-acceptance," are therapists likely to pursue weight loss as a treatment goal regardless? The current study will compare two conditions: one in which the client expresses a desire to lose weight, and one in which the client express a desire to increase self-acceptance. It is expected that these implicit treatment goals will interact with client weight in influencing therapists' clinical judgments and treatment recommendations.

The primary hypotheses are as follows:

- 1) Psychologists will assign a significantly lower Global Assessment of Functioning (GAF; American Psychiatric Association, 1994) score to the fat client than the non-fat client.
- 2) Psychologists will identify weight loss as a treatment goal more often than self-acceptance for the fat client.
- 3) Psychologists will predict a longer duration of treatment required for successful outcome with the fat client than the non-fat client.
- 4) Psychologists will predict a lower level of motivation to change for the fat client than the non-fat client.
- 5) Psychologists will predict a lower level of effort toward treatment goals for the fat client than the non-fat client.

Several other variables and outcomes will also be explored; however, directional hypotheses are not proposed.

The influence of client weight on psychologist assignment of provisional diagnoses and recommendations for treatment modality will be examined. The impact of the client's implicit treatment goals will also be explored. In addition, the impact of psychologist age, sex, ethnicity, and years of experience will be examined.

## Method

### Participants

Questionnaires were mailed to 500 members and fellows of the American Psychological Association's Divisions of Clinical Psychology, Counseling Psychology, Psychotherapy, and Psychologists in Independent Practice. Participants were doctoral level professionals, selected randomly from the American Psychological Association's 1996 Registry. Two-hundred completed questionnaires were returned, yielding a response rate of 40%. Respondents ranged in age from 28 to 81 years, including 123 males and 77 females, and 188 Caucasian and 12 non-Caucasian psychologists. The ratio of male-to-female respondents reflects the ratio within the divisions which were sampled (See Table 1).

### Materials

Each participant received a cover letter and a questionnaire with a photograph attached. The cover letter indicated that the purpose of the present study was to

examine the differential effects of utilizing various types of information in clinical research (Appendix A). Each participant received a photograph of a Caucasian woman appearing fat, or the same woman appearing non-fat (Appendix B). Weight was varied through the use of theatrical makeup and padding. Pilot testing demonstrated both that the weight manipulation was convincing, and that the weight of the target was viewed significantly differently in the two conditions (Appendix C).

The questionnaire included a self-description, purportedly written by the "client" in the photograph, and questions assessing the clinician's perceptions of the client based on the photograph and self-description. Questionnaires were varied in two conditions, based upon the implied treatment goal included in the self-description. In the "lose weight" condition, the statement "Sometimes I think I'd be a happier person if I could just lose some weight," was embedded in the self-description; in the "accept self" condition, the statement "Sometimes I think I'd be a happier person if I could just accept myself the way I am," was embedded in the self-description. The questions to which participants responded were identical in each of these conditions (Appendix D).

### Procedure

Each participant was assigned randomly to one of the following four conditions, based on which versions of the photograph and questionnaire they were sent: "fat/lose weight," "fat/accept self," "non-fat/lose weight," or "non-fat/accept self." An equivalent number of questionnaires were mailed within each condition.

Participants were mailed the cover letter, questionnaire, photograph, and a return envelope. Approximately two weeks after the first mailing, a post-card reminder was sent in a follow-up mailing to those who had not yet responded. Approximately three weeks after the first follow-up mailing, a second postcard was sent to those who had not responded, again requesting that they respond. These procedures yielded a response rate of 40%. This response rate is on the low end of the typical range for a survey utilizing two follow-up mailings; however, it is a typical response rate for a survey of mental health professionals. Thus, this is viewed as a somewhat low, but acceptable, response rate for the present study (personal communication, Jim Walsh, March 28, 1997).

In order to protect respondent confidentiality, each participant was assigned a code number which was recorded on a master list to which only the primary investigator had access. This code number was written on the outside of the participant's reply envelope. As responses were received,



the questionnaires and envelopes were separated, and the respondents' information was deleted from the master list. When all responses had been received, the information remaining on the master list was deleted.

## Results

Results are presented for both the hypotheses being tested and for additional exploratory analyses. Exploratory analyses will be presented with regard to provisional diagnoses and prognosis, treatment modality and treatment goals, main effects for therapist factors (such as age, sex, and years of experience), and the interaction of therapist factors with client weight and statement condition. Results were analyzed through chi squared tests, t-tests, and ANOVA's. When paired comparisons of means are reported following a significant interaction in an ANOVA, these are based on Fisher's Least Significant Difference test, and will be reported as t-scores.

### Weight and Statement

#### Hypotheses and related findings.

It was expected that there would be a significant difference in GAF scores assigned to the fat and non-fat client; a 2 (fat/non-fat) X 2 (lose weight/accept self) ANOVA revealed a trend toward significance in the expected

direction. The fat client was assigned a lower GAF score than the non-fat client,  $F(1, 168) = 2.45, p < .06$ .

With regard to treatment goals, it was hypothesized that weight loss would be considered a more likely treatment goal than self-acceptance for the fat client. This second hypothesis was unsupported; in fact, a t-test revealed that the results were significant in the opposite direction,  $t(173) = 7.63, p < .0005$  ( $M = 5.16, SD = 1.32$ , self-acceptance;  $M = 3.73, SD = 1.14$ , weight loss). Thus, respondents indicated that they considered self-acceptance a more likely treatment goal for the fat client than weight loss. This was also the case for the non-fat client,  $t(196) = 22.19, p < .00001$  ( $M = 5.25, SD = .80$ , self-acceptance;  $M = 2.32, SD = 1.05$ , weight loss), and for the overall sample,  $t(371) = 17.84, p < .00001$  ( $M = 5.21, SD = 1.08$ , self-acceptance;  $M = 2.98, SD = 1.38$ , weight loss). Interestingly, self-acceptance was the fourth most highly rated treatment goal among all 30 possibilities ( $M = 5.20$ ; decrease depression, increase self-esteem, and explore current relationships were rated first through third, respectively).

A comparison of how likely respondents considered weight loss as a treatment goal for the fat client versus the non-fat client was analyzed using a 2 (fat/non-fat) X 2 (lose weight/accept self) ANOVA. Respondents did consider weight loss to be a significantly more likely treatment goal

for the fat client than for the non-fat client,  $F(1, 180) = 76.87$ ,  $p < .001$ . Additionally, weight loss was considered significantly more likely as a treatment goal for the client in the "lose weight" statement condition than in the "self-accept" statement condition regardless of client weight,  $F(1, 180) = 17.81$ ,  $p < .001$ . However, there was no significant interaction between client weight and statement condition for the treatment goal of facilitating weight loss,  $F(1, 180) = .66$ ,  $p < .42$ .

Estimations of client effort, client motivation, and duration of successful treatment were each analyzed by 2 (fat/non-fat) X 2 (lose weight/accept self) ANOVA's. It was hypothesized that therapists would predict a longer duration of treatment for a successful outcome with the fat client than the non-fat client. This finding approached significance in the expected direction,  $F(1, 193) = 2.22$ ,  $p < .07$ . The hypotheses that respondents would predict lower levels of motivation and lower levels of effort from the fat client than the non-fat client were not supported;  $F(1, 195) = .14$ ,  $p < .71$  and  $F(1, 195) = .11$ ,  $p < .74$ , respectively. Thus, weight alone does not appear to significantly affect psychologists' estimations of effort and motivation.

However, a 2 (fat/non-fat) X 2 (lose weight/accept self) X 2 (<40 years old/ >40 years old) revealed a significant interaction between weight and respondent age for predictions of client effort,  $F(1, 186) = 5.94$ ,  $p < .02$ .

Post hoc comparisons of means revealed that younger respondents' estimations of effort appear to be affected by client weight, in the direction of lower estimations of effort for the fat client (nominal  $t_{crit}(186)$ ,  $\alpha < .01 = 2.58$ ;  $P(E) \leq .30$  Bonferroni). Specifically, psychologists who were 40 years old or younger predicted a lower degree of effort from the fat client than the non-fat client. Also, psychologists who were 40 or younger predicted a significantly lower level of effort from the fat client than did psychologists over 40 years old. (See Figure 1). The statement condition also affected respondents' estimations of client effort; respondents predicted lower levels of effort from clients in the "accept self" condition than the "lose weight" diagnoses and condition,  $F(1, 195) = 6.71$ ,  $p < .01$ .

#### Provisional diagnoses and prognosis.

Several provisional diagnoses were influenced by client weight and/or statement condition. All provisional diagnoses were analyzed through chi squared procedures (endorsement: yes/no X client weight, and endorsement: yes/no X statement condition). Respondents were significantly more likely to suggest a provisional diagnosis of an Eating Disorder for the fat client than the non-fat client,  $X^2(1, N = 199) = 8.68$ ,  $p < .01$ . They were also significantly more likely to suggest a provisional diagnosis of Eating Disorder for clients in the "lose weight" condition than in the "accept

self" condition,  $X^2(1, N = 199) = 16.43, p < .001$ . A provisional diagnosis of Adjustment Disorder was significantly more likely to be suggested for the non-fat client than the fat client,  $X^2(1, N = 199) = 7.45, p < .01$ . With regard to statement condition, respondents were significantly more likely to suggest a provisional diagnosis of Somatization Disorder for client in the "lose weight" condition than the "accept self" condition,  $X^2(1, N = 199) = 9.85, p < .005$ .

Utilizing a 2 (fat/non-fat) X 2 (lose weight/accept self) ANOVA, no overall significant difference was found for respondent estimates of prognosis for the fat and non-fat client,  $F(1, 194) = .16, p < .70$ . This finding replicates previous research findings (Young and Powell, 1985). However, a 2 (fat/non-fat) X 2 (lose weight/accept self) X 2 (female/male) ANOVA revealed significant interactions between client weight and therapist sex,  $F(1, 189) = 5.52, p < .02$ . Post hoc comparisons of means demonstrated that female respondents' estimations of prognosis were more positive for the non-fat client (nominal  $t_{crit}(189), \alpha < .05 = 1.96; P(E) \leq .30$  Bonferroni). Specifically, female respondents predicted a significantly better prognosis for the non-fat client than the fat client. Female respondents also predicted a significantly better prognosis for the non-fat client than did male respondents (see Figure 2).

Significant interactions were also found between client weight and therapist age with regard to prognosis, based on a 2 (fat/non-fat) X 2 (lose weight/accept self) X 2 (<40 years old/ >40 years old) ANOVA,  $F(1, 185) = 8.06, p < .005$ . Younger respondents were more affected by client weight when generating estimations of prognosis than were older respondents; this was in the direction of lower expectations for the prognosis of the fat client (nominal  $t_{crit}(185)$ ,  $\alpha < .05 = 1.96$ ;  $P(E) \leq .30$  Bonferroni). Post hoc analyses revealed that respondents who were age 40 or younger predicted a significantly better prognosis for the non-fat client than the fat client, and predicted a better prognosis for the non-fat client than did respondents over age 40. Respondents over age 40 predicted a significantly better prognosis for the fat client than did respondents 40 and younger. Finally, respondents over age 40 predicted a significantly better prognosis for the non-fat client than respondents under age 40 predicted for the fat client (see Figure 3).

#### Treatment modality and treatment goals.

The impact of client weight and statement condition on treatment modality variables was examined using several chi squared analyses. No significant differences were found based on client weight or statement condition with regard to recommended treatment modality (individual, group, marital, or family), recommended length of treatment (brief or longer

term), or treatment setting (outpatient or inpatient). The mean and modal recommendations, regardless of client weight and statement, were for individual, outpatient, longer-term therapy.

Respondents' ratings of different treatment goals were analyzed by 2 (fat/non-fat) X 2 (lose weight/accept self) ANOVA's, as well as 2 X 2 X 2 ANOVA's incorporating respondent age, sex, and years of experience. Several treatment goals were included in the questionnaire for exploratory analysis due to their potential relationship to client weight and desires to lose weight, such as improving body image, exploring cultural expectations, facilitating self-acceptance, and increasing physical activity. Several significant differences were found in respondents' ratings of the likelihood of incorporating these different goals into treatment.

Respondents indicated that "improve body image" was significantly more likely to be a treatment goal for the fat client than the non-fat client,  $F(1, 182) = 18.19, p < .001$ . The treatment goal of improving body image was also significantly more likely for clients in the "lose weight" condition than in the "accept self" condition,  $F(1, 182) = 17.03, p < .001$ . However, no significant interaction between weight and statement were found for this treatment goal,  $F(1, 182) = 1.64, p < .21$ .

With regard to the treatment goal of "exploring cultural expectations," a significant interaction between client weight and respondent age was found,  $F(1, 168) = 4.76, p < .03$ . Respondents under age 40 were more likely than respondents over age 40 to consider this goal in their treatment in general, and considered this treatment goal more likely for the non-fat client than the fat client (nominal  $t_{crit}(168), \alpha < .01 = 2.58; P(E) \leq .30$  Bonferroni). Specifically, post hoc analyses revealed that respondents who were age 40 or younger were more likely to consider this as a treatment goal for the non-fat client than the fat client, and were more likely to consider this for the non-fat client than were respondents over age 40. Finally, respondents who were 40 or younger were more likely to consider this for the non-fat client than respondents over age 40 were for the fat client (see Figure 4). There was no significant difference in this treatment goal based on statement,  $F(1, 176) = 1.08, p < .30$ ; nor was there a significant interaction between weight and statement,  $F(1, 176) = .06, p < .81$ .

Regarding the treatment goal of "facilitating self-acceptance," client weight interacted significantly with the number of years a respondent had been providing direct mental health services,  $F(1, 183) = 4.24, p < .05$ . Client weight appears to affect less experienced respondents' consideration of self-acceptance as a treatment goal, with



it being rated as more likely for the non-fat client than the fat client. Post hoc comparison of means revealed several significant differences between groups (nominal  $t_{crit}(179)$ ,  $\alpha < .05 = 1.96$ ;  $P(E) \leq .30$  Bonferroni). For respondents with greater than 15 years of experience, there was no difference between the fat and non-fat client. However, respondents with 15 years of experience or less considered the treatment goal of self-acceptance significantly more likely for the non-fat client than for the fat client. Respondents with more than 15 years of experience were more likely to consider a treatment goal of self-acceptance for the fat client than were respondents with less experience, and were also more likely to consider a treatment goal of self-acceptance for the non-fat client than less experienced respondents were for the fat client (see Figure 5). No main effect for client weight was found with regard to a treatment goal of increasing self-acceptance,  $F(1, 187) = .37$ ,  $p < .55$ ; nor was a main effect for statement condition found,  $F(1, 187) = .41$ ,  $p < .53$ . In addition, no significant interaction between client weight and statement was found,  $F(1, 187) = .28$ ,  $p < .60$ .

Post-hoc Pearson product-moment correlations were conducted between several of the treatment goals. Significant positive correlations were found between the treatment goals of "improve body image" and "facilitate weight loss" for the overall sample ( $r = .62$ ,  $p < .0001$ ),

for the non-fat client ( $\underline{r} = .48, p < .001$ ), and for the fat client ( $\underline{r} = .64, p < .0001$ ). Significant correlations were also found between the treatment goals of "improve body image" and "explore cultural expectations" for the overall sample ( $\underline{r} = .24, p < .001$ ), for the non-fat client ( $\underline{r} = .22, p < .05$ ), and for the fat client ( $\underline{r} = .33, p < .01$ ). Finally, significant correlations were found for the fat client between "facilitate self-acceptance" and "explore cultural expectations" ( $\underline{r} = .29, p < .05$ ), and between "facilitate self-acceptance" and "improve body image" ( $\underline{r} = .44, p < .001$ ).

No significant results were found for the treatment goal of "increasing physical activity." No significant difference between the fat and non-fat client was found,  $\underline{F}(1, 182) = 1.74, p < .19$ ; nor was a significant difference found for statement condition,  $\underline{F}(1, 182) = .43, p < .52$ . In addition, no significant interaction was found between client weight and statement condition,  $\underline{F}(1, 182) = .07, p < .80$ .

In addition to the target treatment goals described above, several other treatment goals were included to obscure the purpose of the study and reduce response bias. These other treatment goals were also examined out of interest. Several significant differences were found among these treatment goals, but these findings must be interpreted with caution since these were secondary analyses

with no hypotheses proposed. Significant differences based on client weight or statement condition were found for the following treatment goals: increasing sexual satisfaction, increasing assertiveness, addressing affective incongruence, and management of thought disorder.

Respondents indicated that "increasing sexual satisfaction" was more likely to be a treatment goal for the fat client than the non-fat client,  $F(1, 175) = 7.10, p < .008$ . A trend toward significance was found regarding the treatment goal of "increasing vocational satisfaction." This treatment goal was considered somewhat more likely for the fat client than the non-fat client,  $F(1, 174) = 2.81, p < .10$ . In addition, respondents indicated that "enhanced self-awareness" was somewhat more likely to be a treatment goal for clients in the "lose weight" statement condition than in the "accept self" statement condition,  $F(1, 180) = 2.92, p < .09$ .

Differences were also found with respect to the treatment goal of "increasing assertiveness;" a significant interaction between client weight and statement condition was found,  $F(1, 186) = 5.05, p < .03$ . Specifically, a post hoc pairwise comparison of means indicated that respondents rated increasing assertiveness as a significantly more likely treatment goal for fat clients in the "accept self" condition than for non-fat clients in the "accept self" condition, and for fat clients in the "lose weight"

condition (nominal  $t_{crit}(186)$ ,  $\alpha < .05 = 1.96$ ;  $P(E) \leq .30$  Bonferroni) (see Figure 6).

A significant interaction between client weight and statement condition was also found for the treatment goal of "addressing affective incongruence,"  $F(1, 180) = 4.33$ ,  $p < .03$ . Post hoc analyses revealed that respondents considered this goal somewhat more likely for the fat client in the "lose weight" condition than for either the fat client in the "accept self" condition or the non-fat client in the "lose weight" condition, (nominal  $t_{crit}(180)$ ,  $\alpha < .10 = 1.65$ ;  $P(E) \leq .30$  Bonferroni) (see Figure 7).

Regarding the treatment goal of "management of thought disorder," a significant interaction between client weight and statement was demonstrated,  $F(1, 177) = 4.14$ ,  $p < .05$ . Post hoc analyses revealed several trends toward significance for differences between groups (nominal  $t_{crit}(177)$ ,  $\alpha < .10 = 1.65$ ;  $P(E) \leq .30$  Bonferroni). Respondents considered this treatment goal as somewhat less likely for the non-fat client in the "lose weight" condition than for either the fat client in the "lose weight" condition, or for the non-fat client in the "accept self" condition.

Clearly, client weight and statement condition, as well as interactions between them, had a significant impact on respondent ratings of the likelihood of different treatment goals. While some of these treatment goals appear to bear a

relationship to weight or desires to lose weight, the reason for the difference in others is less clear.

### Respondent characteristics

Independent of client weight or statement condition, systematic differences in responses were found based solely on respondent characteristics. These were examined through 2 (fat/non-fat) X 2 (lose weight/accept self) X 2 (sex, age, or years of experience) ANOVA's. Overall, female respondents were significantly more likely than male respondents to consider weight loss as a treatment goal,  $F(1, 176) = 4.29$ ,  $p < .04$ . Female respondents were also significantly more likely than male respondents to consider improving body image as a treatment goal,  $F(1, 178) = 6.62$ ,  $p < .02$ . Age of respondent also affected responses. Self-acceptance was considered significantly more likely as a treatment goal by respondents who were over forty years old than by those who were forty or younger,  $F(1, 179) = 4.16$ ,  $p < .05$ . There was also a trend toward significance with regard to respondent age and GAF scores; respondents who were age forty years or younger estimated higher GAF scores than those who were over forty,  $F(1, 160) = 3.15$ ,  $p < .08$ . With regard to years of experience, respondents with more than 15 years of experience were more likely to recommend improving body image as a treatment goal than those who had 15 years of experience or less,  $F(1, 178) = 4.07$ ,  $p < .05$ . Respondents

sex, age, and years of experience directly affected the treatment goals which they considered for the client, regardless of client weight or statement condition. Due to the small percentage of non-Caucasian respondents (6%), results were not analyzed based on respondent ethnicity.

### Discussion

This study was designed to examine the impact of client weight on mental health professionals' clinical judgments and treatment recommendations. Although a previous study demonstrated that mental health professionals associate client fatness with a greater degree of psychopathology, it is important both to confirm this finding and to explore the influences that this bias may have. An important part of the American Psychological Association's ethical standards includes the admonition that therapists "try to eliminate the effect on their work of biases....," (American Psychological Association, 1992, Principle D) including those based on cultural and individual differences. Most therapists take this responsibility very seriously; however, if it is unclear whether a bias against fat clients influences psychological treatment, then therapists cannot work to reduce these influences. Given the presence of such bias in the culture at large, it is critical to determine the potential impact of client weight on therapists' clinical judgments and treatment formulations.

The findings of the present study demonstrate that client weight does, in fact, influence psychologists' clinical judgments and treatment planning. Provisional diagnoses, estimations of prognosis, estimations of client effort, and treatment goals were all influenced by client weight. Further, these differences were in the direction of more negative views of the fat client.

The provisional diagnoses which psychologists indicated they would consider were influenced by the weight of the client in the photograph. For example, respondents were significantly more likely to consider a diagnosis of Eating Disorder for the fat client than for the non-fat client. This finding indicates a differential perception of the fat and non-fat clients. However, client weight could be viewed as an appropriate factor to consider in this case, and it may be that respondents' differential diagnosis accurately reflects base rates among fat and non-fat populations. This interpretation is worth examining.

In the Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV; American Psychiatric Association, 1994), three eating disorders are described: Anorexia Nervosa, Bulimia Nervosa, and Eating Disorder Not Otherwise Specified (NOS). Clearly, since neither weight condition in the present study met the criteria for Anorexia Nervosa (body weight of less than 85% of that expected; see Appendix B), respondents considering an eating disorder

diagnosis would be considering either Bulimia Nervosa or Eating Disorder NOS. If there exists a higher incidence of either or both of these eating disorders among fat women than among non-fat women, then the results could not be said to reflect bias, but to reflect reality. However, this is not the case. With regard to Bulimia Nervosa, the DSM-IV (American Psychiatric Association, 1994) states that, "Individuals with Bulimia Nervosa are typically within the normal weight range, although some may be slightly underweight or overweight. The disorder occurs but is uncommon among moderately and morbidly obese individuals (p. 547)." Thus, a provisional diagnosis of Bulimia Nervosa would appear to be more logical, statistically speaking, for the non-fat client than the fat client.

The second eating disorder which may be considered is Eating Disorder NOS. A provisional diagnosis of Eating Disorder NOS can be considered for a variety of maladaptive eating patterns, and six examples of likely eating patterns are listed in DSM-IV. However, of the eating patterns listed, only one is likely to be correlated with fatness (binge-eating disorder). None of the other eating patterns are likely to be correlated with fatness (such as meeting all criteria for Anorexia Nervosa except that the individual has regular menses, or repeatedly chewing and spitting out, but not swallowing, large amounts of food). Thus, the conclusion that respondents were making differential



provisional diagnoses of Eating Disorder in accordance with reality does not appear to be supported by the evidence. In fact, if respondents' provisional diagnoses did indeed reflect base rates, they would have been more likely to attribute a provisional diagnosis of Eating Disorder to the non-fat client than the fat client.

An alternative interpretation of this finding is that it reflects our societal belief that fatness is controllable, and that if a person is fat, they must have a disordered eating pattern of some sort. The widespread belief that fatness is controllable has been documented in numerous studies (Crandall, 1994; Weiner, Perry, & Magnussen, 1988). However, this is contradictory to studies which have demonstrated that, on average, fat adults do not have significantly different eating styles than non-fat adults (Garrow, 1974; Kissileff, Jordan, & Levitz, 1978; Rosenthal & Marx, 1978; Stunkard, Coll, Lindquist, & Myers, 1980). This finding also supports anecdotal reports that clinicians often focus on fat clients' weight as a clinically relevant issue, even when the client has not identified it as such (R. Wood, personal communication, August 22, 1995). If clinicians believe that a fat client is likely to have a disordered eating pattern, then it makes sense that they would focus attention on this. Unfortunately, this illusory correlation is likely to lead psychologists to alienate fat clients who do not consider

their weight to be a problem, or worse, convince a fat client that their eating pattern is problematic when it is not (Tenzer, 1989).

Although no identifiable stressor (one of the criteria for a diagnosis of Adjustment Disorder) is described in the self-description purportedly written by the client, psychologists were more likely to assign a diagnosis of Adjustment Disorder to the non-fat client than the fat client. One possible explanation for this finding is revealed by examining the conceptual difference between a diagnosis of Adjustment Disorder and diagnoses of other disorders. Since a diagnosis of Adjustment Disorder inherently identifies an outside factor as the cause of the disturbance, it may be that proposing a diagnosis of Adjustment Disorder is a way to give the client the "benefit of the doubt" that they are not psychologically maladjusted, but that they simply are reacting to an external stressor. If this interpretation is accurate, it may be that psychologists are more willing to give this benefit-of-the-doubt to the non-fat client than the fat client. Thus, psychologists may have a tendency to assume that the fat client's difficulties are the result of intrapsychic factors, while considering the possibility that the non-fat client's difficulties are the result of external factors. Although this explanation is intriguing, interpretation must

be cautious, as it was not predicted. Future research may examine this question empirically.

Bias against fat clients also manifested itself in poorer estimates of prognosis, and lower estimates of effort for the fat client than the non-fat client. These findings were nonsignificant for the overall sample, which is consistent with Young and Powell's (1985) finding regarding prognosis. However, subsets of the sample did distinguish between fat and non-fat clients when estimating prognosis and effort. Female respondents estimated a significantly poorer prognosis for the fat client than the non-fat client, as did respondents under age 40. Respondents under age 40 also estimated lower levels of effort from the fat client than the non-fat client.

If a psychologist has lower expectations for a fat client's prognosis and effort, this may affect treatment in several ways; for example, assigning fat clients fewer therapeutic tasks to accomplish outside of therapy, and setting more conservative treatment goals. These manifestations of bias against the fat client are particularly problematic when one considers a process known as interpersonal construction, or behavioral confirmation. Research examining this process has demonstrated that when one individual has expectations regarding another, the individual may behave in such a way as to elicit confirmatory behavior from the other (Snyder & Swan, 1978;

Snyder, Tanke, & Berscheid, 1977; Skrypnek & Snyder, 1982). Thus, psychologists may inadvertently be leading their fat clients to confirm their expectations by making less independent effort toward treatment goals and manifesting lower levels of positive change. This process may also lead fat clients to set more modest goals for themselves in treatment, and restrict their own expectations of their potential for growth.

Several treatment goals which respondents considered were also influenced by client weight. Respondents were significantly more likely to recommend "facilitating weight loss" as a treatment goal for the fat client than the non-fat client. In light of the accumulating body of evidence that attempts at significant weight loss are largely unsuccessful and difficult to maintain long-term (Bennet & Gurin, 1982; Polivy & Herman, 1985; Stalonas, Perri, & Kerzner, 1984; Wilson, 1994; Wing & Jeffrey, 1979), and may contain certain psychological and physiological risks (Brownell & Rodin, 1994; Fairburn & Cooper, 1982; Koenig & Wasserman, 1995; Mitchell, Specker, & Zwaan, 1991; Polivy & Herman, 1993; Ross, 1994; Stunkard & Rush, 1974; Warren & Cooper, 1988), the finding that psychologists would consider a treatment goal of weight loss for any client is controversial (Brown & Rothblum, 1989). In this case it would even be difficult to justify weight loss as a means for addressing health problems, since it was indicated in

the client's self-description that her health was fine. However, closer examination of the findings reveals cause for hope. The mean rating of weight loss as a treatment goal for the non-fat client is equivalent to a verbal rating of "unlikely to somewhat unlikely." The mean rating for the fat client represents a verbal rating of "neutral to somewhat likely." Thus, although psychologists were more likely to consider weight loss as a treatment goal for the fat client than the non-fat client, they did not overwhelmingly endorse weight loss for either client, on average.

Respondents also made differential ratings on the treatment goals of "improve body image," "explore cultural expectations," and "facilitate self-acceptance," based on client weight. Respondents indicated that improving body image was significantly more likely as a treatment goal for the fat client than the non-fat client. This finding may represent psychologists' increased focus on issues of body size and weight with the fat client than the non-fat client. However, given that both "facilitate weight loss" and "improve body image" were rated significantly more likely for the fat client, this finding raises a question about the specific meaning that respondents attributed to a treatment goal of "improve body image." For example, "improve body image" may imply working toward acceptance of one's body as it currently is, adjusting an unrealistic perception of one's body size to a more realistic perception, working to accept

one's body contingent upon or concurrent with weight loss, or simply "improving" one's body size through weight loss.

Several post hoc analyses were employed to examine this question further. These analyses revealed that for both the overall sample and the non-fat client, respondent ratings on "improve body image" were significantly correlated with "facilitate weight loss," and "explore cultural expectations." For the fat client, respondent ratings on "improve body image" were significantly correlated with "facilitate weight loss," "explore cultural expectations," and "facilitate self-acceptance." It may be that respondents were employing multiple meanings for the treatment goal of "improving body image;" perhaps they were attributing different meanings for the fat client and the non-fat client. This phrase may also simply have been used by respondents to indicate a general awareness of and attention to issues of weight, without carrying an inherent commitment to either weight loss or body acceptance. Similarly, it is possible that this treatment goal is flexible enough that it acquires individual meaning in the context of a particular client's history and treatment, but in the context of this study, is difficult to interpret. This question of the meaning of the goal "improve body image" may be addressed empirically in future studies.

Younger respondents considered "exploring cultural expectations" as more likely for the non-fat client than the

fat client, and less experienced respondents considered "facilitating self-acceptance" as a more likely treatment goal for the non-fat than the fat client. Feminist and contextual therapists often use phrases such as "explore cultural expectations" to refer to the process of examining the impact of cultural beliefs, roles, and stereotypes on self-concept and behavior. With regard to female clients, this may include examining and refuting cultural definitions of beauty, such as "ideal weight." The findings that both "explore cultural expectations," and "facilitate self-acceptance" were rated as more likely for the non-fat client than the fat client suggests that examining the (potentially negative) cultural influences on oneself, and working to accept oneself, are viewed as less valid treatment goals if the client is not "acceptable" by society's standards to begin with (i.e., a woman who is fat).

Finally, it was found that respondents considered "increasing sexual satisfaction" to be a more likely treatment goal for the fat client than the non-fat client, and there was a trend toward considering "increasing vocational satisfaction" as more likely for the fat than the non-fat client. Interestingly, these differences were found despite a lack of information in the self-description referring to either sexuality or vocational issues. These findings must be interpreted with caution, as the analyses were exploratory in nature. However, at least two possible

explanations exist. First, these findings may reflect the broader cultural stereotypes of fat people; fat people are often viewed as more likely to have work difficulties and sexual problems (Larkin & Pines, 1979; Klesges, et al., 1990; Young & Powell, 1985). Psychologists are not immune to these stereotypes. Thus, these findings may reflect a translation of these stereotypes into treatment planning. Second, this finding may simply reflect a more global negative view of the fat client's functioning; that is, psychologists may have assumed that the fat client had more difficulties in more areas of functioning than the non-fat client.

As indicated in the sections described above, several therapist factors mediated the bias that was manifested against the fat client. One powerful mediator appears to be psychologist age. In general, younger psychologists (defined in this study as age 40 or younger) evidenced more bias against the fat client than did older psychologists, and that bias manifested itself in more ways. This is consistent with Young and Powell's (1985) findings regarding the impact of therapist age.

Several potential explanations for this finding exist. It may be that older psychologists are less focused on appearance factors than are younger psychologists, or may be more accepting of deviations from our culture's appearance ideals. This interpretation is supported by the finding that



respondents who were over age 40 considered "self-acceptance" more likely as a treatment goal, in general, than did younger psychologists. In this society, as a person ages, he or she is likely to move further and further from our culture's appearance ideals; they are likely to gain weight, wrinkles, gray hair, and other signs of aging that are not consistent with our society's emphasis on youth as an aspect of beauty. Psychologists who have gone through this process may be more aware of the restrictive nature of our culture's ideals and the futility of attempting to reach them. In general, younger psychologists, not having experienced this process yet themselves, may be more invested in the ideal. This might then translate into less tolerance for deviations from the ideal, and a higher level of fat bias.

A different explanation may involve the fact that normative weight differs by age, and respondents may have been comparing the client's weight to the normative weight within their own age group (even though the client's reported age remained constant at 28 years). If this was the case, then the fat client may not have appeared as deviant from the expected norm to older respondents than she appeared to younger respondents. This may have led older respondents to differentiate less between the fat and non-fat client than did younger respondents. These two possible explanations for the higher levels of fat bias among younger

psychologists cannot be evaluated definitively within this study, but provide interesting questions for future research.

Sex of the respondent also mediated findings of bias, but in a more limited way. Female respondents appeared to be more biased against the fat client than were male respondents; this manifested itself in poorer prognosis estimates for the fat client than the non-fat client, as well as poorer prognosis estimates for the fat client by female respondents than by male respondents. This finding is consistent with Young and Powell's (1985) findings regarding the impact of sex of the respondent. It also reflects the finding that females are more biased against fat people in general (Christian & Beirnat, 1990). Clearly, female psychologists are not immune to this, and it may affect their perception of their fat clients.

Finally, the number of years a psychologist has been practicing appears to mediate fat bias, although in a limited way. In general, less experienced psychologists (defined as those who have 15 or fewer years of direct mental health service provision) showed greater bias against the fat client than did more experienced psychologists (more than 15 years). Specifically, less experienced psychologists were more likely to consider a treatment goal of "increasing self-acceptance" for the non-fat client than the fat client. A previous study which examined the interaction of years of

experience with client weight found no significant interactions between these variables on attributions of psychopathology (Young & Powell, 1985). One possible explanation for this finding may be that more experienced psychologists have been exposed to greater diversity within their clientele, and have more flexible ideas about for whom self-acceptance is an appropriate treatment goal. Less experienced psychologists may have worked with a more limited clientele, and have more rigid views about for whom self-acceptance is an appropriate treatment goal. This question can be explored further in future research.

This study provides evidence that psychologists' treatment planning and clinical judgments are influenced by client weight. However, this study also revealed several areas where bias against the fat client did not appear to exist. One such area involves the initial decisions a psychologist must make when planning treatment for a new client. These include such questions as: should this client be seen in an outpatient or an inpatient treatment setting? Will their needs be met best through individual therapy, group therapy, couples therapy, or family therapy? Can this client's difficulties be addressed through brief therapy, or is longer-term therapy warranted? This study suggests that these questions (recommended treatment setting, modality, and length) are not significantly influenced by a client's weight. In fact, respondents were fairly consistent in their

recommendations for individual, outpatient, longer-term psychotherapy, regardless of client weight.

This finding may be due to the nature of the information about the client's difficulties which was provided to respondents. The consistency of responses suggests that this information was relatively clear in indicating an appropriate treatment approach. This lack of ambiguity may or may not reflect the situation that occurs when a psychologist begins treatment with a new client "in the real world." One advantage of the format of the information provided in this study is that it was in a narrative, self-description format. This format is more likely to simulate the format of information a psychologist would receive from a new client, as opposed to a case summary or third-party description of the client's difficulties. However, a written self-description is still quite different from a face-to-face interview. Additionally, the amount and specific type of information a psychologist receives from a new client would vary considerably from professional to professional, depending on the psychologist's method of gathering intake information. It is possible that different information formats would yield more ambiguity regarding treatment planning, and thus would reveal different results regarding bias against fat clients.

Estimations of client motivation also do not appear to be significantly influenced by client weight. This is

particularly interesting in light of the finding that respondents did estimate lower levels of effort from the fat client than the non-fat client. In addition, psychologists tended to estimate that a greater number of therapy sessions would be required for a successful outcome with the fat client than with the non-fat client, although this finding failed to reach significance. As a whole, these findings appear to reflect one of the most common stereotypes of fat people: that they are lazy or lacking in willpower.

Psychologists estimated that the non-fat and the fat client would have equivalent levels of motivation to change, but that the fat client would put less effort toward treatment goals and would take somewhat longer to reach them. Thus, psychologists may assume that although fat clients are motivated to change, they will not exert as much effort to do so as would non-fat clients.

A final area in which findings of bias against the fat client were not found involves respondents' estimations of the client's overall level of functioning. It was expected that this study would provide support for Young and Powell's (1985) finding that a greater degree of psychopathology is attributed to fat clients than non-fat clients. In the present study, estimations of client functioning were measured through the Global Assessment of Functioning (GAF) scale from DSM-IV (American Psychiatric Association, 1994). Although there was a trend for psychologists to assign a

lower GAF score to the fat client than the non-fat client, this failed to reach significance. Thus, it may be that client weight does not affect psychologists' judgments of overall functioning. However, several methodological factors also may have contributed to the lack of a significant finding.

A number of participants did not respond to the GAF item on the survey (14%), and several who did respond indicated either that they were not very familiar or comfortable with this rating system, or that important information which they would use in their judgment was missing. Thus, the GAF may not have provided the best measure of respondents' perception of the client's overall functioning. In addition, the Young and Powell (1985) study defined psychological dysfunction as the number and degree of psychopathological symptoms estimated to be present. Although one would expect that level of functioning as assessed by the GAF and degree of psychopathological symptomatology would be related, it may be that these measures represent different aspects of psychological functioning. Clearly, the question of a general bias against fat clients in the form of estimations of greater psychopathology/poorer functioning requires further attention.

In addition to examining the impact of client weight on psychologists' clinical judgments, the present study was

designed to explore how psychologists' clinical judgments might be affected by the implicit treatment goals expressed by the client. In the present study, the client either suggested that she wanted to lose weight, or that she wanted to accept herself as she is. Thus, the present study was designed to examine such questions as: How will treatment recommendations and clinical judgments differ for a client who expresses a desire to lose weight, versus a client who expresses a desire to accept herself as she is? In general, it appears that respondents used the client's statements to inform their treatment planning, but only to a limited degree.

Psychologists appeared to use the client's implicit treatment goal in making judgments about provisional diagnoses. Specifically, respondents were more likely to consider a diagnosis of Eating Disorder for the client who suggested that she would be a happier person if she could lose weight. This finding may reflect psychologists' increasing awareness that clients who are excessively focused on their weight and body size may have an increased tendency toward developing an eating disorder, as the result of a pattern of restrictive dieting (American Psychiatric Association, 1994; Fairburn & Cooper, 1982; Mitchell, Specker, & Zwaan, 1991; Polivy & Herman, 1993). Thus, this appears to be a valid use of the information provided by the client's statement.

Respondents were also more likely to consider a diagnosis of a Somatoform Disorder for the client who expressed a desire to lose weight. Although somatoform disorders vary considerably in their symptomatology, their common feature is the presence of physical symptoms that suggest a medical condition, but are not fully explained by a medical condition. This finding is particularly interesting given that no physical symptoms were reported by the client in her self-description. One possible explanation for this finding involves the number of references the client makes to her physical body within each of the statement conditions.

Included in each self-description, regardless of client statement, was a sentence that indicated that the client had gone to her doctor for a physical exam, and that her health was fine (See Appendix D). For the client who expressed a desire to accept herself, this is the only statement in the self-description which refers to her physical body. In contrast, the client in the "lose weight" condition makes two statements which refer to her physical body: the statement about visiting her doctor, and the statement about her desire to lose weight. Perhaps the presence of these two statements in combination was enough to suggest to respondents that this client may be preoccupied with physical symptoms. This potential preoccupation may have led respondents to consider a provisional diagnosis of



Somatoform Disorder. Although the connection between the information provided and the diagnosis considered is less clear in this case, it does appear that psychologists used the client's implicit treatment goal to inform diagnostic considerations.

In addition to affecting provisional diagnoses, the client's implicit treatment goal also affected respondents' estimates of the amount of effort the client would exert toward treatment goals. Specifically, psychologists estimated less effort from the client who expressed a desire to accept herself than from the client who expressed a desire to lose weight. One possible interpretation of this finding involves the degree of specificity of each of these implicit treatment goals. Weight loss is a tangible, measurable goal. "Self-acceptance" is currently a popular concept in our culture, but is more difficult to measure or define. Psychologists may expect a client to exert more effort if that client is describing a specific, measurable treatment goal than if he or she is describing a more general one. Alternately, respondents may have estimated greater effort toward losing weight because typically there are external forces encouraging and supporting this treatment goal, such as family, friends, and the general cultural context. A treatment goal of self-acceptance may generate fewer immediate reinforcers or support for the client.

Although the client's expressed desires are being conceptualized as implicit, client-generated treatment goals, they apparently had limited influence on the treatment goals considered by respondents. Specifically, respondents considered treatment goals of "facilitating weight loss," "improving body image," and "increasing self-awareness" as more likely for the client who expressed a desire to lose weight than the client who wished to accept herself. Each of these findings will be examined separately below.

Psychologists appear to have responded directly to the client's implicit treatment goal of weight loss; respondents were more likely to consider weight loss as a treatment goal for the client who expressed a desire to lose weight than the client who expressed a desire to accept themselves. However, in neither condition was a goal of weight loss endorsed unequivocally. The mean rating for the client with the goal of accepting herself was equivalent to a verbal rating of "unlikely to somewhat unlikely," while the mean rating for the client with the goal of losing weight was equivalent to "somewhat unlikely to neutral." Thus, although respondents appeared to pay attention to the client's implicit goal, they did not endorse it unequivocally. With regard to the goal of weight loss, this finding gives cause for hope, particularly since over half of the respondents were viewing a photograph of a non-fat woman.

Respondents also were more likely to endorse a treatment goal of "improve body image" for the client who expressed an implicit treatment goal of weight loss. This finding is interesting, given that improving one's body image might be an equally logical treatment goal for a woman who wants to accept herself. Thus, this finding raises two questions. First, the question is raised again regarding what definition respondents were attributing to a goal of "improve body image." A second question concerns whether respondents were considering body acceptance as a part of self-acceptance. Post hoc analyses shed more light on this question, and are discussed below.

If respondents were considering acceptance of one's body as a part of self-acceptance, then one would expect the treatment goals of "facilitate self-acceptance" and "facilitate weight loss" to be negatively correlated; that is, as ratings on self-acceptance increase, rating on weight loss should decrease. However, this was not the case. For the fat client, the non-fat client, and the overall sample, ratings on the treatment goals of facilitating weight loss and self-acceptance are not significantly correlated. This suggests that respondents were not incorporating body acceptance into the meaning of self-acceptance. How psychologists' responses may have differed if "body acceptance" was explicitly included in the study as a client's implicit treatment goal, or within the

psychologists' list of optional treatment goals, is an interesting question to be addressed in future studies.

Finally, the treatment goal of "increasing self-awareness" was rated as more likely for the client with the implicit goal of weight loss than the client with the goal of self-acceptance. The explanation for this finding may be found in the wording of the target statement within the client's self-description. After detailing a variety of interpersonal and intrapsychic problems, the client in the "lose weight" condition suggests that, "Sometimes I think I'd be a happier person if I could just lose some weight." Attributing her various difficulties to one tangible factor, such as her weight, may have indicated to respondents that this client did not have a high degree of self-awareness. In contrast, an assertion that she would be happier if she could accept herself implies that the client is aware of her own lack of self-acceptance. This may have suggested some degree of self-awareness on the part of the client who had this as an implicit treatment goal.

One finding regarding the influence of the client's implicit goal on respondents' ratings of treatment goals is most notable for its absence. Consideration of the treatment goal of "facilitating self-acceptance" was not significantly influenced by whether the client suggested that she would be happier if she could learn to accept herself; this treatment goal was rated equivalently for clients in both statement

conditions. This finding may reflect the overall trend for respondents to consider self-acceptance as a very likely treatment goal regardless of client weight, statement condition, or any respondent factors. In fact, of the thirty treatment goals listed, self-acceptance was the fourth highest rated treatment goal. In light of this, the finding that psychologists were not more likely to consider self-acceptance as a treatment goal for the client in the "accept self" condition than in the "lose weight" condition may be interpreted in two ways. First, it may be that a "ceiling effect" obscured any differences that might have been present; that is, psychologists rated this treatment goal high enough in all conditions that differences were not statistically significant. Second, it may be that respondents assumed that learning to accept oneself is a positive and appropriate treatment goal for any client, regardless of whether they indicate they are interested in working on this.

It was expected that client weight would significantly interact with the implicit treatment goal in influencing psychologists responses. In fact, this was the case for only one item. Psychologists were more likely to consider a treatment goal of "increasing assertiveness" for the fat client who expressed a desire to accept herself. This finding suggests that respondents either assumed that a fat client who wants to accept herself is lacking in

assertiveness, or that it will require a greater degree of assertiveness for a fat person to learn to accept herself than it would for a non-fat person with the same desire.

What is most striking is the lack of other significant interactions between client weight and implicit treatment goals. It may be that respondents did not analyze the information at the level of sophistication required to integrate both client weight and the client's implicit treatment goals. However, this sort of analysis occurs regularly within a clinical practice; thus, this explanation seems unlikely. Another potential explanation is that while client weight and implicit treatment goal are each salient factors in treatment planning, the combination of the two does not add any new information. As stated above, this finding was unexpected; future research may examine this question further.

Although this study demonstrated that client weight does affect psychologists' clinical judgments and treatment recommendations, it also contains the inherent limitations that are present in analogue research. First, the interpersonal interaction between a therapist and client can be a powerful source of information on which the therapist bases treatment decisions. Within the format of this study, that type of information was necessarily lacking. Second, many psychologists do not make decisions about treatment setting, modality, and goals without seeking input from the

client. For example, a few respondents indicated on their questionnaire that they would consider particular treatment goals if the client indicated that they were relevant. Finally, it is unclear how a therapist's perceptions of their fat and non-fat clients change across time; for example, does weight remain as salient as it is in the initial meeting, become more salient as the therapist focuses attention on it, or become less salient as more information is gathered? These are the types of questions that this study did not address, and they are difficult to answer empirically. It is also worth noting that the conclusions of the present study are limited to the characteristics of the present sample and the stimulus person. Future research should include mental health professionals of various training backgrounds and ethnic backgrounds, and vary the sex, age, ethnicity, and clinical history of the stimulus person.

Several questions were raised by the current study. First, does bias against fat clients manifest itself in estimates of poorer overall functioning? The findings of the present study suggest that estimates of functioning are not significantly influenced by client weight. However, this finding is in contrast to previous findings (Young & Powell, 1985), and certain methodological limitations may have influenced the findings. Clearly, this question requires further examination.

Second, do mental health professionals consider body acceptance to be a potentially valid aspect of self-acceptance? Post hoc analyses in the present study suggest that respondents did not view self-acceptance as including body acceptance, but this question requires a more stringent empirical examination. If mental health professionals do not equate self-acceptance and body acceptance, how would clinicians' responses differ if they were presented with a fat client who specifically identified body acceptance as a treatment goal?

The purpose of the present study was to determine whether client weight influences psychologists' clinical judgments and treatment recommendations. The findings clearly indicate that client weight does influence treatment planning, and it influences it in the direction of more negative views of the fat client, especially for younger, female, and less experienced psychologists. Given this finding, intervention designed to combat fat bias among psychologists is warranted. The findings of both the present study and previous studies provide guidelines for when and how such an intervention might be most effective.

As demonstrated in both the present study and previous research (Young and Powell, 1985), younger mental health professionals exhibit greater bias against fat clients than do older mental health professionals. There was also some evidence in the present research that psychologists with



less experience are more likely to be influenced by fat bias. Thus, the earlier in one's career that intervention takes place, the more impact it is likely to have. Both undergraduate and graduate training programs provide an opportune time for intervention to occur; recipients are more likely to be relatively young and have fewer years of experience at that level of training. Intervention during graduate and undergraduate training contains the added benefit of a "captive audience." Training education on fat bias could be incorporated into any classes where the impact of value systems on treatment is discussed, such as ethics courses, cross-cultural courses, psychology of women/gender courses, and applied training courses.

An effective format of intervention is suggested by the findings of research examining fat bias in the general population. Research has demonstrated that belief in the controllability of fatness is a key component of bias against fat people (Crandall & Biernat, 1990; Crandall, 1994). Research has also shown that when fatness is attributed to an uncontrollable condition, the fat person is no longer derogated (DeJong, 1980). Finally, it has been demonstrated that changing subjects' beliefs about the controllability of fatness leads to a reduction in bias against fat people (Crandall, 1994). Thus, a critical component of any intervention would involve education which combats the belief that fatness is controllable. A second

component would involve education regarding the impact of fat bias on psychological treatment, as is demonstrated in the present study. The realization that professionals who have already been through training, and have practiced for several years, are vulnerable to this bias may allow students in training to acknowledge their own bias and encourage them to combat it.

Within this century, the field of psychology has become a cultural institution in the United States. As with most institutions, psychology can serve to reinforce the oppression of some members of society or it can serve to combat it. As the official cultural sanctifier of which behaviors and characteristics are "mentally healthy" and which are not, the institution of psychology holds a special power to disenfranchise "unacceptable" members of society.

Despite numerous studies which demonstrate that fat people overall have no more psychological difficulties than non-fat people (Crisp & McGuinness, 1976; Hayes & Ross, 1986; Kittel, et al., 1978; Segers & Mertens, 1974), mental health practitioners still appear to hold negative beliefs about the adjustment and psychological health of fat people (Young & Powell, 1985), and this belief may impact the psychological treatment that fat clients receive. When mental health practitioners themselves believe and are influenced by these myths, it is understandable that the general public would be. Only when psychology as an

institution explicitly acknowledges that being fat is not a mental disorder, and begins to combat fat bias within its own ranks, will this belief and attitude begin to "trickle down" to the rest of society. However, as history has repeatedly demonstrated, institutions can rarely be trusted to make these changes on their own. Only through education about fat oppression, its influences on psychotherapy, and its destructive impact on fat and non-fat people alike, may the institution of psychology begin to empower fat people, rather than disenfranchise them.

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## Appendix A

## Cover letter mailed to participants

Kristen L. Davis, M.A.  
Department of Psychology  
University of Montana  
Missoula, Montana 59812  
(406) 243-4523

July 15, 1996

Dear mental health service provider,

My name is Kristen Davis and I am conducting research for my doctoral dissertation in Clinical Psychology, under the supervision of Dr. Jennifer Waltz (e-mail: JWALTZ@SELWAY.umt.edu). I would appreciate your help very much. This study is designed to examine the differential effects of utilizing various types of information in clinical research, including self-description, case material, and photographs.

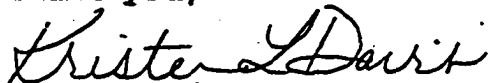
Please read the following information and answer the questions. Although it will be difficult to answer these questions based on the limited information provided, please answer every question.

This questionnaire takes only 10 minutes to complete.

Please send the questionnaire back within two weeks. If I haven't received one from you at that point, I'll drop you a note to remind you. Your responses will be anonymous and confidential. Please return the questionnaire in the business reply envelope provided.

Your assistance is invaluable.

Thank you,



Kristen L. Davis, M.A.  
Graduate Student  
University of Montana



Fat and non-fat photographs mailed to participants



Non-fat photograph



Fat photograph

## Appendix C

Statistical evidence of effectiveness of weight manipulation  
within "fat" and "non-fat" photographs

Table C1

Mean verbal weight ratings of photographs on Likert scales

Photograph condition	Mean rating	Corresponding verbal descriptor
Non-fat photograph	$\bar{M} = 4.00$	"Average"
Fat photograph	$\bar{M} = 6.00$	"Overweight"

Table C2

Mean numerical weight ratings of photographs on Likert scales

Photograph condition	Mean rating	Corresponding weight
Non-fat photograph	$\bar{M} = 3.07$	130 - 139 lbs.
Fat photograph	$\bar{M} = 6.77$	170 - 179 lbs.

## Appendix C continued

Table C3

F-ratio results comparing height/weight ratios for fat and non-fat photographs

Type of rating	F-statistic	Non-fat mean	Fat mean
Verbal ratings	F(1, 26) = 15.62 p < .001	<u>M</u> = .99	<u>M</u> = 1.40
Numerical ratings	F(1, 21) = 31.86 p < .0005	<u>M</u> = .51	<u>M</u> = .96

## Appendix D

## Questionnaire mailed to participants

(photograph)

I am a 28 year old woman, and I've finally decided to start therapy. I grew up with my mother and father, my twin sister, and an older brother. My brother died in a bicycle accident when I was nine. I moved a lot when I was a kid, and now change kind of makes me nervous. My parents and I hardly ever talk nowadays. They live pretty close to me, but whenever we're together I get so mad and frustrated with them it isn't worth it. My sister and I go through periods where we get along great and talk on the phone all the time, but then she'll start talking about me behind my back and spreading rumors, which makes me feel all nervous and paranoid.

I've been married for about five years, and we don't have any children. I guess I haven't been really happy for a couple of years now, and nothing I do seems to help. My husband seems to be just as unhappy with me as I am with myself. Sometimes I think I'd be a happier person if I could just [lose some weight/accept myself the way I am]. I used to love being around people and always had a lot of close friends, but now it seems like people don't want me around anymore. So I usually just spend a lot of time at home. I don't handle stress very well. I can just cry and cry at the drop of a hat - sometimes I can't even watch emotional commercials. I think maybe that's because my family treated me so badly while I was growing up.

I'd just like to fix whatever's wrong with me. I went to my doctor for a physical exam and he said my health was fine, so that's not it. Some days I feel completely worthless, and other days I'm so angry with everyone I can hardly control myself, then other times I'm so jumpy I can't stand to sit still. Sometimes it's like I don't have any feelings at all - I'm like a piece of wood or something. I never can figure out why I feel these ways - they just seem to come out of nowhere.

1. Which of the following types of therapy would you recommend for this person? (circle one)

Individual                      Group                      Marital                      Family

2. Which of the following treatment approaches would you recommend for this person? (circle one)

Brief                                      Longer-term

3. Which of the following treatment settings would you recommend for this person? (circle one)

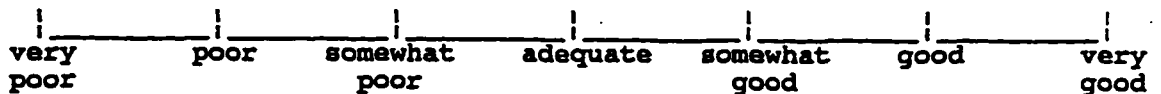
Outpatient                      Inpatient

Appendix D continued

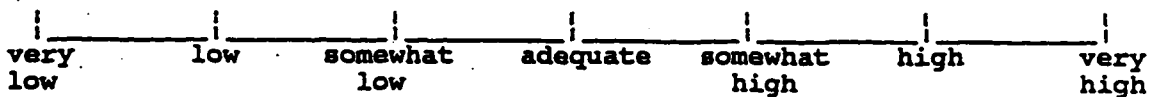
4. Please mark an X next to the diagnoses which come to mind that you would want to explore if working with this person.

- |   |   |
|---|---|
| <p><b>Psychotic Disorders</b></p> <p><input type="checkbox"/> Schizophrenia - paranoid, disorganized, catatonic, or undifferentiated type</p> <p><input type="checkbox"/> Schizophreniform Disorder</p> <p><input type="checkbox"/> Schizoaffective Disorder</p> <p><input type="checkbox"/> Delusional Disorder</p> <p><b>Mood Disorders</b></p> <p><input type="checkbox"/> Major Depressive Disorder</p> <p><input type="checkbox"/> Dysthymic Disorder</p> <p><input type="checkbox"/> Bipolar I or II Disorder</p> <p><input type="checkbox"/> Cyclothymic Disorder</p> <p><input type="checkbox"/> Mood Disorder NOS</p> <p><b>Anxiety Disorders</b></p> <p><input type="checkbox"/> Panic Disorder with Agoraphobia</p> <p><input type="checkbox"/> Panic Disorder without Agoraphobia</p> <p><input type="checkbox"/> Agoraphobia without Panic Disorder</p> <p><input type="checkbox"/> Social Phobia</p> <p><input type="checkbox"/> Obsessive-Compulsive Disorder</p> <p><input type="checkbox"/> Post-Traumatic Stress Disorder</p> <p><input type="checkbox"/> Generalized Anxiety Disorder</p> <p><input type="checkbox"/> Anxiety Disorder NOS</p> <p><b>Somatoform Disorders</b></p> <p><input type="checkbox"/> Somatization Disorder</p> <p><input type="checkbox"/> Somatoform Disorder</p> <p><input type="checkbox"/> Conversion Disorder</p> <p><input type="checkbox"/> Hypochondriasis</p> <p><input type="checkbox"/> Body Dysmorphic Disorder</p> | <p><b>Dissociative Disorders</b></p> <p><input type="checkbox"/> Dissociative Amnesia</p> <p><input type="checkbox"/> Dissociative Identity Disorder</p> <p><input type="checkbox"/> Depersonalization Disorder</p> <p><b>Sexual Disorders</b></p> <p><input type="checkbox"/> Sexual Desire Disorder</p> <p><input type="checkbox"/> Sexual Arousal Disorder</p> <p><input type="checkbox"/> Sexual Aversion Disorder</p> <p><input type="checkbox"/> Sexual Disorder NOS</p> <p><b>Eating Disorders</b></p> <p><input type="checkbox"/> Anorexia Nervosa</p> <p><input type="checkbox"/> Bulimia Nervosa</p> <p><input type="checkbox"/> Eating Disorder NOS</p> <p><b>Personality Disorders</b></p> <p><input type="checkbox"/> Paranoid Personality Dis.</p> <p><input type="checkbox"/> Schizotypal Personality Dis.</p> <p><input type="checkbox"/> Borderline Personality Dis.</p> <p><input type="checkbox"/> Narcissistic Personality Dis.</p> <p><input type="checkbox"/> Obsessive-Compulsive Per. Dis.</p> <p><input type="checkbox"/> Schizoid Personality Dis.</p> <p><input type="checkbox"/> Antisocial Personality Dis.</p> <p><input type="checkbox"/> Histrionic Personality Dis.</p> <p><input type="checkbox"/> Avoidant Personality Dis.</p> <p><input type="checkbox"/> Dependent Personality Dis.</p> <p><b>Other</b></p> <p><input type="checkbox"/> Adjustment Disorder</p> <p><input type="checkbox"/> Factitious Disorder</p> <p><input type="checkbox"/> Malingering</p> |
|---|---|

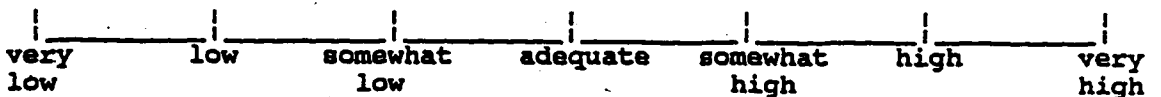
5. What would you predict to be this person's prognosis?



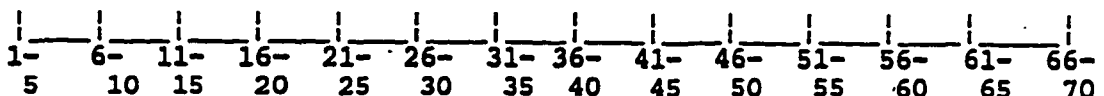
6. What would you predict to be this person's level of motivation to change?



7. What would you predict to be this person's degree of effort toward treatment goals?



8. What would you predict to be the number of sessions necessary for a successful treatment outcome with this person?



## Appendix D continued

9. Please rate how likely it is that each of the following would be a goal in your treatment. Use the rating scale below.

1                      2                      3                      4                      5                      6  
 very                  unlikely                  somewhat                  somewhat                  likely                  very  
 unlikely    unlikely                          likely                          likely                          likely

- |  |  |
|--|--|
| <input type="checkbox"/> Improve anger management skills<br><input type="checkbox"/> Increase self-esteem<br><input type="checkbox"/> Resolution of family-of-origin issues<br><input type="checkbox"/> Explore childhood relationships<br><input type="checkbox"/> Increase assertiveness<br><input type="checkbox"/> Address affective incongruence<br><input type="checkbox"/> Facilitate weight loss<br><input type="checkbox"/> Increase sexual satisfaction<br><input type="checkbox"/> Facilitate insight into difficulties<br><input type="checkbox"/> Decrease depression<br><input type="checkbox"/> Increase vocational satisfaction<br><input type="checkbox"/> Explore current relationships<br><input type="checkbox"/> Facilitate self-acceptance<br><input type="checkbox"/> Awareness of interpersonal patterns<br><input type="checkbox"/> Explore cultural expectations | <input type="checkbox"/> Address parenting issues<br><input type="checkbox"/> Management of thought disorder<br><input type="checkbox"/> Improve interpersonal skills<br><input type="checkbox"/> Facilitate sense of competence<br><input type="checkbox"/> Improve body image<br><input type="checkbox"/> Enhanced self-awareness<br><input type="checkbox"/> Exploration of early trauma<br><input type="checkbox"/> Improve problem-solving skills<br><input type="checkbox"/> Examine patterns of self-talk<br><input type="checkbox"/> Increase physical activity<br><input type="checkbox"/> Improve marital satisfaction<br><input type="checkbox"/> Focus on feelings of inadequacy<br><input type="checkbox"/> Explore sex-role socialization<br><input type="checkbox"/> Increase affective expression<br><input type="checkbox"/> Decrease suicidal ideation |
|--|--|

10. Please provide an estimate of this person's overall functioning utilizing the Global Assessment of Functioning (GAF) Scale (as described in DSM-IV):

GAF: \_\_\_\_\_

Please provide the following information about yourself.

11. Sex        M        F

12. Age \_\_\_\_\_

13. Ethnicity

- European American  
 African American  
 Asian American/Pacific Islander  
 American Indian  
 Latino American  
 Multi-racial

14. Highest degree earned in psychology or related field \_\_\_\_\_

15. Years of direct mental health service provision \_\_\_\_\_

16. Theoretical/clinical orientation \_\_\_\_\_

**Thank you for your participation. Please return this questionnaire in the business reply envelope provided.**

Table 1

Number of Respondents by Sex of Respondent and Weight of Client

	Non-fat client	Fat client	Total
Female	42	35	77
Male	65	58	123
Total	107	93	200

Table 2

Number of Respondents by Sex of Respondent and Client Statement Condition

	Accept self	Lose weight	Total
Female	42	35	77
Male	62	61	123
Total	104	96	200

Figure 1

Impact of client weight and participant age on estimations of client effort

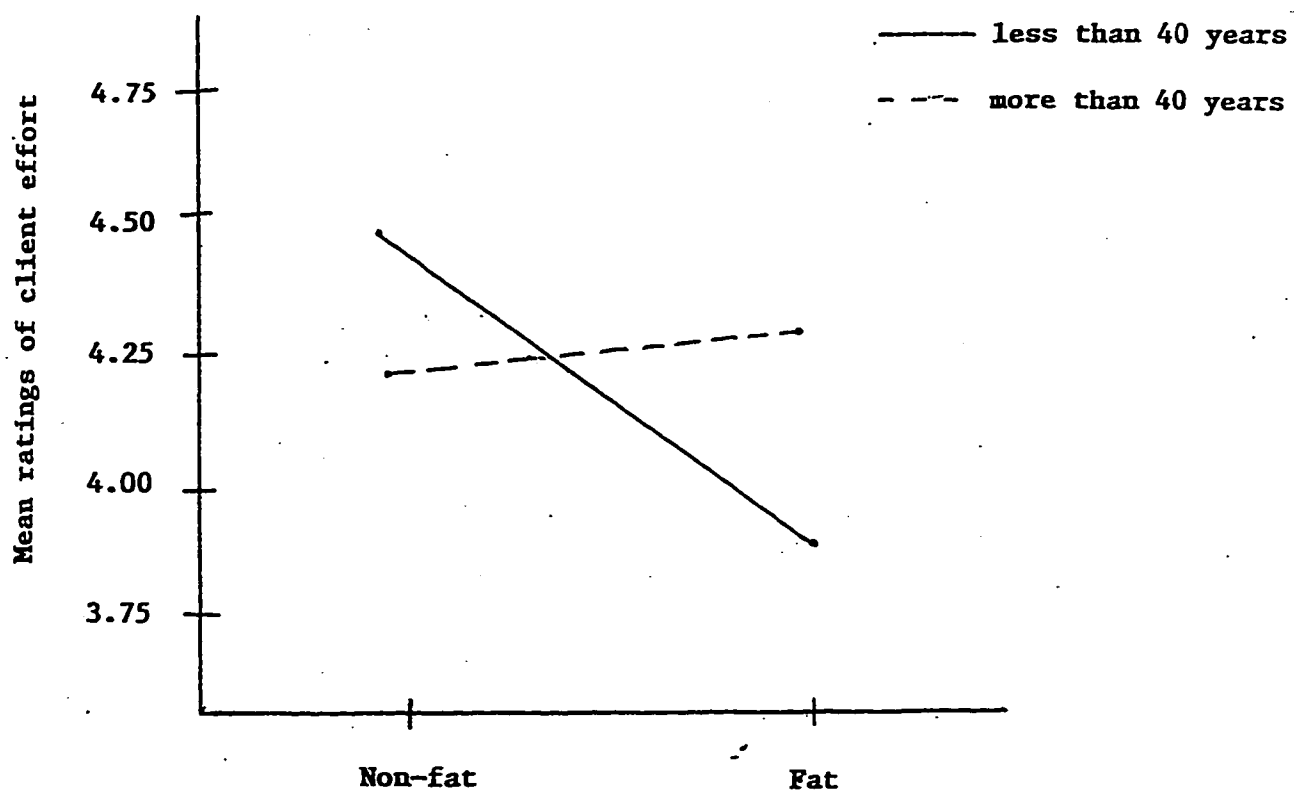




Figure 2

Impact of client weight and participant sex on estimations of client prognosis

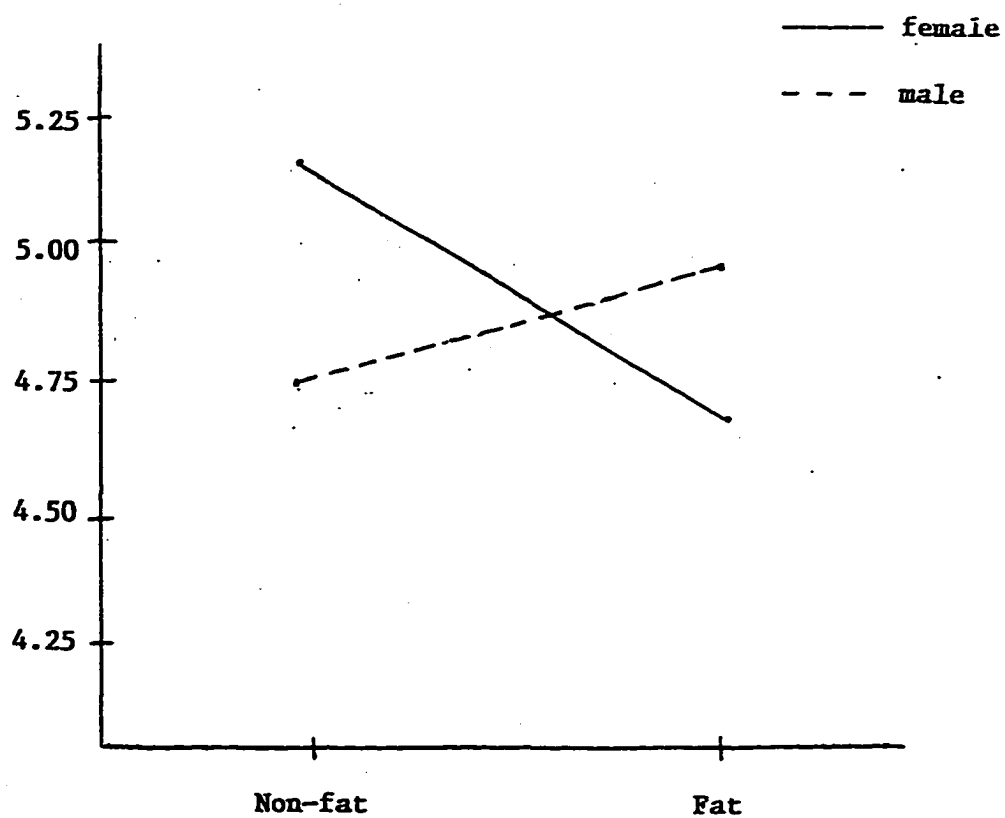


Figure 3

Impact of client weight and participant age on estimations of client prognosis

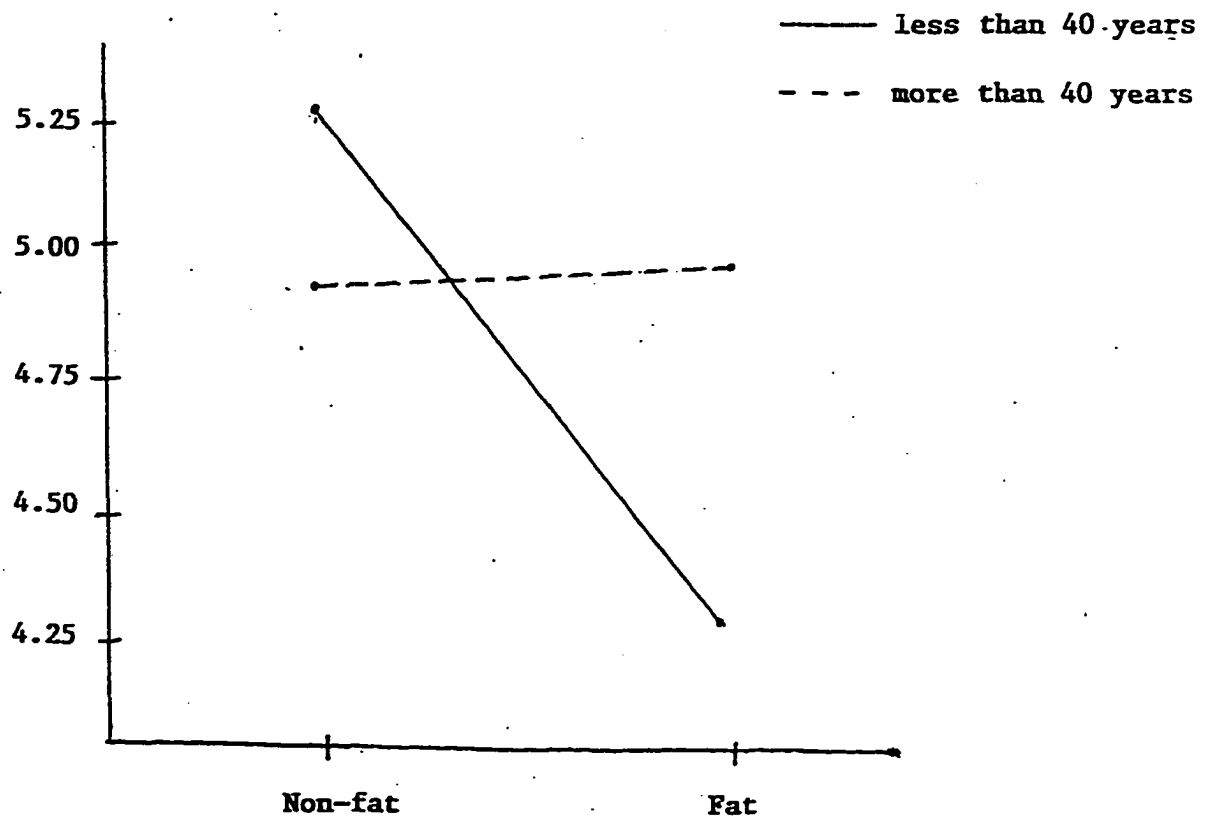


Figure 4

Impact of client weight and participant age on treatment goal "explore cultural expectations"

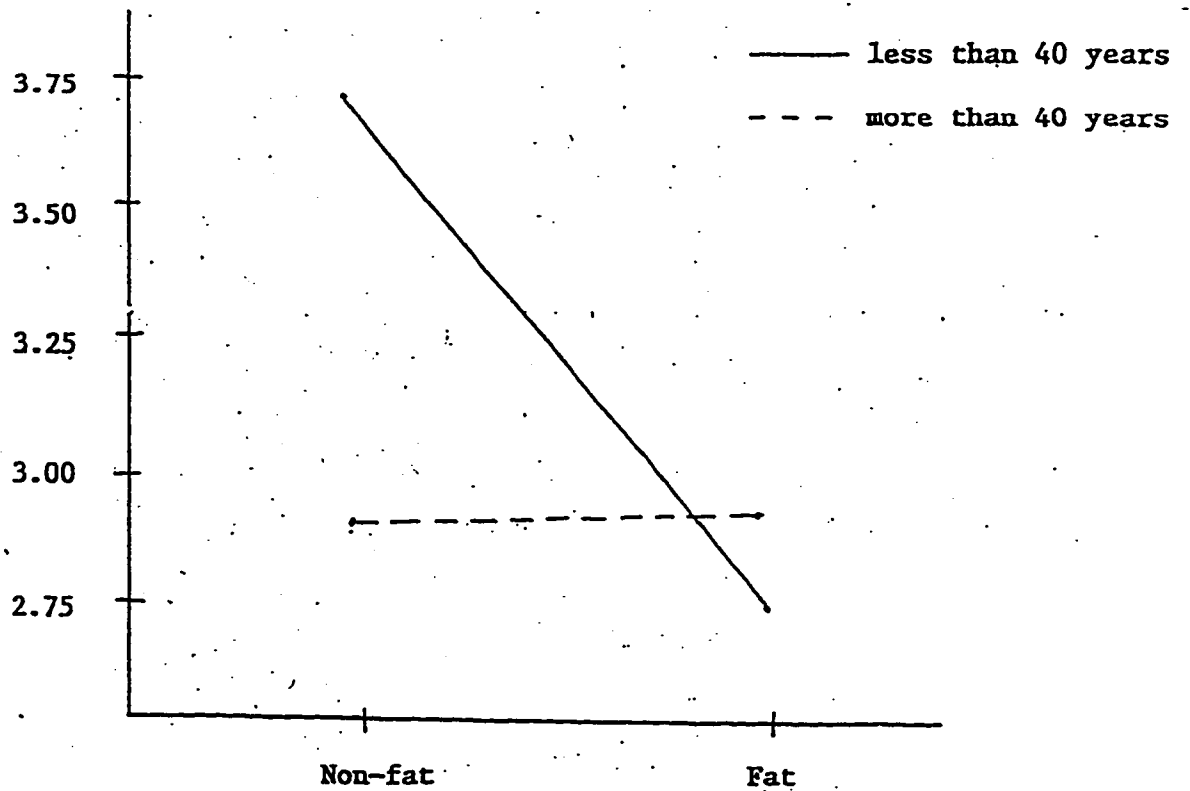


Figure 5

Impact of client weight and participant years of experience on treatment goal "facilitate self-acceptance"

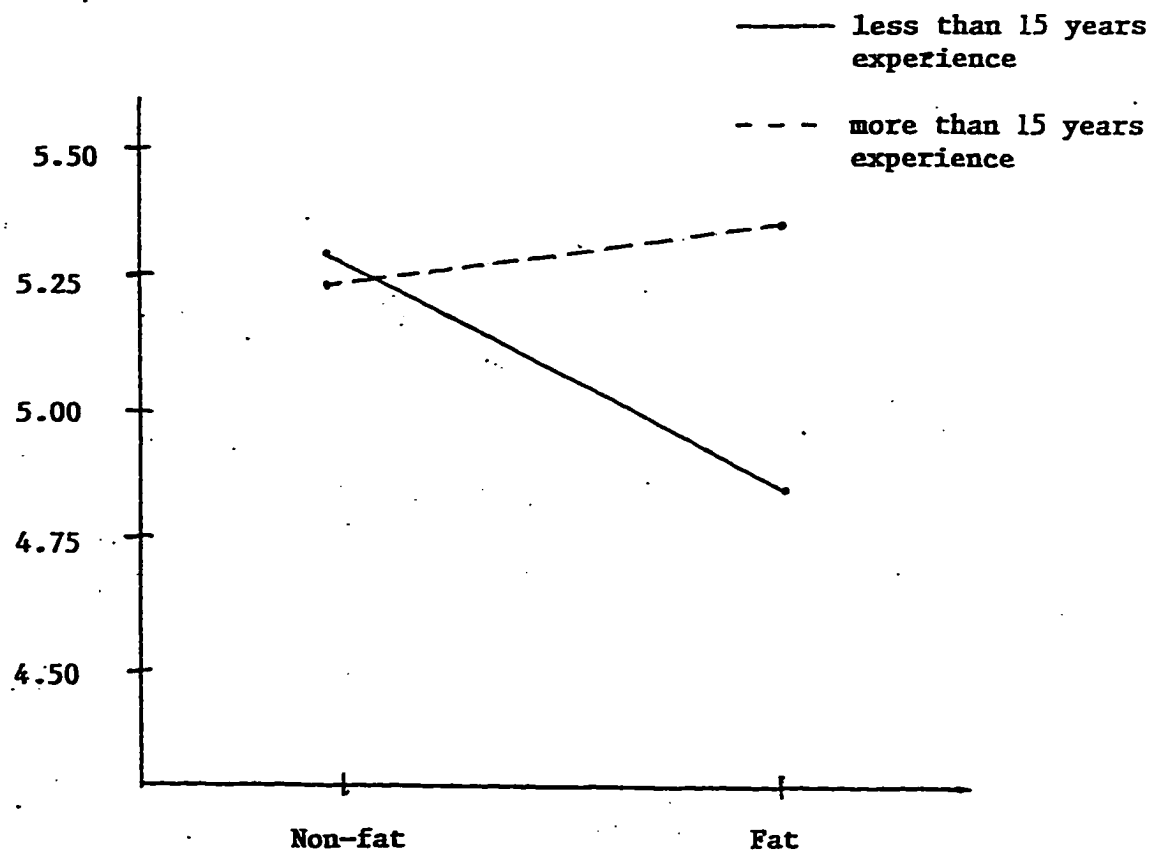


Figure 6

Impact of client weight and statement condition on treatment goal "increase assertiveness"

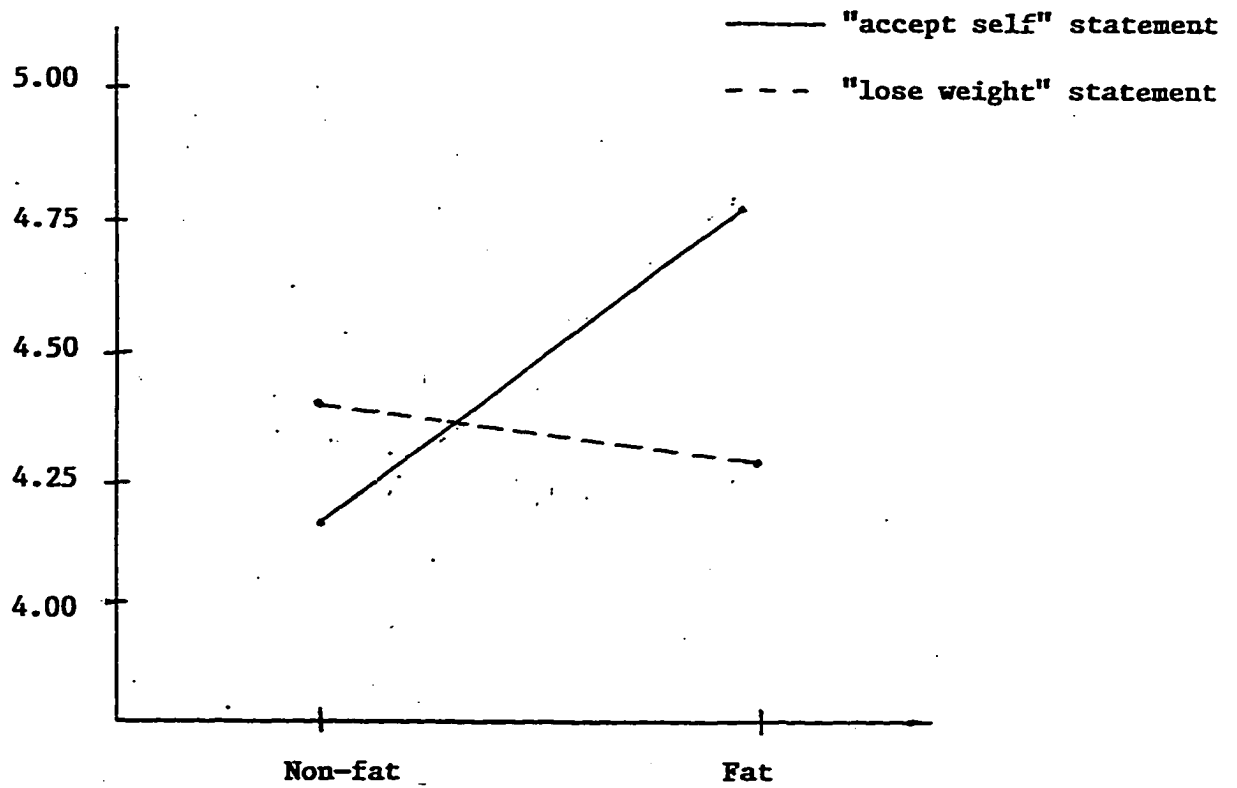


Figure 7

Impact of client weight and statement condition on treatment goal "address affective incongruence"

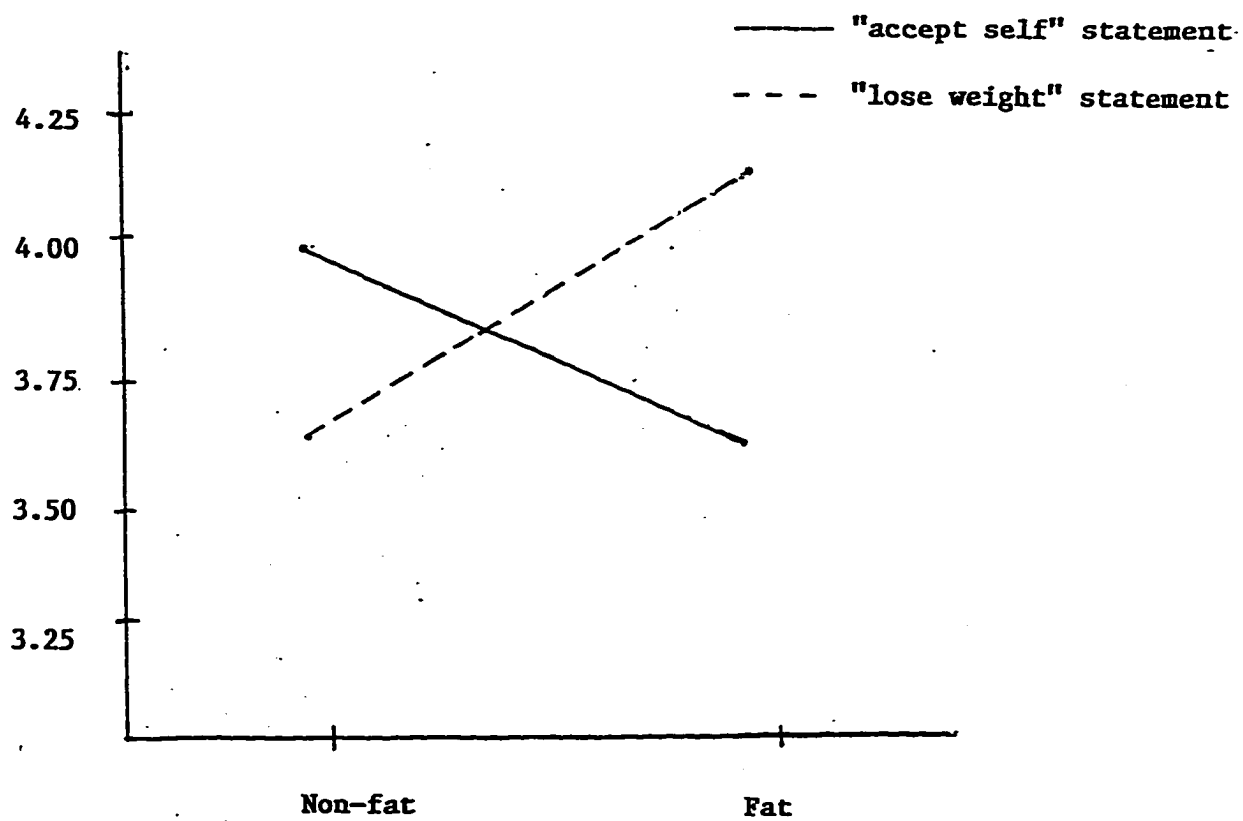


Figure 8

Impact of client weight and statement condition on treatment goal  
"management of thought disorder"

