

DOCTORAL THESIS

Weighing heavily on the mind: An exploration of how therapists construct and manage body weight within therapy

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Weighing heavily on the mind: An exploration of how therapists construct and manage
body weight within therapy

by

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ABSTRACT

This study sought to understand how dynamic and differential meanings of body weight are experienced and negotiated within therapy. Studies have demonstrated the operation of fat bias within therapy affecting clinical judgement and treatment planning (Brown & Rothblum, 1990; Davis-Coelho, Waltz & Davis-Coelho, 2000). Other than literature around eating difficulties (e.g. Bordo, 2009; Burns, 2004; Costin, 2009; Malson, 2009), there is a scarcity of research demonstrating how meanings of body weight shape the therapeutic process. There is however, research urging vigilance for the operation of body politics within therapy: culturally imposed oppressive meanings for the body that may inform embodied and subjective experiences within the therapeutic encounter (Allegranti, 2011; Soth, 2006; Totton, 2012). This research asked how are meanings of the body and body weight constructed by therapists? Using a constructivist grounded theory method (Charmaz, 2014) this study conducted 12 interviews with counselling psychologists and psychotherapists. The findings suggest that therapists construct a 'self' as a body in a space, interacting with meanings of body weight to claim an identity as a therapist. It demonstrates the existence of body weight prejudice in therapy settings, with some therapists sanctioning meaning-making in accordance with a culturally and institutionally approved body order.

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CHAPTER 1: INTRODUCTION

This chapter explores the premise of this research and introduces the issue of body weight and therapy as an area requiring further research.

1.1 Research context

Differences between therapists and clients such as ethnicity, sexuality and gender have been widely researched within psychotherapy and counselling psychology. However, differences in meanings imposed upon 'the body' and 'body weight' have been largely ignored (Brown & Rothblum, 1990; Fikkan & Rothblum, 2011). The body is acknowledged within sociological literature as a site for cultural influence where cultural constructions for the body influence how individuals perceive and receive each other. Within therapy this remains a neglected area of research. Prejudiced thinking about body weight is becoming more widely recognised by feminist and critical literature (Puhl, Andreyeva & Brownell, 2008; Puhl & Brownell, 2001). However, there is very little research that explores whether body weight discrimination pervades therapy, and if and how this is negotiated.

1.2 Meanings for the body and body weight

Meanings of body weight have become synonymous with health (Lupton, 1996; Tischner & Malson, 2012a), with definitions of health demanding that individuals reside within defined parameters of body weight. The Body Mass Index (BMI), calculated by an individual's weight and height ratio, categorises individuals as being a healthy weight, underweight, overweight or obese, and is taken to indicate the likelihood of health problems (NHS, 2013). These classifications for body weight are fixed and do not consider race, social status or an adult's age, only their gender. BMI is often reduced to a "measure of nutritional status" (Szabo, 2004, p.1). According to the World Health Organization (2015), the prevalence of being overweight and obese is increasing in the UK.

While referring to differential constructions of gender, it is suggested that Marecek's (1995) insights could be used to elucidate meanings of body weight: "None of

these views denies biological difference, but they do deny that such differences have a single, fixed meaning and salience whether from one culture to another, one historical period to another, one social group to another, or even from time to time in an individual's experience" (p.162). Magnusson (2011) concludes that symbolic, practical, and political meanings pervade categories for the body, and calls on psychological research to develop new ways to conceptualise difference.

This research adopts a critical, feminist stance to meanings around the body and body weight, recognising normative discourses that have the potential to discriminate operating around these issues. It seeks to explore how culturally constructed language, meanings and practices for the body and body weight are conceptualised and experienced by individuals within therapy, a neglected area of research. It aims to further thinking about difference and diversity and the ethical practice of counselling psychology.

1.2.1 Meanings of body weight within therapy

There is little literature exploring how body weight and cultural constructions for body weight may influence how individuals respond and relate with each other within a therapeutic context. With literature concerning 'fatism' and critiquing terminology such as 'obesity' and 'overweight' there is a greater awareness of prejudiced thinking surrounding body weight (Monaghan, Hollands & Pritchard, 2010; Puhl, Andreyeva & Brownell, 2008; Puhl & Brownell, 2001; Tischner & Malson, 2012). There is also literature that highlights the potency of such thinking for psychological well-being (Monaghan, 2008; Rothblum & Solovay, 2009). Limited findings suggest the operation of body weight bias operating within therapy impacting therapists' clinical judgement (Agell & Rothblum, 1991; Brown, 1989; Davis-Coelho, Waltz & Davis-Coelho, 2000; Pascal & Robinson Kurpis, 2012), and undermining therapist credibility (Rance, Clarke & Moller, 2014; Vocks, Legenbauer & Peters, 2007).

With literature suggesting the operation of body politics within psychotherapy (Allegranti, 2011; Soth, 2006, Totton, 2012), there remains a lack of literature focusing on how meanings of the body and body weight are negotiated within therapy. Beliefs and

stereotypes that become associated with other cultural constructs such as gender or age are widely acknowledged as potentially damaging for the therapeutic encounter, and therapists are urged to examine and interrogate such beliefs and explore their interrelatedness (Hays, 1996). However beliefs and prejudiced thinking about the body, and particularly body weight, appear to be largely ignored in the context of the therapeutic encounter.

1.3 Meanings and definitions in this study

This study includes terms such as 'fat', 'thin', 'overweight', 'underweight', and 'obese' when referring to existing findings, and the accounts of the participants in this research. It does so with an awareness of the hegemonic meanings that can become attached to these expressions, and the powerful and often pernicious implications of these for individual subjectivities (Malson, Riley & Markula, 2009). It is hoped that this research will go some way in exploring these notions and the normative thinking that such language can produce, rather than reifying the discrimination and marginalisation that these terms can create. With an awareness of the term 'fat' being reclaimed by fat activists as a descriptor that does not signify negative connotations (Rothblum & Solovay, 2009), in writing this study I am sensitive that for many, this word may still yield much pain and marginalisation.

I view descriptors such as 'fat' and 'thin' as simultaneously meaningful descriptors and meaningless, entirely dependent on the perspective of the user. After careful consideration, I have adopted symbolic interactionism as a theoretical perspective for this research, because it posits that we interact with and modify meanings (Blumer, 1986). However I am mindful of the power afforded by writing this study, and do not wish to fix others into a position of 'fat' or 'thin' by virtue of my greater access to do the positioning in this research. Instead, this study will illustrate how others construct these meanings and the implications of which for counselling psychology and psychotherapy.

With much of the critical and feminist literature focusing on eating disorders and body weight (Bordo, 2009; Burns, 2004; Malson, 2009; Malson & Swann, 1999), a

simplistic relationship between body weight and eating can become implied by the research available. Pathologised meanings of body weight can become inextricably bound with pathologised meanings of eating, reflective of normative discourses (Lupton, 1996). However, the presence of meanings around body weight do not reside only within the therapeutic domain of eating disorders, and research is needed to explore how language, practices and meanings of body weight are constructed in therapy where bodies are a necessary presence. This study seeks to understand how dynamic and differential meanings of body weight are experienced and negotiated by individuals within therapy, not only those defined as struggling with eating or weight 'problems'.

The term *therapy* is used within this study to reflect this study's exploration of accounts by practitioners fully chartered, registered or accredited with the British Psychological Society (BPS), British Association of Counselling and Psychotherapy (BACP), and UK Council for Psychotherapy (UKCP). Therapists were recruited on the basis of their qualification to ensure participants had 450 hours of clinical and theoretical practice and knowledge. The term therapy in this research also aligns with the pluralistic principles of counselling psychology and its psychotherapeutic principles (BPS, 2015), offering an exploration of all counselling and psychotherapy practice.

1.4 Research aims and question

The aim of this study was to explore body weight within therapy through accounts from fully qualified psychotherapists and counselling psychologists who had been in personal therapy themselves. It hoped to generate a theory for how meanings of the body and body weight are constructed by therapists as they interact with clients and their social settings. A constructivist grounded theory approach (Charmaz, 2014) allowed the exploration of body weight within therapy to be based closely on the phenomenological accounts of individuals, while contextualising therapy and body weight as embedded within culture.

This research began with the research question: How are meanings of the body and body weight constructed by therapists?

1.5 Relevance and contribution to knowledge

In view of research demonstrating the existence of normative and prejudiced meanings for the body and body weight, this study explores how this is negotiated and experienced by therapists and clients. With findings suggesting the presence of body weight discrimination within therapy, this research considers implications for the therapeutic process. This study seeks to open up the research beyond the limited field of eating disorders, recognising the presence of the body within therapy, and as such the embodiment of socially constructed meanings for the body and body weight. This study aims to explore how these meanings are negotiated within therapy and their interrelatedness with other cultural and social meanings.

This research seeks to contribute to the counselling psychology profession. Counselling psychology is a relatively young specialism of psychology, located in the world of helping, with a scientific base and a humanistic approach (Woolfe, 2016). Counselling psychology training emphasises pluralism, reflexivity and reflective practice (Donati, 2016). Professional practice guidelines for counselling psychologists emphasise their responsibility as practitioners to “recognise social contexts and discrimination and to work always in ways that empower rather than control and also demonstrate the high standards of anti-discriminatory practice appropriate to the pluralistic nature of society today” (BPS, 2015, p.2). This research offers counselling psychologists new ways of thinking reflexively and reflectively about the self, identity, the body and body weight within therapy. This study informs the field of counselling psychology and promotes ethical and reflexive practice. It encourages awareness of body weight as an important site of cultural influence and reflecting diversity along with other social constructs more commonly recognised within therapy such as age, gender, race and sexuality.

1.6 Structure of the study

Following this chapter, chapter 2 will explore the existing literature and findings relating to this study. In accordance with a constructivist grounded theory method (Charmaz, 2014) an initial literature review was undertaken to provide a rationale for the

research, and contextualise the research in relation to previous findings. The full literature review presented was conducted after the emergence of the grounded theory, to explore the theoretical concepts that emerged.

Chapter 3 considers ontological and epistemological positions within psychological research and clarifies the researcher's symbolic interactionist and constructivist stance. It explores the evolution of grounded theory and the rationale for using a constructivist grounded theory method that emphasises the reflexivity of the researcher and their interaction with the research.

Chapter 4 outlines the research design and its use of semi structured interviews to explore the accounts of a heterogeneous sample of 12 fully qualified therapists who had experienced their own personal therapy. It describes the ethical considerations of this study, and chronicles the systematic and rigorous data analysis afforded by a grounded theory approach.

Chapter 5 presents the findings of this research and offers a preliminary discussion. It provides a diagrammatical representation of the emergent grounded theory and elucidates the core category found by this research: 'A self as a body in space: claiming an identity as a therapist'. It also explores the two sub-categories encapsulated by this core category: 'interpreting the bodies in the therapy room' and 'making meaning within the therapeutic process'.

Chapter 6 summarises the results and offers a general discussion of the findings in relation to previous literature and research. It also provides an evaluation of the research and research method. It describes the implications of the research for counselling psychology, suggesting an ethical need for therapists, training bodies and regulatory bodies to interrogate meanings of body weight and consider practice that discriminates individuals.

Chapter 7 concludes the new findings of this research that demonstrates therapists constructing a self as a body in space, endorsing or critiquing normative and discriminatory meanings about body weight, to claim an identity as a therapist.

CHAPTER 2: LITERATURE REVIEW

Chapter 1 introduced this research as studying how meanings of the body and body weight are constructed within the therapeutic encounter. It explores whether new meanings of the body are enabled within counselling psychology and psychotherapy. Chapter 2 critiques the existing literature relating to this study, interrogating the research offered by previous authors. This research adopts a critical, feminist stance to meanings around the body and body weight, recognising normative discourses operating around these issues that have the potential to discriminate individuals. This chapter has been divided under 6 headings:

1. Body weight prejudice and the emergence of 'fat studies';
2. Body weight 'disorders' and the role of psychology and therapy;
3. Body weight bias within therapy;
4. Normative body weight meanings, self, identity and experiencing;
5. Body weight meanings, normativity and the role of therapy;
6. The social within the embodied therapeutic process.

The first section in this chapter looks at literature that highlights body weight prejudice operating at a societal level, and a growing interest in the sociological study of 'fatism'. The second section identifies the use of therapy as a treatment intervention to manage body weight 'disorders'. The third section looks at research suggesting the operation of body weight bias within therapy. The fourth section explores research that illustrates body weight meanings informing self concept, identity and lived experiencing. The fifth reviews literature on the management of meanings for body weight within therapy, and findings suggesting a potential to deconstruct normative thinking. The last section examines literature that demonstrates meanings around body weight shaping the therapeutic process and client-therapist relationship.

2.1 Body weight prejudice and the emergence of 'fat studies'

Body weight has been referred to as the last 'socially accepted prejudice' (Puhl & Brownell, 2001). Research in the US reports weight based discrimination as the third most frequent cause of perceived discrimination for women (after age and gender), more prevalent than discrimination based on race, religion, sexual orientation and disability (Puhl, Andreyeva & Brownell (2008). There is a growing awareness of prejudiced thinking surrounding body weight, and the potency of such prevalent thinking for the psychological well-being of the individual (Monaghan, 2008; Rothblum & Solovay, 2009). However, Fikkan and Rothblum's (2011) systematic literature review of weight based stigma remonstrates the scarcity of critical research exploring the lived experience of fat women. Compared to scholarly investment into other forms of discrimination faced by women, or issues related to weight such as eating disorders, the authors condemn the lack of research into body weight bias.

Lupton (1996) suggests that where thin is equated with wealth, power, control, attractiveness and success, fat is regarded as self-indulging, ugly, lazy and reflecting a lack of self-control. Being 'overweight' is commonly viewed as a problem that threatens individual, national and global well-being, and a problem perceived as both preventable and treatable (World Health Organization, 2015). These discourses also intersect with other discriminatory views such as gendered discourses. Fat is understood as not 'feminine', and that mothers are responsible for their child's meals and therefore subsequent weight 'problems' (Throsby, 2007). While a man deemed as overweight may be seen to be invested with power (Lupton, 1996), Monaghan (2008) describes men using alternative gendered discourses and talking of 'looking pregnant' to justify their attempts to lose weight.

Tischner and Malson (2012b) suggest that although the thin body is valued, a body viewed as *too thin* is pathologised. Findings suggest those deemed too thin to have less mind and moral agency (Holland & Haslam, 2013), and stereotyped as having an eating disorder or being depressed (Tantleff-Dunn, Hayes & Braun, 2009). Beggan and

DeAngelis (2015) describe the distress experienced by individuals when their thinness is construed as evidence of an eating disorder. Margins of normativity demand that individuals reside within a demarcated category of 'normal' body weight: with too thin or too fat deemed as undesirable, unhealthy and disordered. In an age of neo-liberalism, health becomes a responsibility for the individual, with those deemed outside the realms of a 'normal' weight seen as failing to make the right eating or lifestyle choices, or not taking personal responsibility for their health (Monaghan, Hollands & Pritchard, 2010; Tischner & Malson, 2010). Crandall (1994) suggests that a cultural preference for thinness and a belief that weight is controllable leads to fat prejudice. The interrelatedness of body weight with other social and cultural constructs such as gender, disability and social class has been explored (Aphramor, 2009; Bell & McNaughton, 2007; Ernsberger, 2009). Findings describe cultural practices of concealed discrimination and amplified oppression for those already marginalised.

Fat studies began as individual researchers and writers demonstrated their investment in critiquing prejudiced weight related beliefs. Wann (2009) suggests the effects of weight related discrimination on healthcare mediate the 'causal' link between weight and health risks, with healthcare professionals offering overweight patients fewer breast examinations and smear tests. Fat studies has grown into a movement that began in the USA but has a growing interest in the UK with Charlotte Cooper (a participant in this research), Lee Monaghan and Lucy Aphramor notable authors. The fat acceptance/activist movement demands the end of fat discrimination, and endeavours to liberate the fat individual. It describes the variation in weights across a population, likening it to that of height and relating it to sociological factors such as economic development and access to medicine and food. It assumes that as with the diversity in heights, the same can be expected of weight, and should not be assumed to be something that is controllable, nor something that implicates health. The Health At Every Size (HAES) approach to health care and policy (co-founded in the US by Deb Burgard, a participant in this research) is an alternative model that advocates size acceptance and a focus on health without implicating weight loss. It suggests that pathologising body weight harms

health through stigmatisation and discrimination, with HAES UK offering training for health practitioners in the UK. With research and fat studies demonstrating the prevalence of body weight prejudice, this study explores whether it pervades therapy and questions how therapists construct meanings of the body and body weight.

2.2 Body weight 'disorders' and the role of psychology and therapy

Tischner (2012) writes that psychology is generally tasked with investigating why individuals behave in ways that supposedly cause obesity, and suggesting interventions to promote weight loss. The author highlights that much of the psychological research is based on normative assumptions that weight is synonymous with health, and that weight loss is always beneficial for those deemed 'too large'. In 2011 the British Psychological Society Obesity Working Group published a report: *Obesity in the UK: A Psychological Perspective*. It argues for the efficacy of obesity treatments when combined with psychological and therapeutic approaches. Dr Waumsley, chair of the working group suggests: "It is clear from this report that obesity is a complex issue. If the 'cure' was as simple as logic suggests (eat healthily and take regular exercise) there would not be an obesity epidemic blighting the lives of so many and draining NHS resources" (BPS, 2011a, p.79). The report concludes: "the world of psychology can make a contribution to addressing the psychological function of overeating and doing what we can to enable distress to be expressed in words, rather than in deeds" (BPS, 2011b, p.72). This suggests a simple causality between overeating and obesity, positioning therapy as able to mediate this link, and implicating those defined as obese as responsible for overeating and draining NHS resources.

Weinstein and Deutschberger (1963) define 'altercasting' as positioning of the other into an identity that meets one's own goals, and describe it as a form of interpersonal control. Szasz (1961) critiques the use of diagnoses and psychological interventions, suggesting their uses are in the interests of manipulating power. Mizock (2012) cautions of the double stigma of being identified as having obesity and a serious mental health illness and rather than promote weight loss, the author argues for the use of

advocating health at every size. There is research contesting commonly held beliefs that body weight is simply a result of eating and exercise choices, that diets are effective for long-term changes in body weight or improving health, or that being 'obese' or 'overweight' affects mortality and morbidity (e.g. Aphramor, 2008; Campos, 2004; Tischner & Mason, 2012a). Much of the critical literature exploring body weight and therapy focuses on clients with eating disorders. It explores the contentious nature of labelling clients, and suggests that working 'therapeutically' in this field may encourage limited discourses and meanings of body weight (Malson, Finn, Treasure, Clarke & Anderson, 2004). It also highlights a blurred distinction between pathologised and therapeutic regimes of weight management (e.g. Burns, 2004; Malson, 2009).

In the critical literature on body weight and therapy there is a turn towards viewing lived experiencing as embedded in and constituted by sociocultural contexts. "Dis-orders of eating and embodiment are constituted within (rather than being deviations from) the normalized (and normalizing) orders of subjectivity, embodiment and body management of contemporary Western society" (Malson & Swann, 1999, p.398). Burns and Gavey (2004) and Malson, Clarke and Finn (2008) note that discourses that denigrate fat and promote a 'healthy' weight normalise and rationalise 'disordered' weight regulatory practices. Bordo (2009) explores the pressures experienced by individuals to obey normative body standards, highlighting culturally differential meanings of body weight, with a larger body viewed as a symbol of racial superiority for some cultures. Bordo suggests that meanings for body ideals are dynamic and culturally diverse, focusing on the implications for which on eating disorders. While the critical literature within this field seeks to expand understandings of body weight beyond individual pathology, it still limits findings to a paradigm of eating dis/orders.

Bidgood and Buckroyd (2005) suggest "counselling could play a greater role in the treatment of obesity" (p.221), highlighting a lack of 'success' in weight loss treatment without such help. While the authors describe widespread discrimination faced by 'obese' participants, the study relies heavily on research by Brownell (1998) that implicates an individual's pathologised eating and exercise behaviours as the 'cause' of obesity. While

seemingly aware of alternative constructions of health beyond parameters of weight, the authors conclude “these obese people want to lose weight, but need detailed advice on healthy eating and exercise, plus on-going support at both a professional and social level” (p.228). The research apparently ignores its own reports of participants wishing to achieve a weight that would be accepted by others, with the problem firmly located in the individual, rather than a society that refuses to accept a diversity in body size. While researchers’ intentions may be to expand existing discourses around body weight, participant recruitment from weight loss clinics or a reliance on a medical model of weight with a focus on food, reifies individuals as pathological (i.e. Braet, 2005; Buckroyd, Rother & Stott, 2006; Crider, 1946; Flack, 1975; Franzini & Grimes, 1981; Goodspeed Grant & Boersma, 2005; Karasu, 2012; Karasu, 2013).

Suggesting a tension inherent in therapies that encourage weight loss, Walker and Hill (2009) caution of the need for more research into the role of child mental health services (CAMHS) working with obese children. The authors write of the complex relationship between obesity and mental health, and the mediating ‘toxic weight-hostile environment’ that children grow up in. The authors suggest that the way a child’s weight is discussed and viewed at both assessment and intervention stages is likely to vary depending on a clinician’s training, personal beliefs around weight, experience of weight-related issues, and practice model. They suggest further research is needed into how often children’s mental health services raise the issue of obesity, by whom and with what effect. While Walker and Hill stress the importance of working with “obese people to enhance a sense of self-acceptance and self esteem...regardless of weight status” they continue “This may in turn lead to the acceptance of modest weight loss as an acceptable goal” (p.118). This suggests that acceptance of a client’s weight perhaps comes with the caveat that a decreased weight is more acceptable. They question “Clinically, how should CAMHS professionals respond when obesity is clearly an issue but no one is mentioning it?” (p.120). Perhaps a question that remains unanswered and that triggers more questions as to whom the issue is for, and when obesity is ‘clearly’ an issue.

There is a call for therapy to treat the ‘overweight patient’ and “her decision to use

the body/and or the function of eating as a defence” (Leach, 2006, p. 229), and support weight loss and dieting (Judith Beck as cited in Madewell & Shaughnessy, 2009). This questions whether therapists are aware of alternative understandings of weight that welcome diversity and do not conflate issues around weight with those of eating, disordered or otherwise (Brown & Rothblum, 1989). It also raises the contentious issue of the ethics of a therapy practice that endorses weight loss (Chrisler, 1989; Courtney, 2008; Dworkin, 1989). Pinhas et al. (2013) demonstrate that interventions aimed at helping young people to achieve a ‘healthy weight’ may not be risk free, and may encourage a preoccupation with weight and the development of disordered eating. Mintz et al. (2013) describe the evidence base that suggests that frequent self-weighing can predict binge eating, unhealthy weight control behaviours, weight gain, decreased self-esteem, increased anxiety and depression. Their study showed that whilst the majority of their participants felt that self-weighing was helpful and not harmful, their results suggest this may not to be the case, with half the participants experiencing their sexuality and self-worth influenced by the number on their weighing scales. The authors suggest “a normative influence of scale number on emotional status” (p.87) that is not identified by individuals as problematic. This raises uncomfortable questions about the ethics of weighing clients or encouraging ‘healthy’ eating and lifestyle practices within therapeutic settings. It also has implications for therapy where therapists may too fail to recognise or encourage exploration of the impact of such body monitoring on emotional well-being, with this study exploring how therapists negotiate meanings around body weight.

2.3 Body weight bias within therapy

2.3.1 The client’s body weight

While prejudice associated with other cultural constructs such as gender or age is widely acknowledged as potentially damaging for the therapeutic encounter (i.e. Hayes, 1996), beliefs and prejudiced thinking about the body, and particularly body weight, appear to be largely ignored in the context of the therapeutic encounter. Psychotherapy and psychology has a long history of pathologising fat (see Gettis (1978) and Yalom

(1989) for very explicit examples). Brown and Rothblum's (1990) seminal work powerfully argues for the recognition of fat oppression within therapy as an ethical issue that must be interrogated and resolved by therapists. Brown (1989) highlights the insidious nature of fat oppression, illustrating feminist therapists actively rejecting other prejudiced perspectives such as racism, while rationalising fat attitudes towards clients on the basis of the existence of a fat body supposedly evidencing intrapsychic conflict. Ingram (1978) and Drell (1988) argue that therapists must recognise their cultural conformity with a preference for thinness, and ambitions to assist clients with losing weight, both of which they suggest interfere with therapy. Sherman-Meyer (2015) highlights similar concerns, and suggests that the effect of fat hatred may lead psychoanalysts to keep fat clients at a psychological distance. Research has demonstrated mental health practitioners presuming negative character traits of overweight clients, ascribing more severe diagnoses and conveying a lack of empathy. These biases were further exacerbated where they perceived the client as having low economic status (Agell & Rothblum, 1991; Pascal & Robinson Kurpius, 2012). Davis-Coelho, Waltz and Davis-Coelho (2000) demonstrate the operation of fat bias within therapy affecting psychologists' clinical judgement and treatment planning; with biased psychologists predicting poorer prognosis for fat clients. The researchers comment on the significance this bias might have for the therapeutic relationship, such as setting more conservative treatment goals and expecting less from the fat client.

Gillon (2003) makes a compelling argument that whilst the dominant perspective in academic literature emphasises body weight concerns as a female issue, there is a growing number of researchers highlighting it as a sociological and psychological issue for men (see Monaghan 2008). Gillon suggests that the feminised language of body weight precludes men, who identify with normative constructions of masculinity, from recognising difficulties related to their body weight. Gillon describes possible implications for therapy including men with body weight difficulties being unable to access therapy, or find a language or a therapist that enables them to share their body weight and lived experiencing. Wiggins (2009) uses discursive psychology to demonstrate how weight

becomes psychologised by clinicians, with the use of the dominant medical model of weight limiting an individual's opportunity to make meanings that draw on socio-cultural issues. Problems become located in the self rather than the broader and more complex issue of the social context, with body weight situated within a discourse of regulatory practices of self discipline and health monitoring. Wetterling's (2001) comparative review of body weight gain with antipsychotics recommends that patients are weighed at least fortnightly, and if there is body weight gain "a strict dietary regimen should be initiated immediately" (p. 71). Paradoxically, the research highlights a possible therapeutic benefit of weight gain requiring further study, and the impact of introducing strict eating regimes is not explored. Perhaps this illustrates a common approach to body weight from a medical model perspective, with this study exploring how meanings of body weight are approached from the perspective of counselling psychology and psychotherapy.

2.3.2 The therapist's body weight

It is not only meanings around clients' bodies that may shape the therapeutic process, with research from within a paradigm of eating disorders suggesting the importance of the *therapist's* body weight. Lowell and Meader (2005) stress the value of inviting talk about the therapist's body within therapy, and exploring beliefs and feelings evoked by the therapist's body. They suggest that therapists' counter-transference of their own body feeling inadequate allows insight into a client's struggles. Picot, McClanahan and Conviser (2010) describe the therapist's body size, appearance and weight as indirect forms of self-disclosure. Vocks, Legenbauer and Peters (2007) speculate that body weight may influence therapist credibility, and that a therapist deemed very slim may induce shame in clients with eating disorders who feel unable to match up to the thin ideal. Similarly the authors suggest that a 'too' thin or fat therapist may be unable to alleviate clients' fears about weight gain. Findings by Rance, Clarke and Moller (2014) support these claims, demonstrating clients' perceptions of their therapist's ability to help them affected by their body size. It also highlighted a therapist's body being deemed as thin or fat affecting a client's willingness to engage in therapy. McHilley (2010) explores the issue of a therapist's weight loss being interpreted by colleagues as symptomatic of an eating

disorder. The author questions whether working within the field of eating disorders conflates weight loss with eating disorders. McHilley suggests that a therapist's weight should be differentiated from their professional performance, but concludes that working within a field of eating disorders necessitates seeking supervision to consider whether a colleague's weight needs addressing.

Writing about the effective use of behaviour therapy for the treatment of obesity, Horan, Robb and Hudson (1975) suggest that therapists must conform to a certain body size. The authors write "there is no longer any reason why practicing counsellors should continue to be burdened by pounds and pounds of hypocrisy" (p.456). It seems likely that anti-fat attitudes exist amongst clients beyond those with eating disorders, with Moller and Vossler (2013) suggesting that counsellors deemed as fat by clients are perceived to be unprofessional and incompetent. However, findings by McKee and Smouse (1983) failed to demonstrate therapist weight affecting client perceptions. Lerman (1989) urges therapists to consider the differences and similarities between their client's body size and their own shaping the therapeutic encounter. Barron and Hollingsworth-Lear (1989) and Brouwers (1990) advise therapists to examine not only their conscious and unconscious beliefs and values about appearance, but also their attitudes towards their own bodies.

The proliferation of fat biased attitudes points to prejudiced views of professional competency from both clients and therapists alike, as suggested by Murray (2010). However, there is little consideration for how this affects therapists, with existing literature limited to the field of eating disorders. Within a culture where anti-fat attitudes are prevalent and normative, research is required to understand how meanings about body weight shape therapy, and whether clients' and therapists' bodies and the meanings around them are negotiated or ignored within the therapeutic encounter. Research within healthcare (Aranda & McGreevy, 2014; Bleich, Bennett, Gudzone & Cooper, 2012; Brown & Thompson, 2007; Perrin, Flower & Ammerman, 2005) suggests that practitioner's body size, relative to their patient's, impacted whether they approached issues around weight, and their perceptions of how patients would view their credibility. The current research study is required to explore if the same is true of counselling psychologists and

psychotherapists beyond the realm of eating disorders.

2.4 Normative body weight meanings, self, identity and experiencing

There is much literature that acknowledges the body as a site for cultural influence (i.e. Shilling, 2003). Foucault (1965, 1972, 1979a, 1979b, 1980) described disciplinary regimes that generate classifications such as underweight and overweight, which we then extend through our own use of such language; cooperating with this subjugation and finding fault in ourselves and others. Magnusson (2011) adopts a symbolic interactionist perspective to describe the effect of such classification on experienced identity. She suggests that individuals respond and interact with classifications they have been assigned to, developing emotions, behaviours and thinking that in turn verify the classification. The self and identity are social concepts, with the self emerging from social interaction and reflexively shaping the ability to reflect and conceive of oneself (Blumer, 1986; Denzin, 1972; Honneth, 1995). Identity is the label by which we give ourselves, or are known, that locates us in relation to others (Altheide, 2000; Snow and Anderson, 1987; Stone, 1962). Berger (1963) describes identities as socially bestowed, maintained, and transformed, while Giddens (1991) suggests that self-identity is a “reflexively organised endeavour” (p.5) that “pervasively affects the body as well as psychic processes” (p.7). Rubin, Schmilovitz and Weiss (1993) describe rituals that individuals perform in order to gain social recognition of their conversion from an identity as fat to one as thin, with body weight seemingly implicated in a person’s identity.

Carr and Friedman (2005) highlight the within-group differences often ignored for individuals defined as obese. Drawing on Goffman (1963), they suggest that at higher weights obesity becomes a characteristic that overrides all other characteristics of a person’s identity. Charmaz (1994) terms this a ‘master identity’. Packer (1989) and Rice (2007) both describe fat as a dominating identity, producing limited access to other identities including gender and sport. Rice’s (2007) feminist post-structuralist theory of fat describes body size as a social form produced by the intersection between bodies, cultural representations and social practices. This results in the ‘unfit fat body’ and limited

opportunities for individuals to contest received meanings and identities. Haworth-Hoepfner and Maines (2005) use Charmaz' (1991b, 1994) concepts of 'master identity' and 'fictionalized identity' along with what they call 'discordant awareness contexts' to explain the persistence of invalidated identities. They suggest that Stryker's theorising (1968) is inadequate in its assumption that when a person experiences their identity claim distinct from the expectations of others they will lower their commitment to it. The authors use anorexia as an example of an invalidated identity that persists. Balogh-Robinson (2010) suggests that the proliferation of body weight issues saturating the media creates an internalisation of the ideas that the media propagates. Not only does the media reflect the dominant ideology of a culture, but reaffirms it, shaping the consciousness and behaviour of its consumers. Before and after weight loss stories serve to redraw boundaries between deviant/healthy, abnormal/normal, and reify that fat is bad. Individuals considering weight loss surgery construct their authentic selves as thin, trapped inside a wrong and fat body (Throsby (2008). These findings suggest that those deemed as overweight are restricted from having an identity other than that culturally prescribed.

Goffman (1959, 1963, 1967, 1971, 2013) provides an analysis of social interaction that illustrates encounters between actors giving rise to social identities that draw on societal meanings and norms. Schwalbe and Mason-Schrock (1996) emphasise identity work as group processes that create "situated self making" (p.115). Schwalbe et al. (2000) present a symbolic interactionist account of the social processes that produce inequality. The authors highlight the use of: othering that identifies a group as subordinate, boundary maintenance to preserve the boundary between the superior and inferior groups, and emotion management to maintain social order. Berger and Luckmann (1966) posit through their social interaction model that we objectivate ourselves and the other through language. Acting in accordance with the expectations of others (Plummer, 2010), and the setting (Reid, Webber & Elliott (2015). Our own subjectivity is informed and limited by the language and discourses available, and as such this may limit how clients construct their issues and their place within them, particularly those clients excluded and marginalised.

Lyons (1989) writes of the process in which being fat dominated her identity: “living from the chin up to desperately try to escape the reality of my fat body” (p.68). Lyons describes the oppression she suffered generating feelings of shame and self-hatred and a disenfranchisement from her own body and what it could do. Objectification theory suggests that females in particular are inculcated to internalise an observer’s perspective, informing their perception of their physical selves. Fredrickson and Roberts (1997) highlight the impact this has on subjective experiences of shame, anxiety and perception of internal bodily states, with increased mental health risks. Fatist views can become indoctrinated with so called fat individuals feeling like failures and believing that fat cannot be attractive. They restrict activities in daily life from a fear of being judged negatively and experiencing low self esteem (Robinson & Bacon, 1996). With less focus on the experiences of individuals considered underweight, those who experience such discrimination are reported to experience similar psychosocial issues as those deemed as too fat and suffer from low self-esteem (Lox, Osborn, & Pellett, 1998). Pascal and Robinson Kurpius (2012) purport that individuals who experience weight stigmatisation are likely to struggle with binge eating and body image disturbance. Schafer and Ferraro (2011) found that individuals who perceived themselves to be discriminated against because of weight, experienced exacerbated problems with mobility, irrespective of actual body weight. The authors emphasise the toxicity of social processes of weight discrimination for an individual’s self concept and lived experiencing.

Charmaz (1991a; 1991b) postulates that the self-concept is resistant to change due to its complex and stable organisation. Murray (2005a, 2005b) suggests the alternative discourse of fat studies is not sufficient in overcoming internalised self-disciplinary regimes and body knowledges. She describes herself seeking to rebuff society ‘reading’ her fat body and to create an alternative embodied subjectivity. Murray (2005a) describes her desire to “re-negotiate the system of ‘knowingness’”, contest the ‘truths’ attributed to the fat person and “reinscribe my fatness with positive and enabling counter discourses” (p.266). However, Murray (2005a) highlights “the complex relationship between the body as it is lived, and the body as it is imagined/perceived by

others, and the way these dominant discourses mediate this relationship” (p.271). A rejection of the fat body identity necessitates a rejection of inscribed understanding of one’s own body and experiencing oneself as an embodied subject. Murray (2005a) suggests that we can’t live outside of the dominant body knowledge and stresses the corporeality of subjectivity that requires more than simply thinking differently about fat. She notes the ambivalence and ambiguity that endures for the fat individual seeking a different sense of self. Murray (2005a) suggests that this ambivalence can’t be resolved, but is often ignored in fat activism that strives to create a unitary sense of self to replace a heteronormative fat identity.

Tischner and Malson (2012a) describe “the imperialising power of medical discourse to pathologise bodies to the extent that we may no longer trust embodied feelings of well-being being or ill-health” (p.56). They illustrate fat women in their research constructing their body weight as a predictor of ill-health, despite explicitly refusing a negatively constructed fat subjectivity and describing themselves as healthy. These participants are seemingly unable to contend with the ‘truths’ produced by neoliberal healthism, where a fat person contesting meanings around health reifies them as ignorant and uneducated about normative body knowledge. In contrast, the authors highlight another participant identifying as fat using her embodied subjectivity as an indicator of health and well-being, empowering and constructing herself as the expert on her mental and physical health and challenging normative discourses. It would seem that using a neoliberal discourse around health creates a potential for the fat subject to become disenfranchised from embodied subjectivity and disassociated from embodied feeling. While, there are alternative discourses available, fat denigrating ‘health’ discourses prevail.

The literature demonstrates society informing self, identity and experiencing as individuals interact with their social settings and the meanings within them. This research explores whether therapy enables clients to construct their own meanings for the body and body weight within a society that largely denigrates the ‘too fat’ or ‘too thin’ individual.

2.5 Body weight meanings, normativity and the role of therapy

Hook (2003) and Rose (1990, 2003) question whether therapists and the therapeutic relationship facilitate or resist the use of alternative discourses. The authors describe how the language therapists use, the structure they reside within and the positioning of client and therapist, reflect the operation of power within the therapeutic encounter. May (2007) suggests that ethical practice demands that therapists recognise the institutions and practices that they operate within, or as Giddens (1990) terms 'expert systems', and the implicit power dynamics within the therapeutic encounter. Erdman (1999) cites the multitude of psychological theories for the 'cause' of the fat body, all resting on a pathologising of fat. Erdman warns therapists to be mindful of weight-loss as a culturally endorsed solution for fat clients, many of whom will be struggling with difficulties faced by individuals of any size. She suggests a responsibility lying with therapists to empower their clients to challenge ideas that locate body weight as the source of psychological difficulties, to recognise the impact of societal fat oppression, and to confront fat-phobia both in and outside of therapy. Erdman suggests therapists consider their clinical space and whether it welcomes size diversity as represented by the seating available and imagery offered by reading material in waiting rooms.

Exercising a 'sociological imagination' (Mills, 1970), Guilfoyle (2001) illustrates how therapists' interventions are guided by their constructions of reality. Constructions that disguise hierarchies of oppression and repression and may perpetuate oppressive thinking. This is powerfully demonstrated by Guilfoyle's case study with a bulimic client where the therapist's interventions refute the client's narrative of their difficulties and shape the therapeutic encounter. De Leersnyder, Boiger and Mesquita (2013) question whether the emotions therapists reflect back to clients are simply those that the therapists expect to find based on their own socialisation, and/or their views of the other. These studies have concerning implications for a therapeutic encounter contextualised against societal body weight bias. McLeod (2003) writes of the importance of affirming and accepting a client's worldview, a concern shared by Gergen (2009). McLeod (2003) also notes the role of therapists to challenge discriminatory reflectivity that may have been

shaped by a client's socialisation; allowing the creativity for new meanings and subjectivity. Reflexivity and reflectivity enable spaces to be opened up to explore given meanings and enabling alternative constructions that allow new understanding of 'problems' (House, 2003; Parker, 1999). An issue relevant for those defined as having 'problematic' body weight, and inferring that therapists have a responsibility to challenge clients' views of themselves that may be informed by normative body weight prejudice.

Tenzer (1989) describes the emotions and experiences that a therapeutic relationship needs to be able to contain, to enable a client who has experienced discrimination for their body weight to 'reclaim' their body. Tenzer describes the anger a client may start to recognise at people that they have felt oppressed or failed by in their attempts to 'help' the client become thin. The author illustrates a process in which a client may start to feel empowered, by recognising repressed feelings and having them accepted within therapy. It is suggested that an acceptance in ones body is preceded by a letting go and mourning of the loss of an idealised body, and Tenzer describes the role of a therapist as one who may challenge a client's 'destructive' attempts to diet or be thin. Tenzer defines the therapeutic relationship as one which enables a client to experience being accepted as they are, and creates an environment in which an individual can learn to have new relationships with others and their body. This research is in stark contrast to that by Weiss (1986) that advocates the position of the therapist to appraise a client's 'realistic' self-image, and assess whether a client is in denial and 'blind' as to how fat they are. Weiss purports that different weights have different personal meanings for clients, with an importance on understanding these differential meanings in order to further weight loss. Therapists are endorsed as able to "evaluate the meaning of fat for each patient" and recognise "any discrepancies in the patient's reality and any areas of denial" (Weiss, 1986, p.525-526). There is little recognition from Weiss for how these differential meanings may be constructed by clients in negotiation with their familial, cultural and social backgrounds, with the therapist firmly positioned as the expert.

Wolszon (1998) comments on research into body weight related anxieties, suggesting that it is "suffused with the tensions of unacknowledged individualism" (p.550).

The author argues that while the research largely acknowledges the role of the cultural thin ideal, it often urges women to reject cultural norms, as if it were possible to become disembodied from culture. Wolszon suggests that inner individual processes are emphasised over cultural contexts, with implications for therapy. Examples include therapists implying that body size concerns are normative but pathologising the women that have these concerns, and interventions that encourage autonomy but position responsibility and blame on individuals that 'allow' themselves to be oppressed. Therefore framing clients as failing to find personal solutions for socio-political problems. Fraser (2003) writes "when misrecognition [of diversity] is identified with internal distortions in the structure of self consciousness of the oppressed, it is but a short step to blaming the victim, as one seems to add insult to injury" (p.26). Wolszon (1998) advises a shift in research focus away from body image as an inner, subjective experience "to a more contextualised focus on the meanings, intentions, purposes, and self-interpretations that are constellated by body image dissatisfaction" (p.553). An appreciation of the interconnecting and intersecting cultural meanings, values and practices around body weight allows a recognition of the inevitability of women (and men) 'soaking up' cultural norms. However, the author concludes, it also positions individuals as active participants, adopting, negotiating and resisting cultural norms around body weight, with a potential to create new self-understandings.

Similarly, Saraceni and Russell-Mayhew (2007) suggest drawing on feminist therapy to encourage clients to locate body image distress within a socio-political context. The authors propose a potential for improved relationships with the body by encouraging clients to critique normative body ideals. They also support raising consciousness of the role of the media in propagating unobtainable body standards that oppress women. McKinley (2004) explores how fat women who endorse fat acceptance and resist predominant cultural attitudes to the fat body experience their own bodies. Her research found that women who supported the need for social change in attitudes towards fat people experienced more self-acceptance, lower body shame and higher body esteem than those who endorsed personal acceptance only. McKinley's findings suggest that

recognising and resisting normalised and oppressive cultural discourses for the fat body can create improved psychological well-being. Moon (2011) writes of the capacity for therapists to challenge the repression and subordination perpetrated by ideological and normative thinking. However, Livingstone (2010) highlights that marginalised clients may want a sense of the meaning of the world and their place in it that does not require them to engage in a political battle with ideological norms. With literature suggesting that therapy can both facilitate or resist the use of normative meanings, the current research explores how therapists and clients negotiate meanings about body weight as they construct and deconstruct meaning within the therapeutic encounter.

2.6 The social within the embodied therapeutic process

Merleau-Ponty (1962, 1968) advocates an inseparability between language and embodiment where the body is not a passive object, but an embodied being and experiencing. Williams and Bendelow (1998) posit that emotions comprise of “corporeal, embodied aspects, as well as sociocultural ones” (p.137). Phenomena such as counter-transference and empathy can be understood as forms of embodied intuition and communication involving bodily and felt experiences (Vanaerschot, 1990). Dekeyser, Elliott and Leijssen (2009), argue for a social neuroscientific perspective that recognises empathy grounded in lived experience and located in a context of social interaction. This suggests the importance of an understanding for how feelings and meanings in and for the body are experienced in the social, dialogical and embodied process of empathic understanding. Hochschild (1983) writes of emotional labour as feelings being managed within encounters in line with the expectations of a job, with Garfinkel (1984) highlighting the distress that can result from deviations from such expectations. Therapy is perhaps an example of a role requiring emotional labour for the feelings evoked by issues around body weight. Costin (2009) and DeLucia-Waack (1999) illustrate the difficulties faced by therapists working with counter-transference issues around body image conflicts, with therapists unsure of what their own difficulties are and what belongs to the client. Costin’s (2009) research reminds therapists to be mindful of “their embodied experience and of the constant cultural pulls toward body dissatisfaction” (p.191). While Costin and DeLucia-

Waack comment on cultural meanings for the body influencing therapists and clients alike, their findings are limited to the field of eating disorders.

Courtney (2008) illustrates the therapeutic benefit of bringing up her own body size with her client, enabling a more meaningful dialogue about issues around body image, and also the here and now relationship between client and therapist. While suggesting that therapists should be willing to raise and explore issues around body weight within therapy, Courtney advises against commenting about clients' bodies. The author alerts therapists to interrogate their own feelings around body image so as not to ignore or silence conversations with clients, Courtney makes observations about her own counter-transference material elicited when working with clients struggling with body size acceptance issues. She describes feelings of envy and shame that might be felt through a process of projective identification when working with clients who have 'achieved' weight loss, possibly split off from a client's feelings of power. She also depicts feelings of self-hatred and anger that might be defended against by therapists unable to contain a client's body hatred. Courtney describes the importance of allowing ambivalence and containing counter-transference feelings of impatience, warning therapists against acting out on polarised feelings of body hate and acceptance, or an idealistic wish for clients to be free from body conflict. With a focus on body size, the author examines the therapeutic process with her clients and notes that therapists must be alert for how their own defences might shape the therapeutic process, and how counter-transference feelings must be acknowledged and explored.

Corning, Bucchianeri and Pick (2014) describe the pernicious effects of 'fat talk': "self-abasing, mutual banter about food, weight or the body in which adolescent girls and women normatively engage" (p.121). The authors describe an iterative process whereby fat talk invites similarly self-abasing responses with significant consequences for body dissatisfaction. Their findings demonstrate differential effects of fat talk dependent on the body size of those doing the talking. Exposure to a thin woman engaging in fat talk was more deleterious for body dissatisfaction than if an overweight woman disparaged their body. However, the research also demonstrated that where thin women engaged in

positive talk about their bodies this also elicited body dissatisfaction in their conversation partner. These findings suggest that therapists must be wary of how they respond to fat talk, with both negative and positive self-disclosure carrying implications for client's body satisfaction.

Developing Benjamin's (1995) notion of intersubjectivity, Allegranti (2013) and Rumble (2010) suggest that the process of becoming embodied selves is an intersubjective process. Therapists must consider whether their participation expands rather than limits the potential for embodiment. Adopting a relational psychoanalytic perspective, Swartz (1998) posits that when client material is concerned with bodies, therapists are obligated to examine the effect of their bodies within the therapeutic relationship. Swartz argues that working within an intersubjective model requires therapists to be aware of their own mind-body relationship. Critical of literature that portrays therapists as disembodied, Swartz suggests that therapists must consider age, gender, ethnicity and sexual orientation affecting intersubjectivity. Commenting on the inadequacy of theoretical considerations of the body within therapy, Swartz describes a culturally determined fear and avoidance of body-talk. "If we, as therapists, show an interest in the language of bodies, we permit (at least potentially), a discursive space in which our own bodies become visible" (p.32). Swartz recognises the relationship between body and mind where the body itself, or the language of the body, allows a space where experiences can be heard and new meanings created. "This includes ways in which gendered and racialised experience forms the bedrock of personhood" (p.32). While Swartz makes no reference to the intersubjective influence of body size, shape or weight within the therapeutic dyad, her insights may be relevant to culturally defined meanings of body weight that inform clients' felt identities and embodied experiences.

Research by Soth (2006) and Allegranti (2011) urges vigilance for the operation of body politics within therapy. It is suggested that culturally imposed objectifying and oppressive meanings for the body may inform embodied and subjective experiences within the therapeutic encounter. Totton (2010, 2012) explores how therapists and clients embody social and cultural meanings for the body, and how these embodiments

interrelate within the dialogical exchange within therapy. The author explores issues of empathy, counter-transference and the therapeutic process; recognising individual and social dimensions of the relationship, with cultural values and meanings for the body imported into the therapeutic encounter. While Totton's (2012) work explores two clients whose body appearance resides outside socially prescribed parameters of normativity, the current study seeks to build on this work with a wider client group and seeking accounts from therapists. With literature suggesting that meanings for the body and body weight do shape the therapeutic encounter, there is little research demonstrating how this is negotiated between the therapist and client.

This chapter has identified literature that indicates the prevalence of body weight prejudice and offers a critical view of normative meanings of the 'too thin' or 'too fat' body. It has explored the positioning of psychology and therapy to 'treat' body weight 'disorders', and also the findings that suggest body weight prejudice operating within therapy. It has reviewed literature that illustrates body weight meanings informing self concept, identity and lived experiencing. This chapter has also explored the limited findings that suggest how meanings for body weight are negotiated within therapy, and outlined theorists suggesting a potential to deconstruct normative thinking and tasking therapists with fostering this. This chapter has also demonstrated literature that indicates meanings around body weight shaping the therapeutic process and client-therapist relationship.

This chapter has reviewed the existing literature that relates to the question asked by this research:

How are meanings of the body and body weight constructed by therapists?

Chapter 3 will outline the methodology used to explore this research question.

CHAPTER 3: METHODOLOGY

Chapter 2 looked at the existing literature relevant to this study. Chapter 3 considers some of the ontological and epistemological positions that have furthered psychological research and outlines constructivism as my own perspective with a focus on symbolic interactionism. Adopting a relativist, constructivist stance, this chapter explores methodological considerations for qualitative research. It outlines a grounded theory method as focused on the study of lived experiences, and the evolution of classic grounded theory to a constructivist grounded theory method, highlighting its appropriateness for the current research. This chapter considers evaluative methods for determining whether a grounded theory is fit for purpose, and considers reflexivity as crucial for its rigour and validity.

3.1 Ontological and epistemological positioning

Ontology considers the nature of reality and being, with epistemology the study of knowledge and the positioning of researcher in relation to the research inquiry (Willig, 2001). My own ontological and epistemological perspective is encapsulated by a constructivist paradigm (Guba & Lincoln, 1994). I believe that we make sense of our realities according to our socio-cultural, historical and personal backgrounds that we interact with as we construct meanings. I locate myself ontologically as a relativist, with an epistemology that recognises the researcher constructing the findings of the research.

Psychology traditionally emphasised essentialism, positivism and the idea of universal truths that could be discovered through empiricism. Social constructionism developed in the 1960s and early 1970s, in opposition to positivism, viewing all knowledge and understanding as socially and culturally situated and constructed (Berger & Luckmann, 1966). Highlighting the complex, multi-directional interaction between socio-cultural contexts and the individuals embedded within them, social constructionism emphasises the socially constructed nature of reality. Constructivism highlights the agency of the individual in constructing their meanings and reality as they engage with their world and make sense of the objects in it (Crotty, 1998).

Holding a constructivist perspective, I have adopted a symbolic interactionist approach that focuses on socially arranged meanings and interaction. Meanings and understandings of the self are critical within counselling psychology, and for this study and its interest in body weight meanings. Symbolic interactionism is usually traced back to the influence of George Mead, a pragmatist and social scientist who adopted a biopsychosocial stance, and suggested that mind and the self emerge through social interaction, specifically through language and gestures (Mead, 1934). Mead suggested that meanings are socially given. Mead's concepts were developed and shared by many other notable scholars (i.e. Dewey, Cooley) including Blumer (1969), who expanded Mead's ideas and developed the field Blumer named symbolic interactionism.

Symbolic interactionism has three main premises: "that human beings act towards things on the basis of the meanings which these things have for them", "the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows" and that "these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters" (Blumer, 1969, p.2). Blumer suggests that the self emerges from society, through interaction with forms of symbols such as language, communication, practices and social relationships that shape consciousness, reflectivity and the self. It is the meanings of these symbols which create, and are created by the interactions between individuals and their contexts, ultimately shaping individuals and society. Clarke (1995) summarises: "symbolic interactionism elevates to centrality the spontaneous interpretive self and the role of the situated and negotiated order" (p.6).

Blumer (1969) extends the work of Mead and clarifies the distinction between an empirical world, presupposing an objective reality, and an empirical science. Blumer suggests that while a fixed reality is *experienced* as such, with empirical science enabling the study of it, that the notion that "the obdurate character, or reality, of the empirical world is fixed or immutable in some ultimate form" is a misconception. Instead Blumer argues "the reality of the empirical world appears in the 'here and now'" (Blumer, 1969, p.23) via meanings assigned by people in their space, time and context. Readings of Blumer's work

include those who construe it as evidence of a post-positivist view of reality, where an objective reality exists that can only ever be imperfectly understood (Annells, 1996; Charon, 2001). In contrast, Charmaz (2000) suggests a reinterpretation of Blumer's reference to reality, to mean that individuals construct a reality that seems real to them, rather than to suggest the existence of a fixed, enduring reality. It is ironic that criticisms of Blumer that suggest he refers to a fixed reality may be based on a misunderstanding of his work, while reflecting the interactional and interpretive nature of meaning.

3.2 Methodological considerations

A feminist perspective allows a qualitative approach to research implicating the body and inequality, grounded in symbolic interactionism (Olesen, 2011). A relativist, constructivist stance suggests that there is no singular reality, only versions of it that differ according to individuals, groups, cultures and historical settings; with differing accounts constructed through interrelated interactions that shape meanings and experience. Empirical study is required to explore how meanings, practices and the implications of which are constructed and consumed, with the resulting knowledge, and means by which it is produced, context specific (Willig, 2001). Qualitative research is accused of being unscientific by subscribers to positivism, with a commitment to qualitative research obliging a researcher to a critique of positivism (Denzin & Lincoln, 2003). This criticism includes that of the notion of there being a fixed, enduring reality that a positivist researcher might 'objectively' study. Instead qualitative research encompasses a view that there are multiple realities and that the researcher aims to create an interpretation of these realities in their inquiry.

Opponents to positivism range from those who view positivist methods as simply different, neither inferior nor superior, to those who contend that positivist methods and their resulting truth claims can be oppressive and marginalising (Brooks & Hesse-Biber, 2007). Rather than quantity, abstractions, and relationships of cause and effect, qualitative researchers focus on qualities, meanings, descriptions of processes, and intricacies of interrelatedness and embeddedness (Denzin & Lincoln, 2003); core tenets of

counselling psychology. Individuals are viewed as embedded in multi-directional relationships at a micro and macro socio-cultural level through which individuals make meanings, construct and are themselves constructed (Coyle, 1997).

This study seeks to make explicit my own constructivist perspective with a belief in multiple, constructed realities, so that this research and any knowledge suggested by it, can be explored and, if necessary challenged. This research starts from a position that the researcher has shaped the research and that it does not seek to produce universal truth claims. Readers from a more positivist standpoint, believing in objectivity and generalisability, might question its relevance. This research seeks to destabilise the truth claims about body weight often produced by 'science' and reproduced in mainstream media. It seeks to offer a different perspective and to herald multiplicity, interrelatedness and variation in a subject area that it is too often simplified and generalised. Complicating existing knowledge about body weight, and arguing for the legitimacy of inquiry into the area of body weight within therapy – an area that to date is largely ignored.

3.3 The evolution of classic grounded theory

Consideration of ontology and epistemology safeguards against methodolatry. The use of a grounded theory method in this study was informed by considering what was important in answering the research question, rather than prescribing to a method at the expense of the research (Coyle, 2007). Grounded theory has always been focused on lived experiences and was developed from a research programme exploring the experiences of patients with terminal illness in the 1950s and 1960s (Glaser & Strauss, 1965). Critical of hypothetico-deductive methods and aware of the inferior status of existing qualitative research methods, Glaser and Strauss developed their grounded theory method. It allowed a theory to emerge encompassing elements of lived experience and their interrelationships, with a focus on the analytical power of empirical study (Glaser & Strauss, 1967). Embedded in a cultural and historical context where positivism and empiricism were the norm, Glaser and Strauss' objective was to be taken seriously in the scientific fields they worked in. As such, classic grounded theory adhered to the

conceptualisations of positivism, with Glaser and Strauss believing that their method allowed researchers to objectively generate a theory that reflected an ultimate truth for the studied phenomenon. Glaser and Strauss later worked separately, producing increasingly differing perspectives. Diverging around the complexity of the analytic procedure, degree to which theory is emergent or forced, and the notion of interpretivism. Strauss moved towards a more constructivist stance, recognising the constructed and situated nature of the social (Clarke, 1995), but still claiming ‘the reality of the data’ (Strauss & Corbin, 1998, p.85). This idea was later revoked by Corbin in his preface, written after Strauss’ death: “The notion of being able to capture ‘reality’ in data was deemed a fantasy. All is relative” (Strauss & Corbin, 2008, pviii).

A revolution of grounded theory was required that sufficiently demonstrated complexities in social phenomenon, rather than being simplified in the analysis. A method that not only describes patterns but also contradictions and ambiguities (Clarke, 1995). Highlighting the silenced, hidden and ignored perspectives and simultaneously acknowledging the researcher as situated within the research inquiry and a user or resistor of meanings, discourses and practices that shape the research and its interpretation. A grounded theory method has roots in pragmatist philosophy and symbolic interactionist sociology, influenced by Strauss’ training with Herbert Blumer and Robert Park. The influence of symbolic interactionism enables a classic grounded theory method to be revised with a constructivist epistemology (Clarke, 2005.)

Charmaz (2003) argues that a grounded theory method does not require subscribing to a specific epistemological position, with the methods available to those working with an objectivist or constructivist approach. Rather than emulating the objectivist and positivist ideals that Glaser, Strauss and Corbin strove to demonstrate in their versions of grounded theory, instead constructivist grounded theory sets out subjectivism at its core. By recognising interaction both within and with the data, the researcher interprets the data, an interpretation that is situated within a historical and social context, just as the research is. Charmaz reclaims the tools made available by grounded theory from its positivist beginnings. Instead, offering a more flexible, open-

ended grounded theory method imbued with fluidity, subjectivity, interaction and interpretation. With the emerging and constructed nature fundamental to both the method of constructivist grounded theory and its findings.

3.4 Rationale for choosing a constructivist grounded theory method

This study adopts Charmaz' constructivist take on classic grounded theory due to its fit with the epistemological stance of the researcher. Holding a constructivist view, I view the nature of reality as constructed, focusing on the interaction between individuals and their contexts in this construction. I deem the research practice as reflexive, with the researcher interacting with the research and interpreting how it is constructed. I suggest that constructivist grounded theory enables the study of differences and variations in perspectives, situations, action, language, practice, discourses and knowledge production that construct and are constructed through lived experiences. Charmaz (2003) distinguishes between 'the real and the true' arguing that while constructed, individuals live in and act on their realities, and the method of constructivist grounded theory aims to render an interpretation of those multiple realities rather than seeking truth or a single reality. Positionality, interrelatedness, multiplicity, and the intersectionality of meanings and cultural constructs can be explored through a constructivist grounded theory method. With this research studying how culturally constructed meanings imposed upon the body and body weight are negotiated by clients and therapists.

A constructivist grounded theory approach allows the exploration of body weight within therapy to be based closely on the accounts of counselling psychologists and psychotherapists, while contextualising therapy and body weight as embedded within culture. It allows a theory of body weight and therapy to develop from the participants' constructions of their lived experiences, and contextualised against other findings such as media reports and online data to understand participant accounts against their cultural backdrop. A constructivist grounded theory approach allows new theory to emerge from the data without constraining it to preconceived notions, and aims to recruit a diverse sample to enrich the findings. It creates theories that accounts for differences and

variations in participant accounts (unlike interpretative phenomenological analysis), with this research endeavouring to create theory that counselling psychologists can use to inform their practice.

A constructivist grounded theory method enables the development of an emergent explanation where relationships are at the core. Relationships to people, organisations, cultures and historical settings that shape the meanings and actions around body weight and therapy, constructed by the research through the relationship between the data and researcher. This focus on interaction and relationships can similarly be found within counselling psychology and psychotherapy, particularly in the development from a one person psychology to a two person psychology, where the co-creation and location of difficulties and therapeutic benefits are found within relationships. Psychotherapy and counselling psychology involves complex interactions between direct and indirect relationships, with the therapeutic encounter 'in here' situated within numerous relationships 'out there'. Aside from their relationships 'out there', clients' accounts may be influenced by their therapist's interventions, their perceptions of their therapist, and their beliefs about themselves and the therapy. The therapist's perceptions of their client may be informed by their theoretical values and beliefs, their relationship with themselves, their supervisor, their work setting, or the wider political sphere.

This complex interplay between individuals, organisations and cultures, creates and sustains values, beliefs and meanings. A constructivist grounded theory approach recognises this complex interaction between individuals and cultures and the process of meaning making. It allows exploration for how prevailing views of body weight are managed within the therapeutic encounter and how this influences and is influenced by the complex interactions between clients and therapists, and their wider social and cultural contexts. This research hopes to generate a theory for how meanings of body weight are constructed by therapists and clients as they interpret and reinterpret meaning. Other researchers (e.g. Guilfoyle, 2001; Throsby, 2007) have utilised discourse analysis to highlight weight related discourses and illustrate how language constructs and accomplishes personal, social, and political projects. However, with discourse analysis, it

is not the participants that are the focus, but instead their language (Widdicombe, 1993). Fassinger (2005) outlines the suitability of grounded theory methods for counselling psychologists and for researching diversity and difference, with a constructivist grounded theory approach allowing a critical approach to research.

3.5 Evaluation of a grounded theory

This study has specifically chosen not to subscribe to quantitative terms of reliability and validity, as the use of which fails to contest truth claims of positivist and empirical epistemologies. A revision of such terms questions how qualitative studies can be evaluated. Alternatives include confirmability, credibility, dependability and transferability (Denzin & Lincoln, 2003); emphasising the situated and relational tenets of qualitative research. The efficacy of constructivist grounded theory comes from its ability to “provide a useful conceptual rendering and ordering of the data that explains the studied phenomena” (Charmaz, 2003, p.252). Rather than seeking to provide a universal ‘truth’, by contextualising grounded theory it strengthens the validity of its findings and enables comparisons between other research findings. This situatedness of the study allows generality to emerge “from the analytic process rather than as a prescribed goal for it” (Charmaz, 2006, p.181). As explored below, the reflexive nature of a constructivist grounded theory encourages findings to emerge from the process, as opposed to the researcher prescribing to a particular standpoint and seeking data to ‘prove’ it.

The potential remains for researchers to simply *claim* to be conducting a genuine grounded theory method that allows the findings to emerge from the data. However, with a constructivist grounded theory method enabling findings to reflect the array of experiences, variations and alternative interpretations inherent in any phenomena, perhaps this risk is reduced. This is in contrast to a classic grounded theory method, which may have inadvertently encouraged researchers to force and limit data into emerging categories (Charmaz, 2006). Yardley’s (2000) criteria for evaluation of qualitative research includes: ‘sensitivity to context’, ‘commitment and rigour’, ‘transparency and coherence’ and ‘impact and importance’. A responsibility on the

researcher to remain as self aware as possible (which may always be partial), and making their research explicit and available for scrutiny and challenge, supports the rigour behind a constructivist grounded theory approach. It offers a means of evaluating the researcher's representation of their participants' accounts of their lived experiences. Emphasising the centrality of reflexivity in a constructivist grounded theory method, Charmaz (2014) endorses the use of Glaser's (1978) criteria for the evaluation of a grounded theory: fit, work, relevance and modifiability. Charmaz (2014) adds the criteria of credibility, originality, resonance, usefulness, aesthetic merit and analytic impact. This is to contextualise the research against the expectations for it, so that conclusions of validity are located in how and why the research was constructed and whether it is fit for purpose.

The validity of grounded theory is strengthened and enriched by the breadth of its data source, with the present study including interviews, media reports and online research, and drawing on a heterogeneous sample of participants. The method does not seek to generate a universal theory, instead to allow a theory to emerge that is grounded in this dataset, and reflects an interpretation of the complexities inherent within the studied phenomena. Charmaz (2003) argues that a grounded theory method has become synonymous with the epistemological basis on which it has been commonly and classically used, and that its criticisms can be contested through a constructivist grounded theory method. Answering and invalidating condemnations such as it reducing and isolating participant experience, diminishing accounts of the social and subjective, and assuming the researcher as expert observer, through its adherence to explicit tenets of the subjective, interactional and interpretational.

3.6 Reflexivity

Reflexivity requires a consideration of the researcher in their research, and the contribution of their prior experiences and knowledge. A contribution which is neither denied nor lauded; simply made explicit and accountable. Glaser (1992) asserted that researchers should approach their research with a stance of unknowing. I deem this an impossibility and suggest that all understanding, analysis and interpretation is predicated

upon previous and culturally situated knowledge and meaning. Charmaz (2006) encourages us to make explicit the purpose of our research, highlighting the impossibility of value neutral research, with personal and professional objectives often ignored or obscured. Charmaz recognises that “knowledge is not neutral, nor are we separate from its production or the world” (p.185). I seek to make explicit my connection to my research, and the personal and professional interests that have contributed to its construction. This reflexivity, through self-monitoring exercises, reduces the opportunities for bias, prejudice and preconceptions to be imported into the data. I suggest that an interaction between a researcher and their findings is implicit in all studies, but often without the safeguard of it being acknowledged and its interpretation challenged.

I have taken a critical stance in this research, questioning how therapists construct meanings of the body and body weight in research, and offering a critique of these meanings through the grounded theory that I have interpreted as emerging from the findings. This study was undertaken with the aim of contributing to the limited research on body weight within therapy, to ensure the ethical and anti-discriminatory practice of counselling psychology. Reflexivity by researchers should raise questions of legitimacy and authority, repositioning the researcher as participant in the research process rather than as ‘expert’ observer. This perhaps complicates notions of informed participation when considering power dynamics inherent in research, and the oppression and silencing afforded by some forms of knowledge production. The method of inquiry must interrogate not only how meanings are understood and used by the research participants, but also how these are interpreted and constructed by the researcher, with the research act viewed as a co-construction. Denzin and Lincoln (2003) use the term ‘interpretive paradigm’ to refer to the researcher’s beliefs and consequentially, the research act, that is shaped by and contains the researcher’s ontological, epistemological and methodological position. As I have outlined, my own interpretive paradigm is encapsulated by my relativist, constructivist stance, a position explicitly recognised as shaping the research act.

As the researcher I endeavoured to go beyond my own embodied and socially

located perspective, while recognising my limitations to do so (Cornish, Gillespie & Zittoun, 2014). However, as someone with a body weight considered by normative standards as 'normal', my participants may have made assumptions about my own meanings about the body and body weight. Dependent on the participant, I might have been considered an 'insider' that shared their experiences and perspectives, or an 'outsider' that had preconceptions of their experience (Corbin Dwyer & Buckle, 2009). While this may have shaped participants' willingness to share their views, I endeavoured not to disclose my own meanings for the body and body weight. However I recognise that for some, the presence of my body within the interview might have been considered a form of self-disclosure.

Inevitably there may be areas that this research may have ignored in its analysis and interpretation. While seeking to study a social phenomenon that may afford improved equality and ethical practice in counselling psychology, as the researcher, I cannot assert that the research was wholly benign and inclusive. Reflexivity requires the consideration of the consequential nature of social phenomenon, including that of the research process. A research study must ask what has been studied, why, with what consequences and for whom (Clarke, 1995). I have considered these questions in the discussion of this study, to explore the "distinctive interpretative community" from which I speak (Denzin & Lincoln, 2003, p.99), and the consequences of which for this research.

This chapter has considered the epistemological and methodological positions of the researcher and this study. Chapter 4 will illustrate the research design used.

CHAPTER 4: METHOD

Chapter 3 clarified my epistemological position and the research methodology of the current study. Chapter 4 outlines the research design that was used in this research and the application of the constructivist grounded theory method.

4.1 Research design

This study initiated with the research question: How are meanings of the body and body weight constructed by therapists?

A constructivist grounded theory approach recognises the complex interaction between individuals and cultures and the process of meaning making that creates and sustains beliefs, ideologies and meanings. It enabled the research to explore how prevailing views of body weight are managed within the therapeutic encounter and how this influences and is influenced by the complex interactions between clients and therapists, and their wider social and cultural contexts, as they construct, deconstruct and negotiate meaning. Pidgeon and Henwood (1996) describe a grounded theory method as “offering ways into the maze of a fractured and multiseamed reality that is infused with multiple and often conflicting interpretations and meanings” (p.86). Using semi-structured interviews, media reports and online data, a constructivist grounded theory approach allowed a theory of body weight and therapy to emerge from the phenomenological accounts of counselling psychologists and psychotherapists and their contexts. Situating the participants, the researcher, and meanings of body weight and therapy as embedded within culture.

With a focus on meaning making, Charmaz (2003) urges the interviewer to delve deeper than surface meanings or presumed meanings for either the participants or the researcher. A constructivist grounded theory method renders an interpretation of the realities of participants; their beliefs and perspectives, and assumptions and ideologies. So that the theory that emerges not only accounts for processes and actions, but how these are constructed and contextualised to create lived experiences: “to get at meaning,

not at truth” (Charmaz, 2003, p.277).

4.1.1 Data collection - interviews

Semi structured interviews were used to elicit indepth reflective accounts from participants, and focus interviews and guide discussions towards subjects and experiences that might generate rich data and new understandings. Initial interview questions were developed as important topics emerged from the data. The relationship with the data, and especially with the interviewees was of paramount importance for this research. I endeavoured to create interviews that felt safe for participants, and was engaged and invested in the relationship with participants so that they might feel able to share meaningful and personal experiences, feelings and thoughts. I utilised skills ascertained from working in a therapeutic dyad, adopting an open, non-judgemental and empathic stance, encouraging clients to express themselves uncensored, while being mindful that the interview was not therapy, and care given to ending the interview properly. I recorded my impressions of the interview in a reflexive journal, capturing my perceptions of how the interview went and responses the interview appeared to evoke for myself and the participant. I noted my rapport with the interviewee, anything that was not said but I felt was inferred, the participant’s affect and our interaction.

The potential for participants to feel disempowered was deemed to be of less pertinence for this research, with the participants all qualified and practicing counselling psychologists and psychotherapists, and myself a trainee aspiring to be in their professional position. However, the participant-researcher relationship and its context was recognised as influential for the co-construction of the interview process. With both researcher and participant striving to portray an image of themselves to the other, meanings of status, professionalism and power dynamics were recognised as imported into the data. As counselling psychologists and psychotherapists, participants are likely to have endeavoured to present themselves to a fellow professional in a way considered favourable by their profession, attempting to demonstrate qualities such as empathy, acceptance and self-awareness. The interview process was viewed as contextual and

mutually negotiated; with the interaction between interviewer and interviewee uniquely creating data in dialogue and consequentially what was explored or ignored within the encounter (Finlay & Evans, 2009; Mills, Bonner & Francis, 2006). Nicolson (2003) stresses the multi-dimensionality of the interview relationship, with the individual and shared consciousness evoked by the interview encounter including “reflexive, discursive and unconscious” elements (p.139); with this method of data collection ultimately shaping the research findings.

4.1.2 Data collection – media and online resources

I collated additional information from television, radio, press, websites, blogs and online social networks (see appendices A, B and C). Gathering data about existing and emerging meanings of body weight, to understand participant interviews against their culture (Charmaz, 2006). Data collection from virtual resources included websites available for therapists to look at in the public domain focusing on body weight such as the NHS Live Well online resource www.nhs.uk/Livewell/healthy-living, National Association to Advance Fat Acceptance (NAAFA) www.naafaonline.com and the Fat!So? website focusing on weight diversity www.fatso.com. While it was not anticipated that the interviewees had necessarily accessed any or all of these resources or worked with clients that had, it enabled further insight into the discourses, meanings and practices surrounding body weight.

4.1.3 Sampling and recruitment

The ensuing data created by the research ultimately determined the sample used. Sampling focused on exploring emerging theoretical concepts and ensuring diversity within the sample across cultural indicators such as age, sexuality, gender, disability, ethnicity, as well as the different organisational contexts that counselling psychologists and psychotherapists work within. The sample size was based on theoretical saturation balanced with the practical limitations of the researcher, and as such a sample of 12 participants were interviewed in line with other grounded theory studies in counselling psychology (e.g. Jordan & Dempsey, 2013).

Fully qualified, registered psychotherapists and counselling psychologists of any modality, who had experienced their own personal therapy (a minimum of 90 hours), were recruited to participate within this study. The study initially focused on a heterogeneous sample of fully qualified therapists from the BPS directory of chartered counselling psychologists, and the BACP and UKCP directories of fully registered and accredited psychotherapists. The research design included recruiting the sample and conducting interviews in stages to allow for theoretical sampling whereby participants were sought to illuminate a specific construct that had emerged from the data. This included approaching participants that specialised in a specific client group, or had particular experiences that could provide insight into the categories and theoretical ideas emerging from the data set, and if necessary, their revision. As such the participant sample was expanded to include a chartered clinical psychologist, based in America, that is a leading name in fat activism and works as a therapist, co-founding the Health At Every Size model.

Potential participants were approached directly through existing contacts, via word of mouth or approached using their professional email address, inviting them to participate in the study (see appendix D). All participants were screened during a brief telephone conversation to discuss the nature of the research and to check that the participants met the criteria of being fully qualified and having experienced their own personal therapy. During this screening phonecall we discussed confidentiality and the participant's right to withdraw from the study, and permission was sought to digitally record and transcribe interviews.

4.1.4 Materials

4.1.4.1 *Information sheet*

An information sheet (see appendix E) was provided and discussed with participants to enable them to choose whether to provide informed consent and participate in the study. The information sheet included: aim of the project, type of data being collected, method of data collection, confidentiality, data protection, approximate time commitment, their right to decline to offer any particular information, their right to

withdraw, the minimal risks to the participant, how the data would be used, the potential benefits of the research and how the results of the research would be made available to participants.

4.1.4.2 Participant consent form

A consent form (see appendix F) was provided and discussed with participants to ensure that participants provided informed consent before participating in the study.

4.1.4.3 Participant waiver of anonymity

On the request of two of the participants, a waiver of anonymity was provided (see appendix G), so that the participants could be credited with their input if they expressively opted out of participating anonymously.

4.1.4.4 Demographic questionnaire

Participants were asked to volunteer demographic information (see appendix H) including age, gender, disability, race/ethnicity, religion, sexuality, area of residence, occupation and organisation they worked within (with the option to opt out of any or all of the questions). This was to seek out heterogeneity rather than homogeneity, unless specified by participant requirements - such as the sample being all therapists.

4.1.4.5 Interview protocol

Semi-structured interviews were used and as such open-ended interview questions were devised beforehand to loosely structure the interview (see appendix I). Questions were developed in accordance with the aims of the research and as a result of exploring existing literature and the gaps within it. Questions endeavoured to elicit participants' experiences of meanings of the body and body weight within therapy, and investigate how these meanings are negotiated by the therapist and their client. Initial interview questions evolved as the research progressed and highlighted areas of interest that emerged from the data.

4.1.4.6 *De-brief leaflet*

The participants' emotional and physical well-being was of paramount importance, and following the interview, de-brief information was provided to the participant (see appendix J). This de-brief included my contact details as the researcher, and my supervisor's contact details, and participants were advised to contact my supervisor in the event of a complaint or concern following participation in the research. Participants were also reminded to share any of their concerns with their own supervisors and of their ability to access personal therapy through the BPS or BACP.

4.1.4.7 *De- brief leaflet for participants who waived anonymity*

For the two participants who waived anonymity, debrief information was similarly provided (see appendix K) that acknowledged that they had waived their right to anonymity, but otherwise was identical to the original de-brief leaflet.

4.1.4.8 *Recording materials*

Interviews were recorded using a digital recording device. Interviews were transferred onto a computer, erased from the recording device and the audio files stored securely on a personal computer and used for the purpose of transcribing only.

4.1.4.9 *Reflexive journal*

I kept a journal and noted down thoughts, feelings or ideas throughout the research process. This was used as a tool to encourage reflexivity and to examine my assumptions about meanings, or my own inherent values and beliefs of relevance to the research. It captured my thoughts or feelings that arose immediately after conducting interviews that might have otherwise got lost in the interview transcription process, so that I recognised my personal connection with the data. It also allowed the data collection process to become more fluid and encouraged me to remain vigilant to capturing implicit cultural meanings that were referred to in passing conversations, or on television programmes that had relevance for the research and my interpretation of it.

4.1.5 Procedure

Interviews were carried out in a place of convenience for the participants, in a confidential setting such as the participants' workplace. Prior to the interview commencing I provided the participant with the information sheet and discussed each of the headings with the participant to ensure that the participant could provide informed consent. I explained very broadly the premise of the research, the participants right to withdraw from the study at anytime, prior, during and after with no time limit, with the caveat that data could be used in a collated form. Confidentiality was also discussed with the participant, informing them that interviews would be digitally recorded and then transcribed with all identifying information removed and pseudonyms used to protect their anonymity (unless confidentiality had been waived), and all research materials kept securely. Informed signed consent was then requested to proceed, with both myself and the participant retaining copies, and participants were asked to complete the demographic details questionnaire.

Interviews were digitally recorded and I transcribed them afterwards. Interviews lasted approximately 1-2 hours and participants took part in only one interview. Interviews loosely followed a set of open-ended and evolving questions that were sufficiently broad enough to enable participants to share their experiences and thoughts freely, while focusing the interview on the aims of the research. I aimed to balance the needs of directing the interview to subjects deemed of importance to the research, while not constraining the interview to preconceived ideas and questions, and enabling new material to arise (Pidgeon & Henwood, 1996). Participants were thanked for participating in the study and reminded of their anonymity and right to withdraw. They were given the debrief leaflet and invited to contact either myself or my supervisor if they wished to add any further thoughts, discuss the research, or with regard to any distress or complaint resulting from participating in the study.

Data collection of media reports and online research was conducted in parallel with the interviews and their analysis, and sought to contextualise interview accounts

within the culture the participants live in.

4.1.6 Ethical considerations

The current study follows the ethical framework set out in the BPS Code of Human Research Ethics (2009) and has the highest regard for the rights and dignity of the participants and the avoidance of unfair, prejudiced or discriminatory practice. Authorisation by the Roehampton University Ethics Panel was sought before the commencement of any research (see appendix L). Participants taking part in this study, as fully qualified, practicing counselling psychologists and psychotherapists, were not deemed to be vulnerable. While it is recognised that body weight can be a sensitive subject, through participants' work and training, they were considered to have worked through any potentially traumatic history in their own therapy, and so any risks were greatly reduced. Participants as fully qualified therapists (and with the researcher a trainee) were perhaps particularly empowered to know where their personal boundaries are and what material they did not wish to share. Participants also had regular professional supervision where they could explore any issues that arose as a result of the research, and were encouraged to do so in the debriefing. Any potential costs to the participant of talking about body weight were considered minimal, and outweighed by the benefits of the study in striving to promote awareness of meanings of body weight as a subject worthy of attention with possible implications for improved ethical practice.

In accordance with the BPS Code of Human Research Ethics (2009) and the guidance on deception, this study provided participants with the broad aims of the research. Participants were not provided with specific details of the study because body weight comes with various meanings constructed by society and negotiated by individuals. This study did not wish to encourage participants to provide modified accounts that they deemed as more acceptable or preferable either to their profession or to the researcher.

Recognising the ethical tensions inherent in online research (Mann, 2002; Mann & Stewart, 2000), this research respects that there is no definitive answer as to whether the internet represents a public or private domain. Accordingly, online data findings are

referred to in generalised terms only, and no individual accounts or direct quotes from blogs are used by the study. The researcher sought only to develop an understanding of the constructed discourses, meanings and practices surrounding body weight in different subcultures, rather than individual accounts. As such, the study respects that online authors own their words, and should not be quoted without their consent. The diverse range of materials that the researcher used to gather these constructed meanings of body weight should allow the ethical practice of exploring meanings from a diverse range of subcultures, rather than only those given precedence in mainstream media.

4.2 Data analysis

A grounded theory approach allows a systematic and rigorous analysis of the data, allowing for new theory to be generated from research material, while remaining faithful to the data itself. Following the work of Glaser (1992), the current study used open, line by line coding, then theoretical coding, and their subsequent sorting through clustering to generate categories from both the interview transcripts and supporting data. The writing of memos was informed by the collection of media reports and online research by the researcher, allowing the analysis to explore how discourses, meanings and practices are culturally constructed and negotiated within therapy. This encouraged a rendering of participant accounts interpreted in terms of their wider sociocultural contexts and power relations, including that of the research process (Pidgeon, 1996). While Glaser and Strauss did not emphasise situatedness in their original formulation of the method of grounded theory, Strauss did in his later revisions (i.e. 1987), encouraging researchers to consider both the research context and the contexts inherent and influential within the research (Strauss & Corbin, 1998). Charmaz (2014) centralises context and researcher reflexivity, highlighting that the whole method of grounded theory is shaped by how the researcher perceives and approaches the data and its analysis - making decisions about research questions, coding, categories, theoretical sampling and the construction of the theoretical framework.

A constructivist grounded theory method emphasises actions and processes and

the multiple layers of meanings within these. Charmaz (2008) offers a process of synthesising, condensing and conceptualising participants' accounts through a grounded theory method that enables abstract ideas to emerge that make explicit these tacit meanings. Offering a set of flexible analytic guidelines, Charmaz (2003, 2006, 2008) suggests an interactive method that focuses data collection, and creates inductive theory through successive and iterative stages of data comparison, analysis and conceptual development. This study specifically chose not to follow the method espoused by Strauss and Corbin (2008), deeming it a more restricted approach to a methodology that aims to enable the free emergence of theory. There was a focus on being immersed in the data to develop the emergent ideas, and develop a theory that reflected the phenomenological accounts described by the participants. Charmaz (2003) acknowledges the creativity lent by her own analytic approach, however cautions that it relies on a researcher's ability to pick up on the nuances within the data, to attend to what is not said as much as to what is said, and to ask questions to capture and maximise the richness inherent within the data. The researcher was familiar with this approach, and confident that her training to qualify as a counselling psychologist would enable a sensitive and perceptive relationship with the data to produce insightful interpretations.

The first stage of data handling and therefore data interpretation, lay with the transcription of interviews into written text (Payne, 2007), with the decision to analyse from both transcripts and audio files, and the chosen level of detail to include within transcripts. Participants were allocated pseudonyms except the two participants that had requested to waive their anonymity. At this point, I opted not to use computer-assisted programmes in the analysis of the data as it was felt to introduce a level of abstraction into the data. Instead I sought to develop an understanding of the data through my emersion in it.

4.2.1 Coding data - initial coding, focused coding and categories

Initial, line by line coding allowed me as the researcher to become very familiar with the data and create meaningful labels that reflected what was being constructed within each line of transcript (see appendices M and N). Care was taken to ensure that the

labels stayed true to the data and the subjects' experiences, and often included the use of participants' own words (Glaser, 1992). Initial coding was deemed important to capture detail, differentiations and intricacies within the interviews, reflecting the interviewees described realities, what was being constructed, and the meanings that I as the researcher made of these accounts. Initial codes were then used as a method of comparing other pieces of data to find similarities and differences, and to begin forming links between the data and more abstract ideas.

Initial codes that appeared frequently became reconceptualised as focused codes, categorising initial codes more precisely through a process of sorting, synthesising and organising. Focused codes (see appendices O and P) accounted for most of the data and reflected similarities and variations within the initial codes. Focused codes then became synthesised into conceptual categories through clustering exercises, which incorporated several focused codes and began to explain the data in terms of the developing analytic frameworks (see appendices Q and R). Categories encapsulated common patterns and themes within a number of codes and clarified ideas, processes or meanings within the data. Categories started to create the link between the empirical realities described within the data and the researcher's analytic interpretation: "categories reflect what you think about the data as well as what you find in them" (Charmaz, 2008, p.99).

Data analysis included the constant comparison of codes within and between interviews; comparing contexts, concepts, and incidents so that categories were continually compared to illuminate similarities and differences, and coding revised and categories relabelled. This iterative process continued throughout every stage of the analysis, revisiting, comparing and revising to generate a sharper conceptual analysis. This constant flitting between coding and conceptualisation enabled insights to emerge that reflected the complexities within the data.

4.2.2 Memoing and theoretical sampling

Memoing is the critical step between creating conceptual categories and the first draft of the theoretical analysis (Charmaz, 2006). It encourages reflexivity and allows the

researcher to capture ideas and impressions and elaborate categories into their subsumed processes, actions, meanings and assumptions in narrative form. Some of these memos became expounded as further data analysis lent more detail, and others were discounted through revisiting the data and the emergence of subsequent ideas. Memoing encouraged creativity and multiple interpretations of the data, with the elaboration of codes into actions and processes, and indepth exploration creating connections so that codes and categories became interpreted within larger, dynamic processes. Charmaz (2003) sees memoing as the tool that enables analytic interpretation to emerge from empirical reality, and is therefore critical for the inductive quality of a grounded theory method. As with all stages of the grounded theory method, memoing was an iterative process and involved the revision of categories and codes through the constant comparisons of the analytic process.

As categories become refined and developed into theoretical constructs, gaps in the data set or within the emerging theory became apparent, and thus theoretical sampling was conducted where specific information was sought to provide clarity. Theoretical sampling enabled the development of categories and refinement of ideas, rather than to increase the original sample size (Pidgeon, 1996), and included further interviews as well as further sampling of media and virtual resources. Theoretical sampling was critical for the development of a theory grounded in the data as it enabled less visible or overt data to provide explanation for the extent to which emergent concepts were applicable to the developing theory. It added explanatory power by addressing the context specificity of categories, how they relate, how they differ, and the conditions under which they arise and vary.

This revisiting and revising of coding, categorising and theorising is characteristic of the dynamic relationship between the data collection and data analysis, and is fundamental for a constructivist grounded theory method. Category 'saturation' refers to the concept that new data only fits within existing categories and as such further research no longer enriches the findings or broadens the researcher's understanding (Glaser & Strauss, 1967). However, it is acknowledged that this is a controversial concept and may

encourage the premature ending of data collection, and that subsequent research may usefully highlight where emergent ideas do not fit or where the emergent theory can not adequately describe the data. The current research adopted Dey's (1999) concept of sufficiency rather than saturation, with research limited by time restrictions, and theoretical sampling sought to the extent that was sufficient and practicable.

4.2.3 Literature integration and writing a grounded theory

Classic grounded theory argues that the literature review should not be undertaken before the beginning of a grounded research study, suggesting that to do so may cloud the judgement of the researcher and prevent the theory from emerging from the data (Glaser & Holton, 2004). However, constructivist grounded theory assumes the need to conduct an initial literature review to understand the limits of existing research, and recognises that the researcher always approaches the study with prior knowledge and experiences, and that to discount these would be impossible. Therefore, an initial literature review was undertaken, to provide a rationale for the study, contextualise the study in relation to previous research, enhance theoretical sensitivity, and develop a starting place for the research and initial interview question. A full literature review was conducted after the research had generated theoretical concepts of note, that continued throughout the analysis of the research material (Charmaz, 2006), and was woven into the final data analysis to demonstrate how the current research compares with existing findings (Charmaz, 2008).

The last stage of a grounded theory method is the emergence of a grounded theory that encapsulates and explains the processes, meanings and actions associated with the studied phenomenon: body weight and therapy. With a grounded theory method based in symbolic interactionism, there was an inherent importance for the writing process of this research, and the language used, to convey the accounts of the participants. The first draft commenced once theoretical constructs were defined, supported by evidence from the data and organised by the written memos. As with all stages of grounded theory, the writing process was an interactive one with each draft striving to create a sharper

theory. The research sought to continue the inductive process of grounded theory and create a written theory that remained faithful to the meanings within the participants' accounts and traverse the link between the empirical data and the emergent theory. Care was taken to render an interpretation that enabled the reader to get a sense of how participants constructed their accounts and made meanings about body weight, while recognising the presence of the researcher in the research process.

4.3 Participant demographics and context

See Appendix S for Table 1 summarising the demographics and work contexts of the participant sample.

This chapter has outlined the research method used by this study. Chapter 5 will outline the results of this study.

CHAPTER 5: RESULTS

Chapter 4 outlined the research design used in this research. Chapter 5 presents the results of this study, and provides a preliminary discussion of the findings. The emergent theory is presented from a symbolic interactionist perspective, emphasising that individuals act on the basis of meaning, with these meanings arising from social interaction, and reinterpreted through social interaction. The findings represent the researcher's interaction with and interpretation of the findings, with the grounded theory emerging from the data.

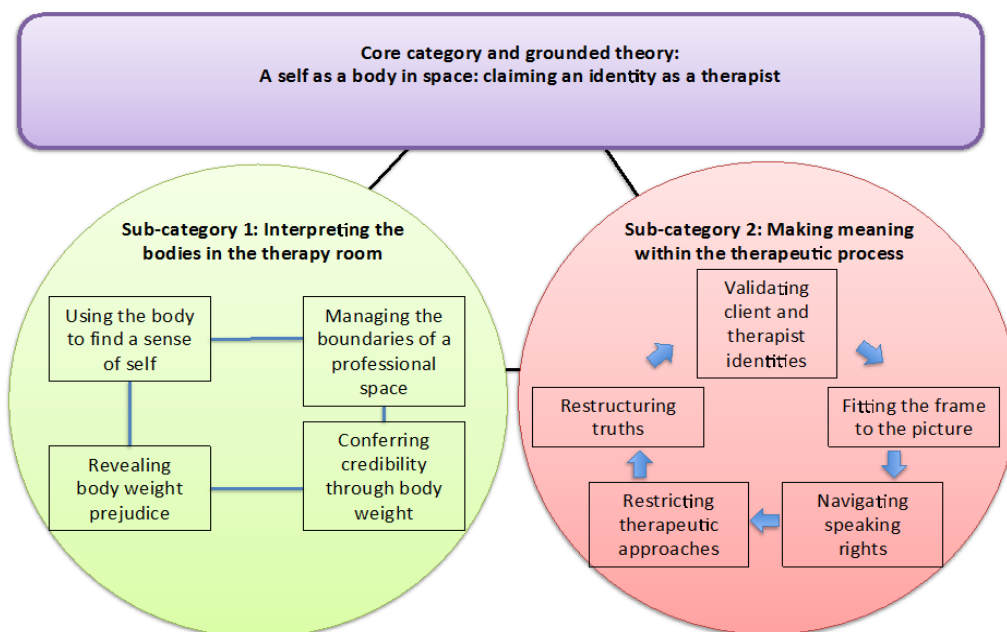
5.1 Main findings

This study explored how meanings of body weight are negotiated within therapy. The therapists that participated in this study constructed a sense of self and identity as a therapist that was informed by their understanding of the body and body weight. Therapists described how their experience of their body and body weight positioned them as able to support clients. The emergent theory demonstrates therapists promoting or undermining normative meanings of body weight, where the 'too fat' body is deemed as unhealthy or undesirable, and caused by problematic eating practices. While some therapists used prejudiced meanings of body weight, others challenged body weight stigma. The identities that therapists construct for themselves, and position clients in, informs the therapeutic interventions that therapists use. These interventions shape the therapeutic process and the accessibility clients have to construct identities for themselves.

5.2 Diagrammatic representation of the grounded theory

A diagram below represents the emergent grounded theory, incorporating the core category and two sub-categories with their theoretical codes.

Diagram representing the emergent grounded theory



5.3 Results and preliminary discussion

5.3.1 Core category: A self as a body in space: claiming an identity as a therapist

Participants described their sense of self as a therapist, and the identity as a therapist they claimed. Therapists in this study illustrated how their own experiences of their body and body weight enabled them to support clients and informed the therapy they offered. Therapists described these experiences of their body enabling them to work in a professional space with clients, where they could offer understanding around issues about body weight. Therapists interacted with normative meanings of body weight, interpreting these to identify others as ‘too thin’ or ‘too fat’, or challenging these meanings and highlighting the prevalence of body weight stigma. The participants’ accounts are used in quotes to illustrate the interaction between the participants and the researcher, with the results grounded in the data.

5.3.2 Sub-category 1: Interpreting the bodies in the therapy room

This category subsumes four theoretical codes: Using the body to find a sense of

self; Managing the boundaries of a professional space; Revealing body weight prejudice; Conferring credibility through body weight.

5.3.2.1 *Theoretical code 1: Using the body to find a sense of self*

Using a symbolic interactionist perspective, the idea of self is always a social self that emerges from social interaction and is negotiated through social meanings, with these interactions reflexively shaping how one reflects and conceives of oneself (Blumer, 1986; Denzin, 1972; Honneth, 1995). Therapists' narratives suggest that their understanding of their 'self' as a therapist incorporates particular ideas about their understanding of their own body. Therapists negotiate different meanings of the body and body weight as they conceive of their self as a therapist. Fran who works in secondary care in the NHS proposed that people can find their different senses of self through their body weight. The researcher asked '*What are your thoughts about body weight?*' Fran answered:

"I look at myself and I think I could lose five kilos, and if I talked to my mum she would probably say that she wants to lose five kilos, and there is something inherent that the vast majority of women they want to have something different in their body. They either want to be a little bit bigger or a little bit smaller... So there is something about using our bodies and trying to find our different senses of self by trying to change something."

Fran suggests that we can access a different sense of self through the body, its weight, and the space it inhabits. She offers a notion that a self and its meaning can be altered according to body shape, suggesting that accessing a different sized body may afford a different sense of self. Fran argues that a degree of dissatisfaction with body size is 'inherent'. This may be important for how she conceptualises her clients' ability to access different senses of self and how body size might be implicated in this.

Therapists described how they understood their own body as having a material presence in the therapy session that could shape their relationship with their clients and their clients' perceptions of them. They also indicated that their experience of their body

was also an important part of their work with clients. Sally described using her body with her clients in her group therapy work, indicating that her body symbolises self acceptance:

“I do hope that I model a level of happiness and comfort with my own body by the way that I sit in the session, in the way that I use my body and that is something that I really try to put across to all clients.”

Sally suggests that it is favourable that she experiences self-satisfaction through her body; ‘modelling’ this to her clients as if wanting her clients to feel something that she experiences in her own body. Courtney (2008) cautions therapists of an inability to contain self-hatred or ambivalence about the body. Sally’s narrative implies a power dynamic within therapy where the therapist may conceive of their body as experiencing in the ‘correct’ way.

Therapists in this study referred to notions of ‘authenticity’ and an ‘authentic self’ as shaped partly by the physical presence of their body. Robin who works in private practice uses her body to construct herself as a conscious, congruent, authentic therapist. The researcher asked ‘*Could you talk a bit more about how your body is involved in your work?*’ Robin replied:

“I can be kind of congruent in the choices around food because I don’t have, I don’t do diets and I don’t do banned foods. What I do is make conscious choices about portion control, I make conscious choices about ultimately how much I have of anything...Because I’ve always identified myself as a slim person, when I started to get overweight it just didn’t feel authentic.”

Robin, like many of the therapists, regards her body as an object that she has learned to manage and control, sharing this ‘expertise’ with her clients. A symbolic interactionist perspective views us as perceiving and conceiving of a self which we act toward, becoming ‘the object of his own action’ (Blumer 1969, p.62). Robin uses an understanding of her body to define her self in relation to others, drawing

on meanings from interactions with others and demonstrating the social nature of the self. She draws on theoretical concepts such as authenticity, congruency, and consciousness, important ideas within the context of psychological therapies, envisioning her body as displaying a self valued in the social world that she exists as a therapist (Goffman, 2013).

Therapists emphasised their own experiences of body weight, with their narratives suggesting these experiences validated their sense of self as a therapist, endorsed through imagining how their clients perceived them. Sam works in a child and adolescent mental health service with children and their families, and points to her weight as providing her with knowledge that informs her work:

“All of my family have talked about weight most of my life so they’re not frightened about it, but I also know how serious it can be and how difficult it can be. I am overweight and I know I am, so I can present myself as someone that can talk about weight.”

Sam locates herself in relation to her clients, conceptualising how she presents to clients and how she might be perceived as someone who ‘knows’ about herself and her weight, deeming this an asset to her role as a therapist. Other therapists in this study also emphasised their knowledge and awareness of body weight, constructing themselves as self-aware and benefiting their clients through their own experiences of their body.

The researcher asked Sally *‘Your thoughts about bodies and body weight what are they and what are they shaped by?’* Sally, who works as a dance movement psychotherapist, replied:

“There is some dissatisfaction for me with my body weight but on the whole that doesn’t diminish how I use my body in my work,...And I think that helps me also with my work with people with eating

disorders because in some ways I can, when I was pregnant I was huge, and that's how they feel, they feel as they gain weight they're huge...So I can really relate to that change of body image and that change in body and body weight and how to cope with that and how to deal with that."

Sally here frames her experience of her body weight and her dissatisfaction towards it as giving her a greater insight and understanding of her clients. Some therapists alluded to a sense of superiority in relation to their clients, where their body experience amounted to expertise that could be shared with clients. This idea of expertise appeared to consist of therapists' knowledge of dieting or ability to 'control' their body weight, creating a power dynamic within the therapy. However, other therapists appeared to perceive their experience of their body as allowing them to empathise with clients through their apparent similarities and difficulties, particularly where they too had experienced body weight stigma. This is described by Simone as she recalls experiences of being discriminated for her weight:

"Once or twice a year I get abuse, but everytime I go out, for every second of my bike ride I am waiting for someone to say something. It doesn't happen very much any more but just waiting for the comment...It makes me more proactive about other prejudices as it has given me an experience of what it is like to be all sorts of marginalised groups."

The findings of this study suggest that therapists construct a sense of self as a therapist, with the body an important aspect of this self concept. Therapists develop a notion of the self through their interactions with others both in and outside of therapy, conceptualising a self as a body that is informed to work as a therapist through experiences of the body. How therapists conceptualise this 'self' has important ramifications for the power dynamic within therapy, with some therapists seemingly imbuing themselves with expertise that their body is deemed as containing and communicating.

5.3.2.2 *Theoretical code 2: Managing the boundaries of a professional space*

Dee works in private practice offering support to clients who want to lose weight. Dee intersected meanings of health and naturalness to develop categories that appeared to represent to her varying degrees of body weight pathology in her work that supported clients to lose weight. Dee referred to people who were “naturally slim”, “naturally chubby” which she understood as meaning “you want to lose some weight and you can do that” and said that you couldn’t be “naturally fat or obese”. The researcher asked Dee: *‘What is your particular approach when you are working with your clients, are you always thinking about the body?’* Dee replied:

“I would usually ask about diet and exercise because I find it a very important part of psychological well being, so if somebody was saying I don’t exercise and I sit at my office, then I would mention it, I would say have you thought about your diet and exercise.”

While Dee claimed authority to work with clients about diet to reach weight loss goals, she also obscured this authority by later in the interview differentiating herself from a nutritionist. Liu (2015) posits that social boundaries, such as professional boundaries, are ‘ambiguous and elastic areas rooted in human interaction’ (p.1). Dee’s ambiguous narrative of the professional space that she worked within made it difficult to challenge her assumed authority, and the expertise she framed as allowing her to ask about diet, eating and exercise, to help her clients lose weight.

In sharp contrast to the professional space Dee claimed, Simone said:

“I see weight loss counselling on the same page as curing homosexuality. It’s so far removed from what counselling is for, which is about being non-judgemental.”

This opinion is shared (Chrisler, 1989; Courtney, 2008; Dworkin, 1989), and demonstrates the fluidity of the professional space that different therapists position themselves working in, and whether this is viewed by others as enabling or oppressive.

Therapists in this study described a professional space that they worked within that appeared important to their sense of self as a therapist. Sally was talking about her work, to which the researcher said: *'It sounds like you're quite confident in your specialist area?'* Sally responded:

"Exactly. I think that it's really important to know what your offering and what you can do and to be very explicit to the patient or the client: 'this is what I can offer you, I can't offer you work with your food, what you're going to be eating, losing weight or gaining weight. I can offer you this, but if you want that I can give you a referral'".

Therapists use a notion of the professional space they work within to demonstrate how they envision their relationships with clients. In contrast to Dee's narrative, Sally emphasises that her work does not include supporting clients with eating, weight loss or weight gain. Albeit a very different space that she occupies in comparison to Dee, like Dee's narrative, Sally emphasises her professionalism. Therapists' interactions with clients appear to be shaped by their conception of themselves as therapists, with this sense of self also emerging from these interactions with clients, with the self 'a process continuously created and recreated' (Berger, 1963, p.106).

The researcher asked what kind of conversations Robin has with clients. Robin said:

"If the doctor or dietician says 'I can see you're overweight so this is a worksheet on this is healthy food and that's bad food, that's junk food and that's healthy food so I want you to follow this diet, goodbye', they haven't understood how people relate to their bodies and how people relate to food and the idea of food. What I do as a clinician is I'm listening to how people relate to their bodies... So the thing about using food, about taking away emotions, is that's about self harm and what I'm trying to help people to understand is the connection with food and emotion."

Robin declares a professional space that she works within that is different to that of the doctor or dietician, but that which asks about food. Robin contrasts herself with other professionals that she understands to not have the same level of understanding that she offers clients. Robin constructs her expertise in the use of food, offering a generic psychological formulation that she appears to understand as demonstrative of a relationship between food and emotion for her clients.

Carla who works in secondary care in the NHS also described herself working in a professional arena that includes asking clients about food. Carla asserts that it is important what weight therapists are, doing 'boundary work' (Gieryn, 1983) to demarcate a 'normal' weight:

"I think what they [clients] would want is somebody whose weight is normal. I'm not, as I keep saying, I don't think a little bit you know. Normal, you know. In the normal range of weight you know. I suppose if we are looking at kind of size, I would think that somebody who is size 16 and above you might sort of think, and then likewise if you were seeing somebody who was a size 6."

Carla appears to construct herself as 'normal' and therefore able to work with clients, by defining her difference to therapists whose weight is beyond the parameters of body weight that she envisages clients wanting from their therapists. Carla defines rigid boundaries, through reference to body size, that categorise therapists she deems as not 'normal' and unsuitable to work with clients.

Asking Deb Burgard to elaborate her Health At Every Size approach, the researcher asked Deb if her approach was *'about having conversations about healthiness without it necessarily becoming about weight?'* Deb referred to her work as necessitating an engagement at both a micro-level and a macro-level to affect change:

"I don't just feel like my work is with an individual person, I feel like my work is with the broader cultural and structural factors that are

making people sicker. Right, so I feel like if I can do both, if I can work with individuals that's great, but I am only going to be able to help them so much when the things that are making them sick are these giant cultural forces. I think we all need to change those giant cultural forces as well."

Therapists construct a 'self in space', describing themselves working with clients within a professional space and drawing on meanings of the body. Some therapists appear to use body weight categories such as 'overweight' or 'normal weight' to define themselves and others, and demarcate a space they work within with clients. Other therapists, like Deb, engage with sociological thinking around the oppressive production of body weight meanings and use this to conceptualise their work with clients.

5.3.2.3 *Theoretical code 3: Revealing body weight prejudice*

Robin had been talking about a client who had received insults about his body weight:

"What does it mean if these teenage kids are making these comments. What is the significance of it. And if he generalises it to 'Everyone thinks that', I would say, 'OK well who else has said that', and some of it was his own internalised shame, his own internalised fat phobia if you want."

While Robin contextualises the client's difficulty, Robin locates the 'fat phobia' within the client and minimises the significance of the influence of others. Fran too identified body weight prejudice within a client, describing the client using normative meanings of fat to 'undermine' herself. Fran appeared to understand the client's efforts to 'address' being 'fat' and losing weight as positive:

"By writing I am fat in big block capitals, underlined, she managed to undermine everything that she had written, and then she could go back and list all the positive attributes. So we used that list and this

statement 'I am fat' as how that services as to her own prejudice against herself... And yes she is fat, she is overweight, but she is trying to do something to address that, so she is being proactive, she is trying to address it in therapy."

Fran and Robin locate the problem of body weight prejudice within the individual that has 'allowed' themselves to internalise body weight stigma (Wolszon, 1998). For both Fran and Robin, the experience of prejudice for these clients reflects the clients' ills, rather than societal ills. This suggests that some therapists may have difficulty with empathising with their clients' experiences of societal oppression, and may contribute to this oppression by deeming the 'overweight' body that tries to 'address' this 'problem' as more acceptable.

Fran described how the client's inability to fit the chair provided for her in the therapy room was discussed in the therapy:

"I was using the CBT approach with her so we did pros and cons with change, so what are the advantages of change what are the cons of change. One thing that would be an advantage of change would be to fit in a normal chair, so that got named and it has, we worked with that."

Fran used the notion of 'normal', inferring that her client didn't currently fit this category, and that change might advantageously afford the client the ability to 'fit in' and be 'normal'. It suggests that the empathy and acceptance that clients experience in therapy may be affected by their therapist's perceptions of their body weight.

Deb talked of 'internalised oppression' located within the client, however she emphasises a process of body weight discrimination that the client has experienced, and frames her role as deconstructing these beliefs with the client:

"When people have internalised oppression, when they believe that they are less worthy because they are in a bigger body, and when they believe they are less worthy because they are not as healthy as

somebody else, when people say those things to them or they have experiences of discrimination, it penetrates in a way...So there are all these different ways that we work on, you know building back that feeling of worthiness and building a sort of political explanation for what it is that you are experiencing.”

Deb frames her role as demonstrating to clients how a sense of self as less worthy may have developed from the responses of others. Deb located the problem as “other people’s bad behaviour”. Goffman (1963) suggests that others may make it possible for a stigmatised individual to try and remedy their ‘failing’, describing these others as ‘fraudulent servers’ that sell corrective treatments (p.20). There is an ethical need for therapists to interrogate the meanings of body weight that they use within therapy if therapists value “the worth of all persons” (BPS, 2009, p.10), and aspire to offer their clients empathy in accordance with the BACP (2013) ethical framework for good practice.

Simone referred to a need for therapists be aware of their own prejudiced ideas entering the therapy, reflecting on a client with whom she realised she was stereotyping as ‘big and strong’ because of the client’s body weight:

“I remember talking to my supervisor and saying ‘Two things just don’t go together for me’. And it was her [the client’s] body size didn’t match her vulnerability she was showing me. And I was like ‘God even I am doing that’. But I couldn’t even see it myself until I talked about it in supervision. I just said ‘She comes in all sort of like, big and strong, and this vulnerability feels really pathetic in relation to it’. And yet if someone was small and talking about her vulnerability I think it would have gone together and been easier for me.”

Simone’s account highlights that even as a therapist that has experienced body weight prejudice herself, that body weight prejudice has pervaded her work with clients. Simone talked of her concern that prejudiced views about body weight are unrecognised:

“Our society has narrowed it down to a really reduced, simplistic formula that allows us to think that if people have got bigger they have allowed it to happen, it’s a weakness, and lack of will power. And I think people can’t even see that as a prejudice. And they might not be outwardly rude to someone, but they might be thinking it. And I think that’s the danger with therapists, there is hardly anything about how to work with fat prejudice that wasn’t fat prejudice itself.”

Simone’s narrative suggests that normative ‘typifications’ (Berger & Luckmann, 1966) of body weight within therapy may disguise oppression and prejudice, where negative meanings about what it means to be ‘fat’ are so normal that it is almost impossible to recognise it as prejudice.

The researcher asked Robin *‘And you talked about being aware of your own internalised ideas about the body and putting them aside, how do you find that process of doing that with your clients?’* Robin replied:

“In a client-therapist relationship there is an element of ‘how attractive do I find this person and how does that impact on my therapeutic alliance’. And I think as clinicians we need to be aware of that so a client might have physical features that appeal to us, or they might have physical features that do not appeal to us, but we do need to be aware of how is this impacting on my relationship with them.”

Robin pronounced her awareness of how a person’s body weight could affect their physical appeal to her, and that she was able to manage this potential prejudice within the therapeutic relationship. However, Robin had also used many meanings in her interview that could be construed as prejudiced. While therapists may construct themselves as monitoring their own body weight prejudice, these findings problematise this notion of self-regulation. Whether this is picked up in supervision depends on whether supervisors are informed to recognise body weight prejudice, with this study suggesting that some are not. Therapists that described themselves as self-aware also used language and discourses

that other therapists highlighted as prejudiced.

5.3.2.4 *Theoretical code 4: Conferring credibility through body weight*

While Robin had referred to a need to be aware of body weight prejudice, when the researcher subsequently asked Robin ‘*Could you talk a bit more about how your body is involved in your work in any way?*’ Robin talked of some training she did in an eating disorders clinic:

“They were doing a course on CBT for eating disorders. One of the things they said is ‘As a clinician, if you are significantly overweight you will have no credibility’. So you can’t sit as a clinician working with eating disorders if you’ve clearly got one. So the same with doctors and dieticians, you can’t have a morbidly obese dietician giving out dietary advice, they would completely lack any credibility.”

Robin constructs a ‘master identity’ (Charmaz, 1994) for the ‘overweight’ or ‘obese’ clinician, that organises all of their other identities, suggesting their weight somehow prevents them making credible claims to an identity as a clinician. Robin’s meanings of body weight limit meanings of identity.

Similarly, Carla talked about her difficulty with supervising a colleague who was “clearly overweight themselves”. The researcher asked ‘*what kind of impact do you think it could have?*’ Carla replied:

“If I was going to see a therapist, and they were significantly overweight, my thought would be, ‘hmm I know what you’re coping mechanism is’ that would be my thought. So, the patient may have a similar thought, they may not put it in those words but they may have a similar thought.”

Carla indicates that her supervisee’s body weight undermines their value to their clients. Carla draws a body weight boundary between superior and inferior therapists, with Schwalbe et al. (2000) highlighting boundary making as a social process that produces

inequality. Carla's account frames a therapist's body weight as communicating to a client meanings about the therapist's lifestyle:

“I suppose the difficulty is that there are other things that you may do, that the client isn't going to know. You may have the odd weekend when you drink too much alcohol. The patient isn't going to know, therefore it isn't going to have any impact. But they can see you. They can see what size you are.”

Carla's account obligates therapists to be agents of self control that must cooperate with disciplinary regimes around body weight (Foucault, 1979). For Carla, a therapist's body conveys information that can credit or discredit their identity as a therapist in their interactions with others (Goffman, 2013). By virtue of the characteristics afforded to the therapist by their physicality, her supervisee is understood to be unable to fulfil the expectations of the therapeutic encounter. Carla's meanings of body weight empower those she defines as 'normal', including herself, while subordinating and marginalising others.

Goffman (1963) writes that an impact of experiencing stigma can be that individuals have an awareness of the possibilities of being accepted or rejected, which those who have not experienced stigma will be less aware of. Deb appears to construct this awareness, and her experiences of stigma, as an attribute that be used within her work:

“The ways that I suffer and the ways that I resist are still useful things to think about and they are things that give me some sort of empathy with people that I'm working with for sure. But I think it also gives the people that I'm working with a sense of, possibilities because I'm so, I don't know, I'm just not conventional about how I carry my body around in the world, or my self.”

This was a perspective shared by other therapists that described having experienced

body weight stigma. Some therapists discredit other therapists on account of their bodies, however, for the therapists that have experienced this prejudice, they see it as informing their work. These therapists described their similarities with their clients in experiencing body weight stigma, enabling them to offer clients a different attitude towards themselves, where clients might become able to accept their body weight even if society and some other therapists could not.

Deb illustrated the different ways that clients may relate to a therapist's body weight and make meanings from it, talking about a new client:

“She said ‘I’m sorry this is incredibly rude but I don’t understand how you are going to be helpful to me because clearly you have a problem yourself’, and I sort of said ‘OK, OK, let’s talk about this, you know...I guess you’re assuming that based on my body size?’ You know I was just trying to get her to talk a little bit more, and she just couldn’t stick with it, I think she felt so mortified, she just got up and left and that was that. And so a few hours later somebody that I had been working with for quite a while came in and she was a supersized woman. We were working on her depression partly and also her pessimismand she just sort of really got pissed off and she was like ‘What do you understand about this? You are an average sized woman, you know nothing about fat.’”

Deb highlights the importance of positionality in the negotiation of meanings about body weight, describing how one client perceived her as ‘too fat’ to help, while another client perceived her as ‘too thin’. Goffman (1963) concludes ‘the normal and the stigmatized are not persons but rather perspectives’ (p. 163-164). Whether a therapist’s body weight is deemed discrediting depends on the perspective of the other. These findings suggest that while some therapists may discredit other therapists’ capacities to fulfil their role by virtue of their bodies, they do not appear to consider their own stigmatising beliefs as discrediting. This is concerning for a profession that is “dedicated to social diversity,

equality and inclusivity of treatment without discrimination of any kind” (BACP, 2009, p.i).

5.3.3 Sub-category 2: Making meaning within the therapeutic process

This category incorporates five theoretical codes: Validating client and therapist identities; Fitting the frame to the picture; Navigating speaking rights; Restricting therapeutic approaches; Restructuring truths.

5.3.3.1 *Theoretical code 1: Validating client and therapist identities*

Identity, like the self, is a social concept emerging from social interaction (Blumer, 1986). Stone (1970) suggests that identity formation and maintenance takes place through a person’s announcements about themselves, and the placing and labelling by others. When there is a conflict between the two perspectives this usually results in a person recreating their identity so that it aligns with the views of others (Snow and Anderson, 1987; Stone, 1970). This study lends support to this theory, illustrating therapists as privileged with the power to do the identity placing, and suggesting that clients may renegotiate their identities to concur, as Robin demonstrates:

“Apart from the fact that he was morbidly obese in a way that clearly is disordered eating anyway. And there was just kind of a moment, a therapeutic moment, where it felt safe and again coming from a very compassionate, because I really felt sorry for the guy, and I said ‘well, and have you talked about your eating patterns with your doctor’, and he looked at me, and I said ‘well I’m guessing here that what you do is that you use food to compensate for your emotions, the times where you’re feeling upset’. And he was really tearful and he said ‘how did you know’ and I said ‘well I know this stuff, I meet a lot of people to whom this is the same.’”

Robin announces herself as the one who ‘knows’, implying a ‘closed’ awareness context (Glaser & Strauss, 1964) where only the therapist can know the client’s true identity. The client complies with the identity, living in the mind of the other (Plummer, 2010), and

playing out the role ascribed to him. As Altheide (2000) suggests 'identity claims require others' concurrence' (p.3), with the identity claim of the therapist that knows, necessitating the complementary identification of the client that does not know and needs to know. Rubin, Schmilovitz & Weiss (1993) describe being unrecognisable to others, due to substantial weight loss, as a crucial element in creating a new identity. This study goes beyond the act of weight loss, to suggest that the unrecognisability and invalidation of an identity as 'fat' and someone who knows, can lead to clients accepting a new identity elected for them by therapists.

When describing her work with clients seeking support with their weight, Dee explained that she always starts by asking about their eating patterns. Dee was asked by the researcher 'So what if a client comes and doesn't think their weight is related to their eating?' Dee replied:

“But they can't think that, if they are overweight it must be because of what they eat, if there isn't a health reason.”

Carla talking of her work in the NHS, similarly indicated a stereotype of 'overweight' people, refuting her client's identity claims as a vegetarian and a vegan, and suggesting that it is Carla that knows her client's 'true' identity as someone 'in denial':

“This particular person, as is with a lot of people who are overweight, there's huge denial. I don't know how she can be, well I do know, she tells me that she's a vegetarian and a vegan, and I'm thinking 'well how on earth, you must eat an awful lot of nuts then', so I'm thinking 'how on earth do you find', and she's gluten-free, and I'm thinking 'how on earth do you find enough food to have, to carry around all that weight', you know. So I'm thinking there's a denial here.”

With the invalidation of an identity as 'too fat' or 'too thin' who knows they are not struggling from 'disordered' eating or a health concern, clients are encouraged to adopt a new identity, the person who has been in denial but confesses their transgressions to the

therapist. The therapist claims an identity as the individual who knows about the client's 'problem' through their greater 'expertise' of the client, and the client is 'altercasted' into an identity with the problem that the therapist knows about (Weinstein & Deutschberger, 1963). Clients have limited means to refuse this identity, as to do so is constructed as remaining in 'huge denial' and 'interpreted as a direct expression of his stigmatized differentness' (Goffman, 1963, p.26).

Claims to an invalidated identity are argued by Haworth-Hoepfner and Maines (2005) to take place in a 'discordant awareness context', when a person refutes an other's view of their identity which leads to the break down of role-taking. Simone narrated her own experience as a client with her therapist identifying her by her weight, and Simone's refusal of this identity placement leading to the breakdown of their relationship:

"I was talking to her about going to the gym...And she said, 'so tell me a bit more about your weight'. I was like 'why would I want to tell you about my weight?' And she said 'well because you're going to the gym to lose weight, how much of an issue is your weight?' And I said 'What?! I'm not going to the gym to lose weight'. And she said 'Yeh and you said that'. And I said 'No I didn't, I'm not going to the gym to lose weight, I go to brighten up my day and do something with my body.' Well that was it. I didn't go back. It was awful, and she couldn't see what she had done. And I said' Why have you bought my weight into it?' and she said 'You brought it up by saying about going to the gym.' You can't see that a fat person goes to the gym for any other reason."

Simone maintained her contested identity, rather than decrease commitment to it, in contrast to Stryker's (1968) theorising of identity invalidation. Simone did not realign her identity claim, unlike Carla's narrative presented earlier of her client 'beginning to see' her previous 'denials'. Simone contrasts her knowledge and experience about the body and body weight as a self-identified 'fat person' with the ignorance of her therapist. Perhaps

Simone's identity as a therapist herself, privileges her with the assumed authority to refute her therapist's identity placement, an authority that may not be afforded to other clients. This supports Haworth-Hoepfner and Maines' (2005) findings that discordant awareness contexts can serve to strengthen an invalidated identity, particularly when someone has a 'master identity' (Charmaz, 1994) and where there is no mutual understanding for meanings of body size. However, Simone describes a cost of refusing this altercasted identity:

"I was having a terrible time at work and I was really depressed and I really needed some support. And it was being offered though my GP surgery which was really rare. So I had to turn it away and there was just nothing else."

Charlotte Cooper, a therapist and author who writes about fat activism, described a similar experience of herself as a client:

"I really felt, not only was my life experience being medicalised and pathologised, but also my body as part of that, was being regarded as part of the same problem. 'You look like this so you must be a pathological person', that's what I got from that interaction. I just never went back...What I needed was for somebody to care about me, and I didn't feel like I was being cared about in that context at all."

With the refusal of an identity placement leading to a breakdown in role taking (Haworth-Hoepfner & Maines, 2005), clients are left without the therapeutic support they were seeking. However, even this may serve to confirm the therapist's construction of the client's identity. When the researcher asked Dee if her approach that assumed a client's weight "must be because of what they eat" was successful in helping them lose weight, she responded:

"Yes, if they stay. Normally it stops the cycle of starving and over-

eating. But some people just come for one or two sessions and find that it goes too deep but they are not ready for that.”

A client who contests the therapist’s identity placement and ends the therapy may be reified as in denial, rather than a need for a therapist to interrogate their approach.

5.3.3.2 *Theoretical code 2: Fitting the frame to the picture*

The therapists in this study were asked ‘*Can you tell me a bit about your approach and the context that you work in?*’ Many of the therapists spontaneously talked about the chair that clients sit in, describing a need for a fit between the client and the therapeutic setting. Goffman (1959) posits that the setting, including the furniture and props, serve to stage a situation, structuring the performance expected of it. Paula, who offers couples therapy in private practice, described how the therapy she offered dictated the way she set up the chairs in her therapy room:

“One of the things they do say, is that when you’re doing couple’s work, you have to have the two seats facing each other. So I won’t sit on that sofa, I’ll sit on this chair, but I’ll sit quite close to them, and they’ll be facing each other.”

The presence and positioning of the chairs symbolises that the space is a therapeutic space, with tacit rules of what can be expected of the participants within it. Therapists made reference to the importance of the client being able to physically fit in the chair within the therapeutic setting. Goffman (1959) describes how ‘first impressions’ serve to define the interactions expected by each participant, with subsequent interactions developing from this initial definition of the situation. Through these first impressions, an individual implicitly (if not explicitly) makes claims to be a particular kind of person, obliging others to treat them as expected for a person of their kind. Foregoing “claims to be things he does not appear to be” (Goffman, 1959, p.24), and their corresponding treatment.

Robin talked about her first impression of a client struggling to fit the chair provided for him, appearing to perceive this as the client's claim to having an eating disorder:

“The client who came to my room and he struggled to get through the front door. Now I’ve got an old house so it’s got double doors, and they’re about 20 inches wide. And he had to physically try to squeeze through the doors. And when he sat in my chair, he filled the chair. He literally filled it to the point where I wondered if he would actually be able to sit in it or whether I would have to find another chair for him. And his doctor had never talked to him about his eating disorder.”

The chair is an active component of the therapeutic setting, not only serving to communicate the performance expected within the setting, but shaping interactions between participants as they cooperate, or ‘fail’ to cooperate with the setting. A disjuncture between the setting and the client leads to subsequent interactions developed from this initial act, with Robin’s ensuing approach developed from her formulation of her client’s ‘eating disorder’. Goffman (1959) writes that when participant interactions contradict that which were expected by the first impression, the interaction can become disrupted, with participants feeling ashamed, hostile or embarrassed. Fran describes this experience when working with a client who didn’t fit the chair that Fran provided in her NHS setting. Fran however, describes this necessitating adjustment of the setting, to allow the performance to take place and to manage the first impression that she projects:

“Next time when I see someone in the assessment who has that BMI, then that’s probably going to be the first thing that comes to mind. Will this person fit the chair that we have, if not, what facilities have we got that can accommodate that person. So going back to your question, how do we navigate that, at times with difficulty. But yes, just you know, you keep on talking to the person, saying ‘Is this OK, this is the only thing that I have at the moment and we are trying to get a chair”, and just being open and honest about it... You know I

think it was something that felt quite humiliating and exposing, perhaps for both of us, not just her.”

The chair becomes a symbol capable of eliciting shame and embarrassment as the participants try to manage their performance together around it.

Charlotte described her decision-making process about what sort of chair to provide for her clients in her private practice, proactively trying to avoid clients being unable to fit in the chair:

“So I’ve deliberately got quite a big comfy chair for clients because I thought if I’m going to see fat clients they need to be able to have a chair that the fattest person I know can fit in....I notice how much I fill the chair, and I notice clients’ bodies and the way they fill or the way they don’t fill the chair that they’re sitting in. And some clients are very tiny and just kind of perch on the end, and other clients are quite fat and fill the chair like I might fill a chair. And other clients sort of sit on the chair in a very kind of relaxed way, some sit on the chair and cross their legs on it. It’s funny, I notice the different uses of space.I think it’s about power and how comfortable people might feel in that chair, the kind of you know, when people are quite sort of closed down, the way that people claim the chair, or are able to sit on it and claim the space around them.”

Charlotte demonstrates herself inferring possible meanings about the client from the way they interact with the chair, although these meanings do not appear to problematise the client as Robin describes. This suggests that the same client’s physical ability to interact with different therapy settings may be received very differently by therapists. Reid, Webber and Elliott (2015) purport that individuals constrain their presentation of selves to meet the purpose and expectations of the situation. This has implications for a therapy setting whereby the structure may restrict the selves clients present, to that which is obligated or expected by the setting. Therapists have greater control over the staging of

the therapeutic structure, and the expectations it communicates. How a client interacts with and uses the setting has consequences for how they might be identified by the therapist, structuring subsequent interactions between client and therapist and the therapeutic process.

5.3.3.3 *Theoretical code 3: Navigating speaking rights*

The researcher asked *'And in terms of my interest in body weight and how that does or doesn't get talked about in psychotherapy, do you have any experience of working with clients where body weight has been significant in any way?'* Robin described a first session with a new client who had made no reference to her eating or body weight, and was going through IVF to try and get pregnant. Robin demonstrates herself breaking from the norm of 'tactful blindness' (Goffman, 1967, p18), where it is assumed impolite to draw attention to the body:

"No one had been honest with them, no one had been upfront with them, and that just really upset me and offended me because I can quite often read when someone has an eating disorder and I will bring it into the room....I think in her case I actually upfronted it. I might have said something like, I think with her because it was so obvious, I said something like 'so did they ever discuss with you the impact of your eating disorder on your ability to get pregnant?'"

Within the therapy setting there is perhaps a 'fixed permissiveness' (Goffman, 1959) about what can and can't be said, where for some therapists usual social conventions are deemed to not apply. The researcher asked Robin *'You use the term "upfront", it sounds like that's something quite important for your work?'* Robin replied:

"Someone with disordered eating generally knows it, they're generally caught up in a lot of shame about it. So if it's sat there stark staringly obvious and we're not talking about it, for me it feels like, you know, it's too shameful to talk about it, and what I'm trying to do is

deconstruct shame. And the really obvious cases I can just upfront it in a very direct but compassionate way, in the more tentative cases I will just approach it in a very normalising way, so there might be times where I say, I might ask, ‘So are there times when you use food to take away the painful feelings of feeling upset?’

The client’s body identifies to Robin a need for their weight to be discussed, with how Robin raises it is informed by her perception that weight communicates a client’s relationship with food. How Robin initiates these conversations may make it very difficult for clients to make sense of their experiences in a different way.

Sam also described her perception of a client’s weight affecting her interventions with her clients who are children and adolescents. Sam explained:

“If weight was low enough I would literally say what is happening with your weight, are you restricting eating, what is going on. But one of my remits is to talk about risk, so I am really clear from the beginning ‘we need to talk about risks and weight is one of those risks’. If the person is really overweight, then I would bring that up as well and say ‘How do you feel about your weight?’ Straight forward.”

The researcher (using the therapist’s words) subsequently asked Sam to elaborate, asking: *‘What is it that informs your judgement of when you are going to say it to somebody, because they haven’t offered it? So if you’re thinking ‘OK you’re a bit overweight’, what makes you decide that?’* Sam replied:

“Do you know it’s often what’s been admitted. So when it’s a family, at one point, where a much younger child who was immediately visibly obese, so was her brother and so was her mum, and it was inevitable to talk about that. So for me that was exactly where I wanted to go. Why do we never talk about your eating, why do we never talk about your weight in the family generally. So that was a beacon for me.”

Sam, like Robin, describes her understanding of her clients' body weights communicating their relationship with eating, and necessitating that it is 'admitted' and talked about in therapy. This suggests that some therapists claim the authority to make this decision on behalf of the client, drawing on normative discourses to describe clients' experiencing, and in doing so exercising power (Foucault, 1979).

Simone who works in private practice described seeking permission from clients about what words she should use, or using the words that they used. Charlotte also talked about the language she uses with clients:

“My preference is to use ‘fat’, but also I work with people for whom that is a really difficult word, and I think what a shame that’s a really difficult word for you and maybe at some point it will be a less difficult word for you, or maybe it won’t, I don’t know. I would be very mindful of the language that is used to describe things, and there might be a period of skirting around it a little bit, and enabling it to be articulated gently and perhaps more clearly as time goes on.”

In contrast to the accounts presented earlier, Simone and Charlotte viewed their role as allowing clients to construct their experience using the words and discourses the client chose, rather than imposing language on to the client.

Deb was asked to describe her work that critiques normative ideas about body weight. She spoke of her strategy to manage client's expectations for how she thought and talked about body weight from their initial enquiry, seeking their 'informed consent':

“They’re saying ‘I want to lose weight and I want to understand why I can’t lose weight’ and so on and so forth, and so for me, in either case I feel like I need to do some informed consent on the phone. I basically say ‘You know, I am not someone who prescribes weight loss or the pursuit of weight loss. In fact I will challenge that, and I want you to know before you have to pay any money for this. I want to

know that you are a customer for that because not everybody is.”

Charlotte similarly talked about permission being granted by the client for her to present a non-normative and critical view of fat. While therapists in this study talked of their wish to make the client's body weight a topic that was not shameful to be talked about, clients may not be given a choice over its relevancy to their therapy. Informed consent may be sought to present non-normative meanings about body weight, however this research suggest that clients may not be given a choice about engaging with normative meanings.

5.3.3.4 *Theoretical code 4: Restricting therapeutic approaches*

Asking Dee to describe her work, the researcher asked ‘*How do you know if you have reached their weight loss goals?*’ Dee answered:

“You talk about it almost every session, ‘what do you want to do today?’ ‘Do you want to change the goals?’ Quite often they want to change the goals, they want to lose more, so they should be flexible.”

Dee positions herself as supporting her clients to lose weight, with the therapy used to monitor the client's progress. Carla spoke about one of her clients, suggesting too that the therapeutic aim for the client might include weight loss:

“A lot of it is about becoming more aware of when she overeats and actually becoming aware of what she is eating. So that you know it's like ‘Oh I'm not eating much, I should have lost weight, why haven't I lost weight?’ And it's being able to say ‘Well actually, if you were eating as little as you tell me, you would have lost weight.”

Foucault (1965) suggests that agents of social control within society may encourage conformity to normative discipline. Szasz (1974) proposes that psychological interventions can be used to coerce clients to adhere to the order of normalcy.

Charlotte described her concerns, framing some therapists as oppressing clients:

“I have plenty to say to therapists and people working within models that further marginalise fat people. I think it's outrageous that that happens and I certainly see it. Well I guess it's something that I haven't talked about is, clients that come to me after having terrible experiences with other therapists... So yes clearly there are things going on where people are having bad experiences, and that can't continue. But I think it probably will continue within this discourse of obesity killing the NHS, that sort of fat panic rhetoric.”

Monaghan, Hollands and Pritchard (2010) refer to ‘obesity epidemic entrepreneurs’ as those with a vested interest in the continuation of the ‘war on obesity’ (Monaghan, 2008), and share Charlotte’s concerns for those being marginalised.

Simone also talked about her concern that therapists’ approaches might propagate normative and prejudiced views:

“If someone comes along and are saying ‘I hate my body size, I have all this trouble in my life and people are mean to me’, the counsellor might start colluding with this view that life would be easier if they were thinner because clients generally come with that view... And what worries me is that if supervisors are not enlightened, then they are not going to pick up on those comments, or sentences that are used and challenge them either. It's a real hidden prejudice. And the client isn't thinking that it is prejudice either. So it is so factual in our society that it isn't challenged, and then the people that do challenge it look mad.”

Bovey (1989) agrees that fat prejudice is particularly malicious because of its insidiousness. Referring to supervisors and society, Simone situates the therapeutic process occurring within organisations that structure normative meanings. Simone suggests that the ‘orderliness’ (Goffman, 2013) of the therapeutic encounter leads to the reproduction of body weight prejudice, with

clients, therapists and supervisors using normative societal meanings that a thinner body is a more acceptable body.

Charlotte also described being limited to challenge normative ideas about body weight, referring to the professional body she affiliated with:

“I do feel slightly awkward talking about therapy as activism because I think it’s a bit of a no no to talk about this stuff. Yeh, I don’t know where I get that feeling from. Possibly because I’m so orientated towards the professional body values which to me are extremely mainstream and quite problematic in many ways.”

Goffman (2013) highlights that when a definition of a situation is being maintained, it excludes other definitions. Confusion can occur if an individual tries to ‘break frame’ and assert an alternative perspective from that which was expected. Simone describes a difficulty with ‘breaking frame’ in her work with clients when they refer to themselves as being ‘overweight’:

“But it is difficult when clients say things but it’s not the point of the work, so you can’t really go there as it’s not what they are asking for, but it probably underpins their self esteem and self worth so it is hard. Particularly in six session work, we can’t go in to that. And I have said something to people and they have looked at me as if I was bonkers, and I have thought ‘God I am going to get struck off for this’ so I have to let it go.”

Simone’s narrative suggests that both time and the regulatory body restrict her engagement with non-normative meanings of body weight with clients. Sam spoke about economic restrictions that favoured brief therapy, framing cost cutting as taking priority in clinical practice:

“Because the emphasis is on cutting costs and value for money, the professionals that put forward cases for brief therapy win every time.”

So the commissioners and the politicians and the managers of the trust who are not necessarily clinicians will be drawn to the practices that kind of say they can do it quickly, whatever they can do, which is mainly stop spending money on the patient.”

Jess who worked in a drug and alcohol service described how the amount of time she had with clients could influence her approach, suggesting that this could result in a form of control or oppression in the therapy:

“If I was more pushed for time I would have to be more challenging and more direct but that often mirrors what these women have come up against...often they don’t feel control of their own lives so the last thing they need is me then saying well, pushing them even more.”

These findings suggest that therapists may exercise power to encourage clients to take action to try and reside within body weight parameters of ‘normalcy’. While some therapists actively refute normalising discourses, they described being limited to engage with non-normative meanings through restrictions imposed by time and organisational systems.

5.3.3.5 *Theoretical code 5: Restructuring truths*

The interviews revealed normative meanings about body weight operating within therapy. Sam was asked whether she felt body weight was always related to eating, she replied:

“No, sometimes it can be exercise, sometimes it can be, obviously eating, no it’s usually about relationships, that’s the thing I find. It’s usually about what’s going on in their life. Not necessarily eating.”

Sam was asked to expand on this, with the researcher asking ‘*So body weight and relationships, how do they get associated?*’ Sam responded:

“When people are very overweight sometimes it can be an over-

connection with the parents, they are all overweight, they are all eating together constantly, so its part of the relationship, its hard to separate it. It's part of family life to eat together and then they go out and eat more together, and they don't exercise and they watch television. And that's the important thing, what does than mean to them, what are they losing if you gave it up."

While Sam's approach is framed as relational and exploring the clients' meanings, she draws on normative discourses of being 'overweight' relating to food and exercise (Lupton, 1996; Monaghan, Hollands & Pritchard, 2010).

Robin described using 'cognitive restructuring' in her work to encourage clients to think and behave differently. Robin also conflated meanings of body weight with meanings about food, demonstrating how a 'psy discourse' (Guilfoyle, 2001) can problematise clients' experiences:

"It's a cognitive restructuring of 'If I tell myself this is comfort food and this is comfort eating', I'm going to feel positive towards it. Whereas if I recognise it for what it is, which is this is self-harm, I am using food to harm my body because I'm angry with myself. I'm using food to try and take away a physical sensation which isn't hunger, it's upsetness. It's discomfort. It's discomfort food. Is it so tasty now? So the strategy is by using cognitive reframing I am trying to empower the client to make a more conscious choice about will this food help me or harm me."

Foucault (1979a) suggests that we can never have access to reality beyond discourses, which determine our perception of reality and truth. These findings suggest that some therapists determine which discourses are available to clients. Robin illustrates how therapists' chosen therapeutic interventions shape the encounter, based on their constructions of reality.

Carla similarly described her sense of reality differing from her client's:

“I think the only time I find it difficult is if they deny it. I mean I had one woman who must have been about 16 stone, and about my height, and ‘I don’t eat, I starve myself. I’ve been told the reason why I am this size is because I’ve starved myself for so long so any food my body does ingest it stores as fat.’ Well you know. But that was also what she was like throughout the therapy with most things, the denial.”

When the researcher asked “*And how did you respond?*” Carla described this conflict resulting in a form of emotion work (Hochschild, 1983), and influencing subsequent interactions with the client:

“Well then you feel angry, you think, ‘oh do you think I’m stupid’. I think you have to work with them to try and get them to see what they are doing and it’s about their motivation a lot of the time. And obviously the therapeutic relationship you have with them. With some people like the woman who came in because of that, and she is now able to see that she is probably eating more than she thinks she is otherwise she would have lost weight, so she is kind of beginning to see that. But a lot of people remain in denial.”

Garfinkel (1984) proposes that powerful emotions arise when routine order and taken-for-granted assumptions of the situation are threatened. Carla suggests a process of maintaining order, with her constructions of reality over-ruling those of the client's; reinscribing her client's 'denial' with Carla's reality.

In her exploration of illness, Charmaz (1991b) terms 'fictional identities' as an identity that ill people unintentionally construct for themselves that emerge from a "lack of awareness, partial knowledge, and the absence of apparent symptoms. Thus these fictional identities are not lies, pretense or manipulations" (p.74). While Charmaz adopts

the term to describe identities people claim for themselves, these findings suggest that the notion of a fictional identity is used by therapists to strengthen their placement of a client's identity. Thus not only is the client's identity claim invalidated, the client is identified as making claims to a fictional identity, positioning them as lacking awareness and knowledge, and requiring the therapist's greater insight.

Goffman (1959) talks of orderly interactions requiring a shared definition of the situation, suggesting that participants attempt to avoid open conflict regarding these definitions. Carla's narrative of her anger and private thoughts suggests that while therapists and clients may sense a conflict between their definitions of the situation, participants manage this conflict between them. Reid, Webber and Elliott (2015) suggest the existence of implicit rules guiding 'appropriate' action within different occasions, with Carla and Robin indicating the scripting of differing roles for therapist and client in the therapeutic situation. These findings suggest that normative meanings of the therapy situation and the therapist's presumed authority, can oblige the client to 'fit in' (Goffman, 1963, p11), engaging in 'corrective behaviour' to maintain routine order (Garfinkel, 1984).

Fran spoke of her awareness of the operation of power within the therapeutic relationship that guided her interventions:

“Because if you adopt that stance of let's change what you are doing, someone is going to succeed, and someone is going to not succeed, and so the patient can feel, the client can feel that if they are doing what the therapist is recommending, then they are losing, and I think that's not a very helpful dynamic with this battle of power, it's not very helpful.”

Fran talked of a possible consequence of therapists trying to change their clients' behaviours and suggested a risk to the client's self-worth. Fran's concerns for the potential operation of oppressive power dynamics within therapy, and its impact for the client, is shared by theorists (e.g. May, 2007; Moon, 2011; Rose, 2003). These findings suggest normative meanings of body weight, and the privileging of the therapist's power,

is common practice in some therapy settings. Therapist construct ideological truths about body weight, with their understanding of a client's body weight 'reality' informing their use of interventions; encouraging clients to 'restructure' their thoughts and behaviour to share this reality.

This chapter has presented the results of this study, and provided a preliminary discussion of the findings drawing on relevant literature explored within the literature review. The following chapter provides an indepth discussion of the findings and presents implications of this study for the field of counselling psychology. It also provides a critique of the present research and reflexively considers the researcher's interaction with the study, in accordance with the tenets of a constructivist grounded theory method (Charmaz, 2014).

CHAPTER 6: DISCUSSION

Chapter 5 explored the findings of this research and presented a preliminary discussion. Chapter 6 summarises the results and gives a general discussion of this study in relation to previous literature and research. It offers a critique of the current research and research method, and provides reflexive considerations. This chapter also describes the implications of this study for counselling psychology.

6.1 Summary of results

This study began with the research question: How are meanings of the body and body weight constructed by therapists?

A constructivist grounded theory method (Charmaz, 2014) allowed the findings to emerge from the narratives of the participants. It situated the participants, and myself as researcher, within a complex interaction of encounters between individuals and their social environments, with meaning making arising from these interactions. These findings illustrate therapists engaging with normative meanings of body weight prevalent in mainstream media and utilised by the NHS, that denigrate the 'fat' or 'overweight' body as unhealthy and undesirable (see appendix T). Alternative meanings of body weight that welcome size diversity are available for therapists to interact with, such as those used by fat activists (see appendix U). However, these findings suggest that these alternative meanings have to be actively sought out, and are not used by most therapists.

The grounded theory and core category that emerged from the results was 'A self as a body in space: claiming an identity as a therapist'. It demonstrates therapists interpreting and reinterpreting body weight meanings to construct their sense of self and identity as a therapist. The core category encapsulated two sub-categories: 'interpreting the bodies in the therapy room' and 'making meaning within the therapeutic process'. The first sub-category: 'interpreting the bodies in the therapy room' emerged as therapists described using the body to find a sense of self as a therapist and the professional space that they worked within. Therapists talked of body weight prejudice operating within

therapy and that a therapist's body weight could discredit their identity as a therapist. A second sub-category also became clear: 'making meaning within the therapeutic process'. Some therapists claimed identities for themselves as the therapist who 'knows' about a client's body weight, utilising normative meanings of body weight and placing their client into an identity as naïve, unconscious and unknowing. Other therapists spoke of non-normative meanings of body weight being curtailed by systemic prejudiced beliefs, with normative discourses about body weight pervading relationships with colleagues, supervisors and regulatory bodies.

6.2 Core category: A self as a body in space: claiming an identity as a therapist

A new finding of this study posits that not only do we construct a 'self in time' (Charmaz, 1991a), but a self as a body in space. Therapists described using the body to develop a sense of self as a therapist. They described themselves accruing experience through their bodies, and working in a professional space as a therapist that allowed them to demonstrate this knowledge and understanding. Some therapists had experienced body weight stigma and framed themselves working with clients in a space that aimed to challenge prejudice. Others classified themselves and their clients according to body weight, using terms such as 'underweight', 'overweight' or 'normal weight', and demarcated a space that demonstrated their expertise to ask about food and body weight. This study furthers Liu (2015), to suggest that while social boundaries *can* be 'ambiguous and elastic' (p.1), some therapists establish rigid body weight categories. Therapists who identified clients as 'overweight' claimed an identity as the therapist that could help with this 'problem'. Cooley (1902) and Mead (1934) posit that the formation of the self is a reflective process, with interactions with others critical for the emergence of a self-concept. A process of 'envisioning self through others' (Anthony & McCabe, 2015, p.70). This research suggests that therapists envision a self and an identity for themselves through their relationships with clients. Therapists form a sense of self as a therapist through their interactions with clients, and their perceptions of how their clients perceive

them, whether as the superior expert with 'normal body weight', or as someone with their own experiences and difficulties with their body.

As posited by Lupton (1996), this study demonstrated therapists appropriating body weight discourses that construct 'overweight' clients as lacking self-control.

Therapists also used a 'psy' stance that constructed these clients as in denial, and in need of the therapist's greater understanding and expertise. This study lends support that therapeutic interventions that ascribe pathology to body weight may be experienced as oppressive and marginalising (Beggan & DeAngelis, 2015; Brown, 1989), as therapists limit clients' speaking rights and 'restructure' clients' truths. How a client interacts in a therapy setting may be understood by therapists as either normative or disordered, dependent on whether therapists problematise clients in relation to their body weight. Therapists referred to the body mass index and its categories of 'overweight' or 'obese' as a rationale for their interventions. This research suggests that the therapeutic encounter is situated within a world of body weight meanings: a 'knowledge base', created and governed by 'expert systems' (Giddens, 1990). Some therapists supersede and invalidate clients' knowledge, utilising the 'expertise' and moral authority designated to them by institutions such as the NHS that determine what constitutes as 'normal'.

Intersubjective theory argues that 'the other' must be recognised as a subject for mutual recognition to become possible (Benjamin, 1995). However, this study points to clients being identified as 'overweight' and being objectified and devalued. It suggests clients comply with therapists' 'regimes of truth', internalising oppressive practices and reinscribing their own truth; offering legitimacy to their subordinate and 'unknowing' position through this process (Guilfoyle, 2001; Lewis, 2009). Moon (2011) argues that the 'self' that clients have access to is limited by normative values that are legitimised in therapy, with this study demonstrating similar findings. These findings posit that recognition takes place between therapists and clients within sociopolitical parameters of body weight normativity, with implications for how clients recognise their own subjectivity. Fraser (2003) concludes that recognition is a matter of justice, locating misrecognition

within social relations, and requiring the addressing of institutionalised norms which prevent equality. This study points to misrecognition and inequality within the therapeutic encounter that may require addressing at an institutional and societal level, to challenge normative meanings of body weight and their presence within therapy.

This study notes a spectrum of 'false consciousness' within therapy (Berger & Luckmann, 1966). Some therapists engaged with the notion of a fixed reality that is 'denied' by clients, while others demonstrated a 'sociological imagination' that recognises reality as constructed (Mills, 1970). Some therapists interrogated meanings of power within therapy, suggesting that the operation of power could oppress clients and limit their opportunities to frame their experience. However, clinical practice and interactions within the client-therapist dyad were also experienced as restricted by an institutional and social order that propagate normative meanings of body weight that denigrate fat. These findings suggest that regulatory and training institutions must engage in a process that challenges existing rhetoric about body weight to ensure ethical practice, as first urged by Brown and Rothblum (1990) twenty five years ago. Rather than resistance viewed as 'denial' and symptomatic of a client's weight 'problem', a client's resistance could be understood as a challenge not only to their identity placement, but to the identity claimed by the therapist as the 'expert' within a system of institutionalised inequality.

6.3 Sub-category 1: Interpreting the bodies in the therapy room

This research adds to a dearth in literature that explores the lived experiencing of those identifying, or identified, as 'fat' (Fikkan & Rothblum, 2011). Some therapists in this study inferred that therapists that are 'overweight' or 'obese' are less credible as therapists. Other therapists described experiences of being identified as having a weight 'problem' that others construed as undermining their professional credibility. It is suggested that therapists that are identified, or identify, as 'fat' are confronted with 'identity dilemmas' (Charmaz, 1994). These findings demonstrated the maintenance of an identity as a therapist is disrupted by body weight meanings that deem those outside the margins of normative body weight as failing to make the right choices (Monaghan,

Hollands & Pritchard, 2010; Tischner & Malson, 2010). Therapists who had experienced being discriminated because of their body weight, appeared to challenge body weight stigma. Rather than their body weight discrediting their identity as a therapist, those identified or identifying as 'fat' relocated their identity within a context of inequality and ignorance. They framed the understanding they offer clients as enhanced by these experiences of marginalisation and discrimination, and reclaimed their identity as a therapist.

Therapists in this research referred to clients' 'own' fat stigma, talking of shame and self hatred as described by Lyons (1989). Some therapists challenged the pursuit of weight loss, and were mindful of the influence of social norms that vilify fat. However, other therapists that did not construct body weight self-loathing as symptomatic of societal oppression, appeared to psychologise and pathologise the 'overweight' client. These therapists segregated prejudiced meanings about body weight from socio-cultural issues, locating the problem in the client, as illustrated by Wiggins (2002) and Wolszon (1998). Some participants in this study talked of the harmful affects of feeling stigmatised by their own therapist because of their body weight. They described the potency of body weight prejudice for individual psychological well-being (Monaghan, 2008; Pascal & Robinson Kurpis, 2012; Rothblum & Solovay, 2009; Schafer & Ferraro, 2011). Altheide (2000) describes power 'as the ability to define a situation for self and others' (p.5). This research points to clients having unequal access to define body weight meanings used in the therapeutic encounter, with deleterious effects for the individual. This adds to Robinson and Bacon's (1996) findings that a fear of fatist views may not only restrict daily life, but access to therapy, with participants describing their experience of weight prejudice in therapy and ending the therapy as a result.

These findings suggest that the body is used to develop ideas about 'the self', supporting Murray's (2005a) notion of the corporeality of subjectivity being shaped by meanings about body weight. Therapists constructed themselves as embodied subjects and objects, describing how their body communicated their self acceptance or

dissatisfaction. Some therapists acknowledged that while others might construe their body weight as pathological, that this was not how they experienced their body. This implies that it is possible to refuse normative prejudiced meanings of body weight, and experience oneself as an embodied subject, which Murray (2005a) questions. Merleau-Ponty (1962) rejected the concept of the body as an object, instead viewing the body as the mode of being through which experience, subjectivity and consciousness emerges. Merleau-Ponty's theorising has been criticised for its inability to encapsulate both the body as subjectively experiencing society, as well as being objectified by society. The current study found that while therapists used the body to construct a sense of self and experience subjectivity, some also described the body being objectified by a society that is largely prejudiced about body weight.

This research posits that meanings of the self are embedded with meanings of the body, with these meanings emerging from interactions with society. This study supports Shilling's (2005) argument for a focus on the interaction between the embodied subject and society, to view how 'the body constitutes a means through which individuals are attached to, or ruptured from, society' (p.69). This study expands previous literature on the process of embodiment as an intersubjective relating between client and therapist, and the therapeutic dyad and society (Allegrant, 2013; Rumble, 2010; Swartz, 1998). It adds new theory to suggest that therapists must interrogate their meanings for body weight, and their interactions with clients, and question what kind of embodiment and relationship with the self and society they enable within therapy.

6.4 Sub-category 2: Making meaning within the therapeutic process

This research supports previous findings that fat bias within therapy can affect clinical judgement (Agell & Rothblum, 1991; Davis-Coelho, Waltz & Davis-Coelho, 2000; Pascal & Robinson Kurpius, 2012). Therapists' impressions of their clients' body weight seemingly affected their formulations of clients' difficulties and their subsequent interactions. Therapists also described their experience of clients making meanings from the therapist's body, with clients suggesting that therapists identified as 'too fat' would not

be able to offer them help. This concurs with previous findings that clients' perceptions of their therapist's ability to help them are affected by body weight (Lerman, 1989; Rance, Clarke & Moller, 2014; Vocks, Legenbauer & Peters, 2007). Therapists and clients enter the therapeutic situation with expectations based on normative meanings of body weight, with this understanding seemingly affecting the client-therapist interaction. This research finds that when clients are identified by therapists as 'underweight' or 'overweight', a client's assumed level of understanding and self-awareness is undermined. It may be difficult for clients to claim an identity as self-aware, if they are placed into an identity as 'too thin' or 'fat'. These findings posit that clients may be unable to reinterpret the placing of this identity, because to do so only reinforces their identity as naïve and in denial. This aligns with previous findings that being identified as 'fat' or 'obese' limits access to other identities (Carr & Friedman, 2005; Packer, 1989; Rice, 2007).

Clients may be afforded limited access to their own vision of self or identity within therapy. This study points to the existence of oppressive interventions within therapy that may result in clients adjusting their identities to align with the identity placements accorded by their therapist. Schwalbe and Mason-Schrock (1996) suggest that ineffective identity work can create anxiety, confusion, isolation and feeling devalued. This points to concerning implications for the well-being of clients who are identified as 'too thin' or 'too fat' by therapists and the institutional order that therapy exists within. Some therapists talked of their clients as in denial of their eating practices, with their client's body weight understood to corroborate this. Gergen (2009) postulates that the notion of an objective reality being denied serves to produce hierarchies of inclusion and exclusion. This study suggests that the ethics of therapists using normative meanings of body weight that implicate an 'underweight' or 'overweight' or 'too thin' or 'too fat' body requires further interrogation. Further consideration is required as to whether some therapists are benefiting as body weight 'entrepreneurs' (Monaghan, Hollands & Pritchard, 2010), at the expense of clients already marginalised by societal meanings of body weight.

This research includes narratives of clients being encouraged by therapists to reinterpret thinking, feeling, behaviours and emotions, and adopt proffered accounts to describe their lived experiencing. Some therapists prescribe 'codes of knowledge' for how feelings should be experienced, expressed and explained, with clients developing their subjectivity through this process (House, 2003; Parker, 1999; Rose, 1996). Clients' embodied subjectivity appears unable to oppose the 'truths' of denigrating body weight discourses (Tischner & Malson, 2012a), as clients learn the 'ethical' repertoire of a therapy that is framed as being in their interests (Hook, 2003). This research demonstrates therapists policing and sanctioning meaning-making in accordance with a culturally and institutionally approved body order, as suggested by previous research on body politics (Allegranti, 2011; Soth, 2006, Totton, 2010, 2012). It indicates that therapy can become a disciplinary method whereby individuals surveil, monitor and govern themselves, aligning their bodies, behaviours, thoughts and feelings in accordance with normative expectations of body weight (Rose, 1990; Foucault, 1979a; Goffman, 1963, 2013). These findings suggest that normative and prejudiced meanings of body weight are openly accepted, as described by Puhl and Brownell (2001), even in therapeutic contexts.

6.5 Evaluation of research and research method

These findings are not presented as a monolithic truth for how meanings of body weight operate within therapy. Instead it presents a grounded theory that has emerged from my interaction with the data. It is suggested that these findings are critiqued along side other theories of body weight and therapy. This study is offered as a contribution to knowledge that might inform how institutions work with practitioners, and therapists work with clients, while acknowledging the findings' context specificity (Willig, 2001). The research demonstrates the participants embedded in complex, interrelated interactions with clients, therapists, supervisors, organisations, cultures and personal and historical settings. It does not presuppose that the experiences constructed by these participants are necessarily shared by others. Instead it offers a theory for how participants construct their experiences, and the implications of which, suggesting that how therapists interpret

meanings of body weight has a potential to be oppressive. Rather than producing a universal truth, it seeks to problematise simplistic, generalisable meanings about body weight and suggests that just as this research is context specific, so are the lived experiences of clients. This research uses factors suggested by Glaser (1978) and Charmaz (2014) to critique this study, using the criteria of relevance, credibility, originality and usefulness. It specifically evaluates the research and its research method together, with the findings concomitant with the constructivist grounded theory method used.

6.5.1 Relevance

A research method that explores meanings and processes was required to investigate the research question initiating the current study: How are meanings of the body and body weight constructed by therapists? Other researchers have used discourse analysis to study weight related discourses, however this research was interested in the *experience* of the meanings of body weight within counselling psychology, which discourse analysis was deemed insufficient to illuminate. A constructivist grounded theory method was considered more relevant in accordance with the professional practice guidelines of the division of counselling psychology that 'seeks to develop phenomenological models of practice and enquiry' and 'engage with subjectivity and intersubjectivity, values and beliefs' (British Psychological Society, 2015, p.1). Denzin and Lincoln (2003) emphasise the situational and relational principles of qualitative research, with a constructivist grounded theory method's strength in elucidating relationships and positionality; critical tenets of counselling psychology. A constructivist grounded theory method allows a study of difference and diversity in perspectives, settings, actions, processes, discourses and knowledge production; key for the exploration of body weight as an indeterminable social construction.

An interpretative phenomenological analysis (IPA) (Smith, 1995) and grounded theory (Charmaz, 2014) are both interested in meaning making. Smith (1995) refers to Charmaz' constructivist grounded theory as 'writing from a broadly similar perspective' to Smith's version of IPA with both 'interested in learning something about the respondent's

psychological world' (p.18). However, a constructivist grounded theory method was considered more appropriate as it enables the study of diversity, unlike IPA that seeks homogeneity in the recruitment sample (Smith, 1995). It is proposed that one of the strengths of the current study lies in its interaction with very different narratives, with the emergent theory encapsulating this variance. To ensure a heterogenous sample, having interviewed participants that appeared to use stigmatising meanings of the body, the researcher sought subsequent narratives from therapists that had an interest in fat activism, allowing further study of the emerging theoretical concepts. Two of the participants as leading authors in this field requested that their anonymity be waived. This may have affected their narratives compared to the rest of the participants who were guaranteed confidentiality.

Despite efforts to recruit men for this study, men's voices are largely ignored in this research, as with much of the literature that explores men's experience of fat stigma (see Gillon, 2003 and Monaghan, 2008 for notable exceptions). With the intersection of social constructions such as age, gender and race suggested as critical for the embodied experiencing of the social and the self, this study's sample has potentially limited the emergence of intersectionally relevant material. While the researcher travelled to multiple geographical locations, it is noted that using a sample from across the breadth of the UK may have resulted in different findings, with the interaction between the therapists and their context a key finding of this research.

Few participants in this research talked of clients being 'too thin', and none of the participants spoke of personal experiences of identifying or being identified as 'too thin', an area in need of further research as suggested by the work of Lox, Osborn and Pellet (1998). This may be due to the sampling, where participants were not recruited in accordance with body weight, and therefore the study could not ensure a breadth of experience across body weights. However, a strength of this study also lies in this sampling method. Participants were not asked to identify themselves by their body weight, with meanings of the body and body weight and how this related to self and identity

emerging from the data, rather than a preconception of this research. While all of the therapists recruited had been clients themselves, the research recruited therapists rather than clients. Participants' spontaneous accounts of their own experiences of being stigmatised in therapy perhaps reflects the pertinence of this research. However, it is acknowledged that the experiences of clients in therapy who are not therapists themselves may be very different, particularly in view of the power dynamics that was noted in the study between client and therapist. For clients that are already, or go on to become therapists, this may mediate their experience and meaning making of their interactions within therapy.

6.5.2 Credibility

The research took three years to develop, while I undertook a training that confers to the rigor required to offer findings that might contribute to the theory and practice of counselling psychology. As a relative novice to grounded theory, I attended a qualitative methods conference with a workshop on constructivist grounded theory lead by Kathy Charmaz, to become more proficient with the research method. Books and journals pertaining to qualitative research methods, including critique of the grounded theory method, were also consulted. I endeavored to become familiar with the strengths and limitations of the research method, and develop the skills required for the data collection and analysis. Regular supervision, peer support meetings and the use of a reflective journal were used to bring fresh insights to the research, and to monitor whether my personal standpoint was limiting emerging findings. Similarly, I also used therapy to explore any personal experiences that were elicited by the research, to reflect on my position and to try and stay true to the participants' narratives.

While it was considered, participants were not offered the opportunity to review or revise their transcripts as suggested by Lincoln and Guba (1985), due to a risk of the narratives becoming edited and less reflective of an emergent phenomenological account. However, all of the research data has been retained such as raw data, memos, processed data and products of the analysis process to enable auditing of the research enquiry. I

have attempted to present the findings so that the reader can interact with the participants' narratives and draw their own conclusions. Interview extracts have been provided to enable the reader to make sense of participants' narratives and offer transparency. However, the extracts presented are edited from hours of interviews, and another researcher may have selected different extracts. In addition, my initial interview questions may have shaped the direction of the interview, however most participants required few prompts. Accustomed to listening to others' narratives, I was able to manage the uncertainty of whether the interview would elicit any pertinent findings, enabling new and unpredicted findings to emerge from the data. Therapists may have edited their accounts in speaking to another professional within their field. However, it is suggested that as a trainee myself and the participants all qualified therapists, perhaps participants felt less concerned that they might be judged by a peer.

A second researcher may have offered a different perspective to the analysis of this research, and allowed ratification of the emergent categories. However, this study is presented as a constructivist grounded theory, with this research method reflective of the interaction between the researcher and the data, regardless of the number of researchers involved. While a critique of the research sample is presented above, I question the possibility of reaching participant saturation in such an under researched field. It is suggested that the use of a heterogenous sample of 12 participants allows the findings to reflect a diversity in phenomenological experience that is encapsulated by a grounded theory method (Charmaz, 2014). It is proposed that the sample offers valuable insights into how some therapists are negotiating meanings about body weight in some settings, indicating an ethical need for further exploration of this area. These findings offer a grounded theory emerging from the participants' interactions with their context, and the researcher's interaction with the data, to further thinking about the interaction between body weight and therapy.

6.5.3 Originality

Whilst committed to the counselling psychology doctorate timeline, I began the research enquiry at an early stage, allowing sufficient time to recruit the sample and engage with the research method. I had time to interact with the data, with the findings emerging from the data rather than the data being forced. This allowed unexpected findings to emerge and further literature to be reviewed, to understand existing theory implicated by the data, and recognise the new findings of this research.

This study is a unique empirical research enquiry into how meanings of body weight are constructed within therapy, exploring phenomenological accounts that are pertinent for the field of counselling psychology. The emergent grounded theory offers an original perspective for how therapists develop a sense of self as a therapist, constructing a self as a body in space, and interacting with meanings of body weight to claim an identity as a therapist. It points to a new theory of therapists promoting or resisting normative meanings for the body and body weight in therapy, and the implications of which for clients. The findings of therapists utilising stigmatising meanings of body weight within therapy, as well as being faced with clients' meanings of body weight that discredit therapists, suggests a need for therapists to be trained to respond to meanings of body weight. This study offers unique findings that suggests a need for regulatory bodies and institutions to consider how to promote difference and diversity that is inclusive of body weight. The findings add to existing research and offers new directions for further enquiry.

6.5.4 Usefulness

This research suggests that psychological assessment, formulation and the therapeutic process is impacted by body weight. Yet there is little literature studying this phenomenon in a context where body weight is gaining increasing interest in the public domain, and within the field of mental health and psychology. While this study did not demonstrate the interrelatedness of meanings of body weight with other social constructs highlighted by previous research (Aphramor, 2009; Bell & McNaughton, 2007; Ernsberger, 2009), it does suggest the concealment of oppression within therapeutic practice that is all

the more concerning for clients already marginalised. This study has implications for therapists, supervisors, institutions and training bodies and points to the urgent need for further research to be undertaken exploring body weight in therapy.

This research is presented as indicative of the context of both the participants and the researcher, with the findings a construction of my interpretation of the participants' accounts. However, while caution is advised in considering the wider significance of the research, it is suggestive that normative meanings of the body and body weight interact with the process of therapy. A constructivist grounded theory method enabled this under-researched area to be explored to propose new theory. Further qualitative and quantitative research on a larger scale is needed to determine any generalisability of the results.

6.6 Reflexive considerations

Charmaz (2014) describes the researcher as embedded in a grounded theory study, with the researcher an active part of the research project and central to the construction of its findings. Charmaz warns of the impossibility of neutrality of the researcher, and instead reminds researchers to interrogate their preconceptions that could force the data rather than allowing the findings to emerge. I developed an interest in this research area having experienced a lack of focus on the body in my training as a counselling psychologist. I became curious as to why the body was acknowledged in our study of gender, race, age and sexuality, but that body weight was ignored in my training embedded in a society that gives it great attention. As I considered my own meanings about body weight, I became aware that I had previously expressed prejudiced views about body weight, making presumptions about individuals' health and eating habits, based purely on my interpretation of their body weight. That my thinking was influenced by pervading discourses that discriminate and stereotype individuals is now very clear. As I sought to find out more about this area of difference and diversity, I noticed the dearth in literature and training available to therapists and was encouraged to conduct my research in this area.

As a white, British female I am afforded some privileges while being excluded from others, however my experience of my body weight and the meanings imposed on it by others has always been favourable as someone that identifies and is identified by others as slim. I have however experienced my body being objectified by myself and others, and through my training, research and therapy have begun to claim my body as an embodied subject. My interest in this area is also shaped by my commitment to equality, and my work with people that have not had access to equal opportunities. However, I entered this research without experiences of body weight marginalisation, and was curious to learn if and how therapists were able to engage with meanings of body weight within a society that stigmatises body weight.

I have been very aware of the sensitivity of my research subject, and endeavored to ensure that my research did not come at the expense of my research participants. I tried to communicate to my participants my respect for their views, and my appreciation of their participation. Through out this study I was aware that my own body may have informed the interview situation, with some participants perhaps expecting me to share their meanings about the body. My own body weight may have afforded me a position within the interview encounter where participants felt able to talk about the meanings they impose on the body, which some may not have if they had perceived me as 'too thin' or 'too fat'. My assumptions about my own body and the bodies of others needed to be explored in my own therapy, in order to engage with the accounts of my participants and challenge my own preconceptions for how to make sense of body weight. I have welcomed the new awareness that embedding myself in my research and my participants' narratives has given me, with this insight changing my relationship to my own body in unexpected ways.

6.7 Implications for counselling psychology

The implications for this research for counselling psychology are discussed for both clinical practice and further research.

6.7.1 Clinical practice

This study suggests that therapists' meanings around body weight are shaped by prevailing norms, with weight related biases pervading therapeutic encounters even for therapists that challenge body weight prejudice. It supports Murray's (2010) concern of the existence of fat prejudice from both therapists and clients within therapy, and a need for therapists to consider whether their therapy settings welcome a diversity in body weight (Erdman, 1999). This research suggests that some therapists are encouraging clients to make sense of their experiencing according to oppressive body weight typifications. However, body weight is ignored in much of the research that considers the effect of social constructions in therapy that can categorise and stigmatise, such as age, race, gender and sexuality (i.e. Hays, 1996). This study demonstrates interactions between self, identity, body weight ideology and embodiment, perhaps implicit in all therapeutic encounters. It points to a responsibility for therapists to challenge their practice, and question whether their interventions enable or limit clients to make sense of their self and identity, as urged by previous authors (i.e. House, 2003; Livingstone, 2010; Parker, 1999), but with this research providing new findings that pertain to meanings about body weight.

This research suggests that the therapeutic process is grounded in the embodied experiencing of both the client and therapist, with their encounter located in a context of sociopolitical interactions and meanings for the body and body weight. Recognition between therapists and clients occurs within parameters of normativity, with this study suggesting that this can affect how clients experience their own subjectivity. Williams and Bendelow (1998) conclude: 'As complex physical, cultural and relational compounds, emotions underpin the sensual experience of our bodies and selves, providing the existential basis for social reciprocity and exchange' (p.154). If the counselling psychology and psychotherapy professions are to train therapists to work with emotions and subjectivity, they must train therapists to engage with clients' embodiment, and interrogate personal, sociocultural and institutionalised meanings of the body and body weight. This

study highlights concerns for the ethical practice of therapy in accordance with the BPS (2009), BACP (2013) and UKCP (2009) codes of ethics, that state the importance of respecting difference, and not allowing relationships with clients to be prejudiced by personal views. However, with none of the regulatory bodies making any reference to body weight, this study urges for body weight to be considered further at both a local and institutional level.

This study highlights body weight being talked about in diverse ways within therapy settings, as reported by Walker and Hill (2009) who attribute this to therapists' clinical training, personal beliefs, experience of weight-related issues and practice model. Participants in this research constructed a self as a body, with some talking of managing their weight, or wanting to lose weight. Previous authors have concluded that therapists must explore their attitudes towards their own bodies to work with clients with these issues (Barron & Hollingsworth-Lear, 1989; Brouwers, 1990; Costin, 2009; Courtney, 2008; DeLucia-Waack, 1999). Some participants in this study spoke of the importance of deconstructing clients' discriminatory reflectivity shaped by normative prejudiced meanings about body weight, while other therapists appeared to endorse these meanings. While constructing varied professional spaces to work with issues of the body and body weight, all of the therapists interviewed in this study said that body weight was not discussed in their core training other than related to eating disorders. This research suggests that therapists are ill prepared to consider if and how to challenge their own and their clients' judgements about bodies and body weight. It is also proposed that therapists need to explore the ethics of supporting clients with weight loss pursuits, as urged by some of the participants in this study, and highlighted by findings of previous authors (Chrisler, 1989; Courtney, 2008; Dworkin, 1989; Erdman, 1999; Mintz et al., 2013; Pinhas et al., 2013). Consideration is needed for how this aligns with the ethical principles of counselling psychology and psychotherapy, whether therapists are trained to engage in this field, and the evidence that suggests risks inherent in weight-loss regimes (e.g. Aphramor, 2005; Mintz et al, 2013).

Indebted to the literature and participants' accounts highlighted in this study, this research recommends that training for counselling psychologists should:

- Make explicit the notion of body weight as a social construction that symbolises difference and diversity, and should be considered alongside other social constructs such as age, race, ethnicity, gender, disability and sexuality.
- Educate trainees about the stereotypes and prejudiced thinking that can be associated with body weight, and consider how this may affect therapy including assessment, formulation and the therapeutic process.
- Enable trainees to recognise the normative discourses operating around body weight promoted in the media and used by institutional and governing bodies, and allow trainees to access alternative discourses such as those used in the fat studies literature and fat acceptance movement.
- Promote reflexive and reflective practice and urge trainees to interrogate their own thinking, behaviours, language and practices towards their own body and the bodies of others, particularly their clients.
- Ask trainees to consider how their self-concept and identity might intersect and interact with meanings around their body and body weight and what this might mean for the therapy they offer.
- Encourage trainees to consider whether the settings that they work in are accepting and accessible for all clients, regardless of body weight, with consideration for any images or objects that clients might interact with.
- Explore with trainees how they might use their own bodies in their work with clients, and how they might respond to clients talking about their own and their therapist's body and body weight.

- Further thinking about power dynamics inherent in therapy, and the potential for therapy to construct, deconstruct, accept or resist meanings, with a focus on the body and body weight.
- Consider the ethics of therapy engaging in practices such as weighing clients, promoting weight loss or encouraging particular eating or lifestyle practices.

6.7.2 Future research

While some of the participants in this research had been clients themselves, and talked of experiences of their own personal therapy, further research is needed to explore *clients'* experiences that includes a diversity in attitudes to body weight. This study demonstrated some therapists deconstructing normative meanings of body weight, with further research required to explore how this is experienced by clients. Previous research suggests that recognising oppressive normative discourses around body weight can create improved psychological wellbeing (McKinley, 2004; Saraceni & Russell-Mayhew, 2007). The current study included female participants and one trans-woman and one trans-man, despite efforts to include male participants. Using male participants may provide different phenomenological accounts of the experience of body weight within therapy, resulting in new theory for how meanings of the body and body weight are negotiated within counselling psychology and psychotherapy. Findings that pertain to intersectionality between body weight and other social constructs such as age, gender, race and sexuality may emerge from a larger and more heterogenous sample.

This chapter has provided a discussion of this study in relation to previous findings and has offered an evaluation of the research and its research method, describing the implications of this research for the field of counselling psychology. Chapter 6 concludes this research and summarises the new findings.

CHAPTER 7: CONCLUSION

Chapter 6 discussed the findings of this study in relation to existing literature and research, and evaluated this research, outlining its implications for counselling psychology. This chapter concludes the new findings of this research.

This study adds to the limited research into body weight and therapy, and supports a need to consider the presence of the body and its meanings within therapy (Allegranti, 2011; Soth, 2006, Totton, 2012). It provides findings that suggest the operation of body weight prejudice within therapy (Agell & Rothblum, 1991; Brown, 1989; Davis-Coelho, Waltz & Davis-Coelho, 2000; Pascal & Robinson Kurpis, 2012), and offers a constructivist grounded theory for how using meanings of body weight can affect the therapeutic process. This research proposes that therapists construct a sense of self as a therapist through their interaction with meanings for their own body. Therapists interpret and reinterpret meanings of the body and body weight, conceptualising themselves as therapists working in a professional space with clients, conceiving 'a self as a body in space'. Participants in this study constructed a sense of self as a therapist through how they envisioned their clients perceiving them, whether as the expert with 'normal body weight', or as someone with their own experiences of their body. These findings suggest that there is a power imbalance within therapy that may limit clients' opportunities to modify body weight meanings used by therapists. It suggests that the therapeutic process may restrict clients to an identity that corresponds with that which they have been placed into by their therapist, according to the therapist's perception of their client's body weight and the identity as a therapist they claim for themselves.

This study demonstrates therapists either endorsing prevalent meanings of body weight that denigrate the 'too fat' body, or facing the challenge of interrogating normalised and institutionalised meanings of the body and body weight. This study points to an urgent need for further research into body weight and therapy that incorporates a larger sample including the accounts and experiences of clients, men, and those identified as 'too thin'. This study highlights body weight as a potential source of inequality within therapy, and

posits that regulatory bodies such as the BPS, BACP and UKCP must consider the ethics of therapies endorsing weight loss pursuits. This research suggests that therapists must interrogate their personal, sociocultural and institutionalised meanings of the body and body weight. It proposes a need for training institutions to consider whether therapists are being trained to respond to meanings of body weight, and their engagement with difference and diversity in relation to body weight.

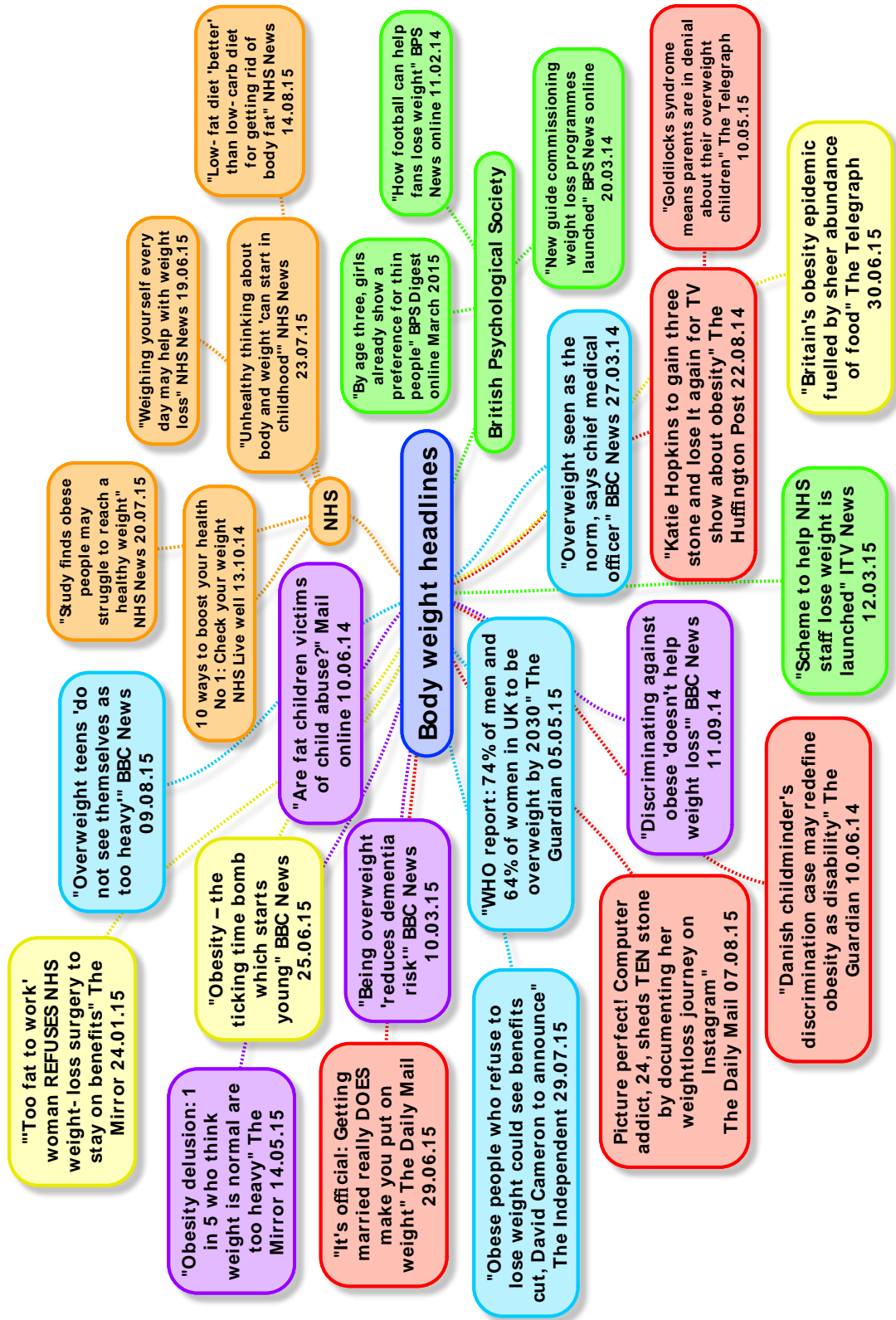
Appendices

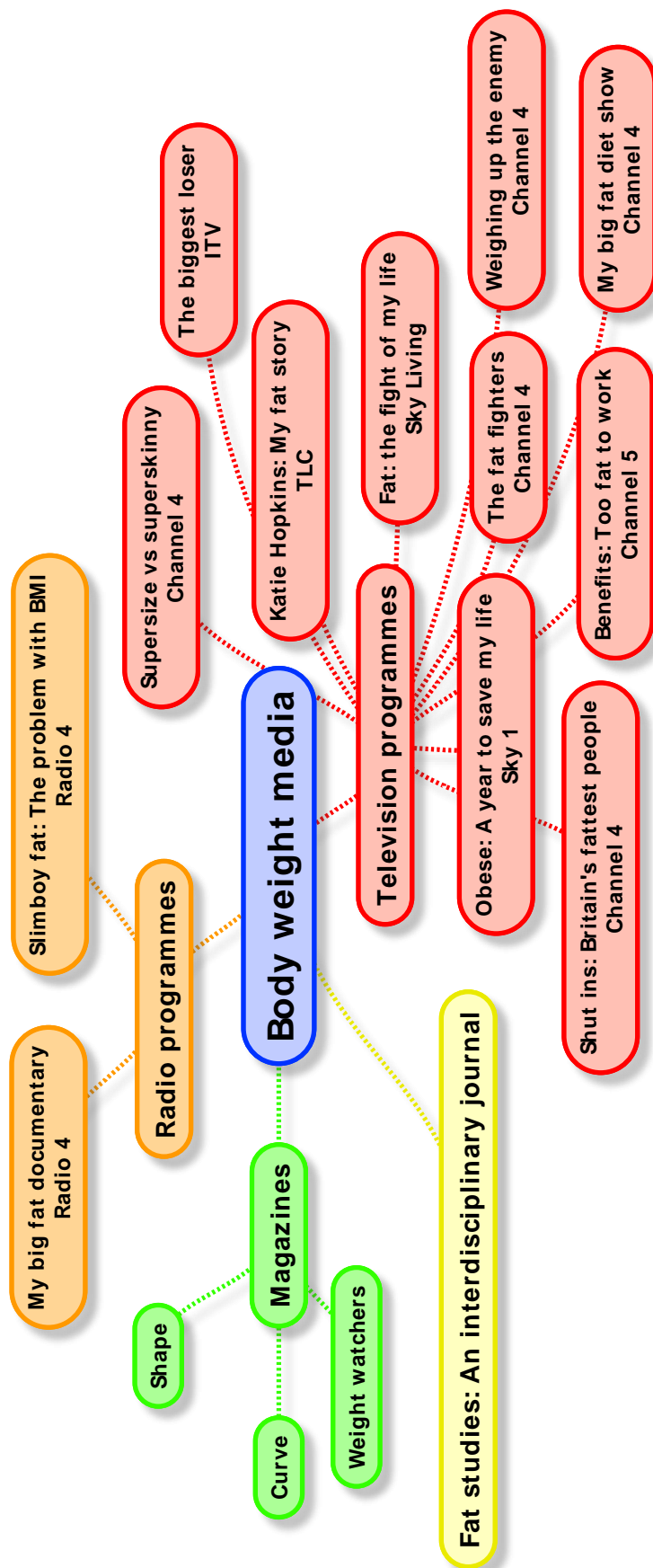
Appendix A	Body weight headlines
Appendix B	Media research of body weight meanings
Appendix C	Online research of body weight meanings
Appendix D	Email/letter to prospective participants
Appendix E	Information sheet
Appendix F	Participant consent form
Appendix G	Participant waiver of anonymity
Appendix H	Demographic questionnaire
Appendix I	Interview protocol
Appendix J	Debrief leaflet
Appendix K	Debrief leaflet for participants who waived anonymity
Appendix L	Ethics board approval
Appendix M	Extract of initial line by line coding of Robin's interview
Appendix N	Extract of initial line by line coding of Carla's interview
Appendix O	Extract of focused coding of Simone's interview
Appendix P	Extract of focused coding of Jess' interview
Appendix Q	Clustering exercise 1
Appendix R	Clustering exercise 2

Appendix S:	Table 1: Participant sample demographics and work context
Appendix T	Normative meanings of body weight
Appendix U	Alternative meanings of body weight

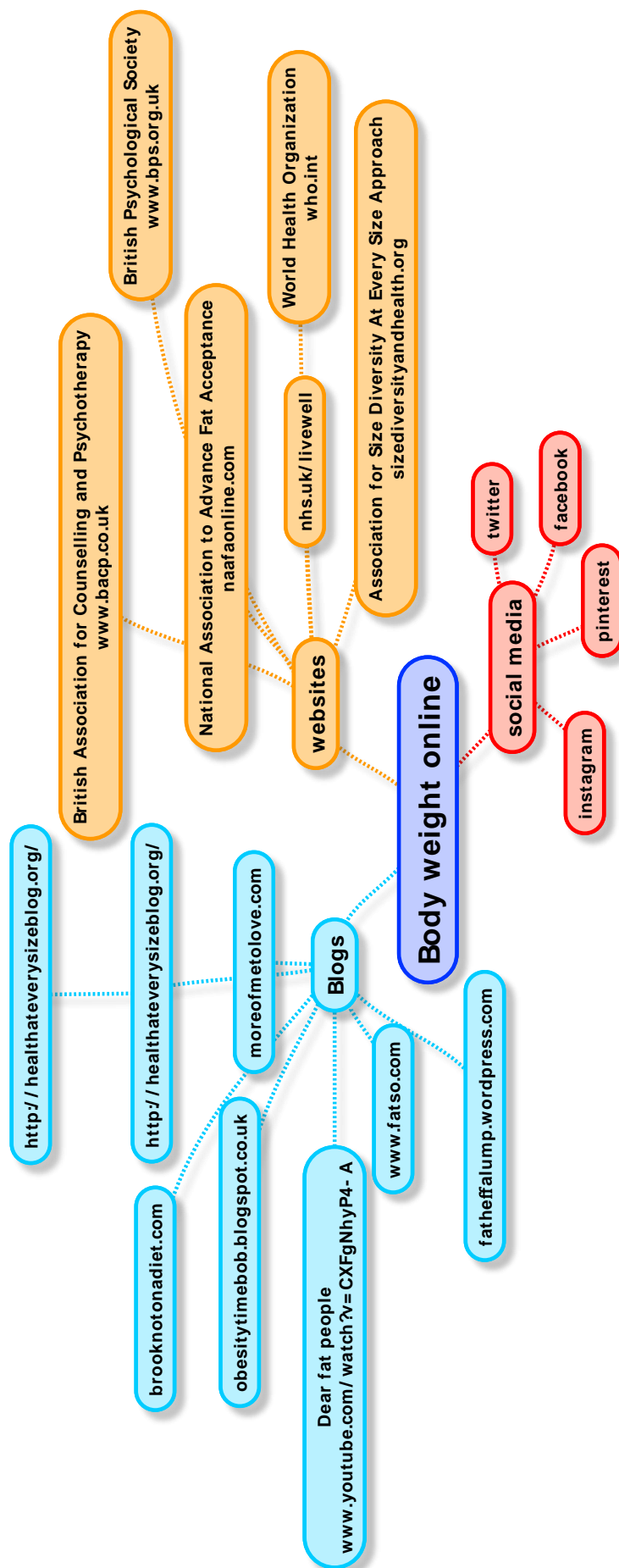
Appendix A

Body weight headlines





Online research of body weight meanings





Email/Letter to prospective participants

An exploration of bodyweight within psychotherapy – can you help?

I am a PsychD research student and trainee counselling psychologist at Roehampton University and am looking for therapists to participate in my research study. The aim of this research is to explore what issues around bodyweight are of importance within counselling psychology and psychotherapy and how they are managed. This study seeks to use a grounded theory approach to develop a theory for how bodyweight operates within counselling psychology and psychotherapy.

Therapists must be BPS chartered counselling psychologists, or BACP or UKCP accredited therapists currently practising in either a voluntary setting, private or National Health Service (NHS).

All participants will be required to participate in one semi-structured interview that will last approximately 1-2 hours (participants can dictate the maximum duration of the interview). The findings of this research may bring awareness to the field of counselling psychology and psychotherapy and bring greater understanding for how bodyweight operates within psychotherapy.

I have enclosed an Information sheet that provides more details about the study and your involvement should you be interested in participating.

If you are interested in participating or if you have any questions, comments or concerns about the research, please contact the researcher at grayc@roehampton.ac.uk or 07980 706574.

Many thanks

Claire Gray
Trainee Counselling Psychologist

Email: grayc@roehampton.ac.uk
Telephone: 07980 706574



Information sheet

Aim of the project

The aim of this research is to explore what issues around bodyweight are of importance within counselling psychology and psychotherapy and how they are managed. This study seeks to use a grounded theory approach to develop a theory for how bodyweight operates within counselling psychology and psychotherapy.

Type of data being collected

This study is collecting accounts from qualified counselling psychologists/psychotherapists. Participants will be asked to share their experiences of working with clients where issues of bodyweight have been of importance, and will be asked to talk about how these were managed.

Method of data collection

This study is using semi-structured interviews that will be digitally recorded and transcribed.

Confidentiality

All data collected by this study will be treated as confidential. Interviews will be digitally recorded and then transcribed with all identifying information removed and pseudonyms used to protect anonymity, and all research materials kept securely in line with data protection protocols. Limits to confidentiality: in the event of the disclosure of material revealing a risk of significant harm to self or others, confidentiality would be broken and the relevant authorities contacted in accordance with BPS and BACP guidelines.

Right to waive anonymity

It is normal practice within this study for participants to be anonymised. Should a participant wish to waive their right to anonymity and to be identified within this research then this will be respected, unless to do so would compromise the confidentiality of any clients. Any participant who wishes to waive their right to anonymity must raise this with the researcher at the time of the interview, and will be asked to sign a waiver form.

Data protection

All data (including audio recordings, transcriptions, consent forms and demographic questionnaire) will be stored securely in accordance with the 1998 Data Protection Act and University guidelines.

Approximate time commitment

Interviews are expected to last approximately 1-2 hours. Participants can state beforehand the maximum duration of the interview.

Right to decline to offer any particular information

Participants can choose not to answer any information within either the demographic questionnaire or the interview without explanation and without prejudice. Participants will not be coerced to disclose information they prefer not to share. The interview can be stopped at any time should the participant wish.

Right to withdraw

Participants will be informed of their right to withdraw from the study at anytime, prior, during and after without prejudice and with no time limit and all raw, transcribed and analysed data will be destroyed. However, this withdrawal may have implications, as the data may still be used or published in an aggregate form. Following the interview, participants will be provided with a de-brief leaflet that will include the researcher's contact details and that of the researcher's supervisor whom they can contact should they wish to withdraw from the study.

Withdrawal of participation by the researcher

The researcher may end the interview and withdraw you from participating in the research if circumstances arise that warrant it, including the interview process eliciting any risk of emotional distress. The interviewer would make this decision and let you know if you were unable to proceed to protect your health and safety.

Minimal risks to the participant

There is a risk that you may find talking about bodyweight within psychotherapy upsetting or unnerving in any way. If any of the questions during the interview process cause emotional distress the interview can be stopped at any time. Following the interview you will receive a de-brief leaflet providing you with sources of support available to all participants that can be contacted at any point after the interview.

How the data will be used

Data will be analysed using Grounded Theory and will form the researcher's research project as a PsychD research student and trainee counselling psychologist at Roehampton University. Findings may be published or disseminated through journals or research conferences.

Potential benefits of the research

This study seeks to generate a theory for how bodyweight operates within psychotherapy and counselling psychology. Findings may inform psychotherapy and applied psychology, and expand the research in this field.

How the results of the research will be made available to participants

If you wish to find out the results of the overall findings please contact the researcher who will write you a letter explaining the overall findings.

What to do in the event of questions, comments or concerns

Should you have any questions or concerns either prior or after participating in this research please contact the researcher, Claire Gray email: grayc@roehampton.ac.uk or telephone: 07980 706574.

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:

Dr Lyndsey Moon
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
LONDON
SW15 4JD

lyndsey.moon@roehampton.ac.uk
Telephone: 020 8392 3500

Head of Department Contact Details:

Dr Diane Bray
Department of Psychology
University of Roehampton
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Holybourne Avenue
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SW15 4JD

d.bray@roehampton.ac.uk
Telephone: 020 8392 3627

ETHICS COMMITTEE

PARTICIPANT CONSENT FORM

Title of Research Project: An exploration of bodyweight within psychotherapy.

Brief Description of Research Project:

This study seeks to explore how psychotherapists and counselling psychologists work with issues around bodyweight within psychotherapy.

The aim of this research is to explore what issues around bodyweight are of importance within psychotherapy and how they are managed. Bodyweight is an area under-researched within literature regarding psychotherapy and this study seeks to use a grounded theory approach to develop a theory for how bodyweight operates within psychotherapy. You will be asked to share your experiences of working with clients where issues of bodyweight have been of importance, and describe how these were managed. This study may inform ways of working where bodyweight is of significance.

Participants will be chosen who are fully qualified, practicing psychotherapists/counselling psychologists who have undergone personal therapy as part of their training. A minimum of 14 participants will be chosen to participate in the research and interviews will last approximately 1-2 hours. Participants are asked to take part in only one interview, however in exceptional cases where the researcher wishes to pursue more material than the initial interview allows, and the participant is in agreement, a second mutually convenient interview will be arranged. Interviews will take place at a place of convenience for the participant including their work place/home or the University premises. Travel expenses associated with the interview will be reimbursed on production of a receipt in the form of Marks and Spencers vouchers.

Interviews will be audio recorded and transcribed with all identifying information for both participant and their clients removed. It is normal practice within this research project for participants to be anonymised. Should a participant wish to waive their right to anonymity and to be identified within this research then this will be respected, unless to do so would compromise the confidentiality of any clients. Any participant who wishes to waive their right to anonymity must raise this with the researcher at the time of the interview, and will be asked to sign a waiver form. All data will be stored securely assuring confidentiality for participants and their clients.

During the interview you will be asked questions from the interview protocol as well as questions that arise as a result of conversations with the researcher. You have the right to choose not to answer any question, as well as withdraw from the study at any time before, during or after the interview without giving a reason and without prejudice by quoting an 8-digit ID number (ABCD1234), which will also appear on your debriefing form, however data may still be used/published in an

aggregate form. Should you have any concerns, complaints or issues that you wish to discuss, please contact in the first instance the investigator, Claire Gray, or the Director of Studies, Lyndsey Moon (using the details below).

Investigator Contact Details:

Claire Gray
Doctoral Student Researcher (Psych D)
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
LONDON
SW15 4JD

Email: grayc@roehampton.ac.uk
Telephone: 07980 706574

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point without prejudice. I have read the Information Sheet and understand that the information I provide will be treated in confidence by the investigator and that my identity, and that of my clients, will be protected in the publication of any findings. I agree to the interview being audio recorded and understand that all data will be stored securely in accordance with the 1998 Data Protection Act and University guidelines. I understand that I can withdraw from the study at any time by quoting the 8 digit number on my de-brief form, and understand that this withdrawal has implications as the data in an aggregate form may still be used or published

Name

Signature

Date

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:

Dr Lyndsey Moon
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
LONDON
SW15 4JD

lyndsey.moon@roehampton.ac.uk
Telephone: 020 8392 3500

Head of Department Contact Details:

Dr Diane Bray
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
LONDON
SW15 4JD

d.bray@roehampton.ac.uk
Telephone: 020 8392 3627



London

PARTICIPANT WAIVER OF ANONYMITY

Title of Research Project: An exploration of bodyweight within psychotherapy.

It is normal practice within this study for participants to be anonymised. At the time of interview you expressed a wish to waive your right to anonymity. Please consider the following information carefully before completing this form.

The information you provide will be analysed using grounded theory and will form the researcher's research project as a PsychD research student and trainee counselling psychologist at Roehampton University. Findings may be published or disseminated through journals or research conferences and your name and identifying details may be included, and your contribution credited.

Please be aware that once you have waived your right to anonymity this decision can not be nullified. You have the right to withdraw from the study at any time by quoting the 8 digit number on the top of your debrief form and all raw and processed data will be destroyed. However, should you waive your right to remain anonymous, withdrawal has implications as the data in an aggregate form may still be used or published which may include your name and/or identifying details.

Consent Statement:

By signing this waiver I am voluntarily electing to waive my right to remain anonymous, and authorise the researcher to include my identifying information, unless to do so would compromise the confidentiality of any client. I understand that the information I provide will be analysed using grounded theory and will form the researcher's research project as a PsychD research student and trainee counselling psychologist at Roehampton University. Findings may be published or disseminated through journals or research conferences and I understand that my name and identifying details may be included. I understand that by making the decision to waive my right to anonymity, this decision can not be nullified. I understand that should I choose to withdraw from the study at any time, the data in an aggregate form may still be used or published which may include my name and/or identifying details.

Name

Signature

Date



Demographic questionnaire

Please could you complete the following demographic details. **Please feel free to opt out of any of the questions where you do not wish to disclose details.**

Please delete or complete as applicable:

1. ID number: ABCD1234

2. Profession: Psychotherapist/Counselling Psychologist

3. Workplace organisation?

4. How do you define your working life?

5. Town/City of residence?

6. Age: 20-29 30-39 40-49 50-59 60-69 70-79

7. Experience as a psychotherapist/counselling psychologist? (years)

8. Gender: Male Female Transgender Other
_____ (please specify)

9. Disability: Yes/No

10. Nationality: _____

11. Ethnicity: White-British White-Irish Any other White background
White and Black Caribbean White and Black African White and Asian
 Any other mixed background
Asian-Indian Asian-Pakistani Asian-Bangladeshi
Any other Asian background
Black –Caribbean Black-African Any other Black background
Chinese
Other _____ (please specify)

12. Religion: Buddhist Christian Hindu Jewish Muslim
No religion Other _____ (please specify)

13. Sexuality: Heterosexual Lesbian Gay Bisexual
Other _____ (please specify)

Interview protocol

Initial open-ended questions

1. What are your views about bodyweight in general? What do you think these are informed or influenced by?
2. Is the body and bodyweight something that your clients ever talk about in their sessions? (What/Why/When/How/Who?)
3. Do you consider the body to be of importance in your work with clients? Is bodyweight associated in any way?
4. Is the body and bodyweight something that you might raise with your clients?
5. Can you share any experiences where body size or weight has had any significance within psychotherapy?
6. Have you experienced issues around bodyweight varying depending on gender/ethnicity/religion/sexuality/disability and social status? Does your approach change?
7. Has any training/information/guidance/research/advice regarding bodyweight ever informed your work?

Intermediate questions

8. Have you ever experienced a difference in bodyweight between you and your client being of importance?
9. Do you consider your own body and bodyweight to be of any importance within your work?
10. Is there anything relating to bodyweight that you haven't or wouldn't discuss in your work with clients?
11. Have you ever encountered any problems or difficulties as a psychotherapist/counselling psychologist relating to the body and bodyweight?
12. Has any organisation/training or professional ever been helpful to you with regards to any issues around the body and bodyweight and your work?
13. How, if at all, have your thoughts about the body and bodyweight changed since you started practicing as a psychotherapist/counselling psychologist?

Ending questions

14. What do you think are the most important ways to work as a psychotherapist/counselling psychologist around the subject of bodyweight?
15. Have any of the experiences we have discussed changed you personally or professionally?
16. From your experience, is there advice that you would give others that relates to bodyweight and psychotherapy?
17. Is there anything that has occurred to you through this interview that you might not have thought about before?
18. Is there anything else you think I should know to understand bodyweight and psychotherapy better?
19. Is there anything else you would like to tell me or ask me?



De-brief leaflet

De-briefing form for the study entitled: An exploration of bodyweight within psychotherapy.

Dear participant

ID number (ABCD1234)

Thanks you for participating in the preceding study. You have been asked to share your experiences of bodyweight within psychotherapy.

You are reminded that your original consent form included the following information:

I agree to take part in this research, and am aware that I am free to withdraw at any point without prejudice. I have read the Information Sheet and I understand that the information I provide will be treated in confidence by the investigator and that my identity, and that of my clients, will be protected in the publication of any findings. I agree to the interview being audio recorded and understand that all data will be stored securely in accordance with the 1998 Data Protection Act and University guidelines.

You have the right to withdraw from the study at any time by quoting the 8 digit number on the top of this leaflet and all raw and processed data will be destroyed. However withdrawal has implications as the data in an aggregate form may still be used or published.

If you have any questions or concerns as a result of participating in this study, or would like to request a copy of the final report please contact the researcher Claire Gray using the following contact details:

Investigator Contact Details:

Claire Gray
Doctoral Student Researcher (Psych D)
Department of Psychology
University of Roehampton
WhitelandsCollege
Holybourne Avenue
LONDON
SW15 4JD

Email: grayc@roehampton.ac.uk
Telephone: 07980 706574

Alternatively if you prefer you can contact the researcher's Director of Studies, Dr. Lyndsey Moon at lyndsey.moon@roehampton.ac.uk or 020 8392 3500.

Should you have experienced any distress or have any uncomfortable feelings as a result of participating in this study at any point following the interview, and would like to speak to a professional, please see a referral list of mental health providers

for your use. Participants are also reminded to talk about any issues that have arisen from their participation in this study with their supervisors.

Association of Therapeutic Communities
Tel: 01242 620 077
Web: www.therapeuticcommunities.org

The British Association for Counselling and Psychotherapy (BACP)
Tel.: 01455 883300
E-mail: bacp@bacp.co.uk
Web: www.bacp.co.uk

British Psychological Society (BPS)
Tel: +44 (0) 116 254 9568
E-mail: enquiries@bps.org.uk
Web: www.bps.org.uk

United Kingdom Counsel for Psychotherapy (UKCP)
Tel: 0207 0149955
E-mail: info@ukcp.org.uk
Web: www.psychotherapy.org.uk

Many thanks for your participation in this study, your contribution is appreciated.

Name:
Date:

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies:

Dr Lyndsey Moon
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
LONDON
SW15 4JD

lyndsey.moon@roehampton.ac.uk
Telephone: 020 8392 3500

Head of Department:

Dr Diane Bray
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
LONDON
SW15 4JD

d.bray@roehampton.ac.uk
Telephone: 020 8392 3627



De-brief leaflet – for participants who have waived right to anonymity

De-briefing form for the study entitled: An exploration of bodyweight within psychotherapy.

Dear participant

ID number (ABCD1234)

Thank you for participating in the preceding study. You have been asked to share your experiences of bodyweight within psychotherapy.

You are reminded that your original consent form included the following information:

I agree to take part in this research, and am aware that I am free to withdraw at any point without prejudice. I have read the Information Sheet and I understand that the information I provide will be treated in confidence by the investigator and that my identity, and that of my clients, will be protected in the publication of any findings. I agree to the interview being audio recorded and understand that all data will be stored securely in accordance with the 1998 Data Protection Act and University guidelines.

It is normal practice within this study for participants to be anonymised. At the time of interview you expressed a wish to waive your right to anonymity. You are reminded that the waiver you signed included the following information:

By signing this waiver I am voluntarily electing to waive my right to remain anonymous, and authorise the researcher to include my identifying information, unless to do so would compromise the confidentiality of any client. I understand that the information I provide will be analysed using grounded theory and will form the researcher's research project as a PsychD research student and trainee counselling psychologist at Roehampton University. Findings may be published or disseminated through journals or research conferences and I understand that my name and identifying details may be included. I understand that by making the decision to waive my right to anonymity, this decision can not be nullified. I understand that should I choose to withdraw from the study at any time, the data in an aggregate form may still be used or published which may include my name and/or identifying details.

You have the right to withdraw from the study at any time by quoting the 8 digit number on the top of this leaflet and all raw and processed data will be destroyed. However withdrawal has implications as the data in an aggregate form may still be used or published which may include your name and/or identifying details should you waive your right to remain anonymous.

If you have any questions or concerns as a result of participating in this study, or would like to request a copy of the final report please contact the researcher Claire

Gray using the following contact details:

Investigator Contact Details:

Claire Gray
Doctoral Student Researcher (Psych D)
Department of Psychology
University of Roehampton
WhitelandsCollege
Holybourne Avenue
LONDON
SW15 4JD

Email: grayc@roehampton.ac.uk
Telephone: 07980 706574

Alternatively if you prefer you can contact the researcher's Director of Studies, Dr. Lyndsey Moon at lyndsey.moon@roehampton.ac.uk or 020 8392 3500.

Should you have experienced any distress or have any uncomfortable feelings as a result of participating in this study at any point following the interview, and would like to speak to a professional, please see a referral list of mental health providers for your use. Participants are also reminded to talk about any issues that have arisen from their participation in this study with their supervisors.

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Tel: 01242 620 077
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E-mail: bacp@bacp.co.uk
Web: www.bacp.co.uk

British Psychological Society (BPS)
Tel: +44 (0) 116 254 9568
E-mail: enquiries@bps.org.uk
Web: www.bps.org.uk

United Kingdom Counsel for Psychotherapy (UKCP)
Tel: 0207 0149955
E-mail: info@ukcp.org.uk
Web: www.psychotherapy.org.uk

Again, many thanks for your participation in this study, your contribution is greatly appreciated.

Name:
Date:

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies:

Dr Lyndsey Moon
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lyndsey.moon@roehampton.ac.uk
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Head of Department:

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d.bray@roehampton.ac.uk
Telephone: 020 8392 3627

Appendix L

Ethics board approval

The research for this project was submitted for ethics consideration under the reference PSYC 13/110 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 18th December 2013.

Appendix M

Extract of interview with Robin with initial line by line coding. Extract taken from beginning of interview.

Note: 'R' denotes the researcher. 'P' denotes the participant.

Interview transcript	Initial coding
<p>R: Would you be able to tell me a bit about the context that you work in, the clients that you see, that kind of thing?</p>	<p>Contextualising work</p>
<p>P: Yes sure, I'm a private clinician, I see a handful of clients still for employment assistant programme but that's dwindled to almost nothing, the majority of my work is private referrals now, they find me by personal recommendation or through some of the marketing. It's a mixed caseload, I typically see between 20 – 25 clients per week, typical issues: depression, anxiety, relationship difficulties, relationship breakdowns, work related stress. I will sometimes see people with issues around gender, people with autistic spectrum and ADHD stuff and sometimes eating disorder explicitly in the room, more often than not, implicitly. So I think that's probably, a range of durations, because [the area that I work in] is poor, people tend to need sometime fairly quick so a lot of my cases I turn around in 6-8-10 sessions, while I have one client that has been with me since 2005, and another couple for about 18 months, most of them are in and out in 2-3 months.</p>	<p>Identifying as a private 'clinician' Context of austerity Recommended by others Typifying issues Outlining difficulties Seeing people and their issues Demarcating explicit and implicit 'disorder' Emphasising poverty limiting access 'Turning around cases' varying lengths of duration 'In and out'</p>
<p>R: And is there a specific approach that you use?</p>	<p>Asking about approach</p>
<p>P: Yeh, I would say that my core model is CBT, I work in quite an integratively way, I hold to the core, some of the basic tools, especially in the early work, so the first few sessions to create the most effective change I'll be much more strongly focused on CBT techniques and technologies and interventions and once the client has internalised the basic framework of that, then the longer term work sometimes is a but more kind of organic so I'm drawing on some of the psychodynamic, psychoanalytic, humanistic perspectives but the core model is CBT but it's a rich model. The trouble is when you mention CBT some people associate it with psychiatric nurses who have done a 10 week introduction and that's not how you use CBT it's a much richer model. I'm also quite</p>	<p>Integrating with CBT Viewing therapy as consisting of tools 'Creating change' Encouraging 'internalising' of interventions Therapy as a framework Drawing on different models Prioritising CBT model Privileging longer training Differentiating between others</p>

<p>creative, I use a lot of metaphor and analogy and I know that's a big part of why I'm effective.</p> <p>R: And in terms of my interest in body weight and how that does or doesn't get talked about in psychotherapy, do you have any experience of working with clients where body weight has been significant in any way?</p> <p>P: Yeh, the ones that really stand out for me, the woman who was anorexic who had been going through IVF and the morbidly obese guy who ere 2 clients for whom no one had been honest with them, no one had been upfront with them and that just really upset me and offended me because I can quite often read when someone has an eating disorder and I will bring it into the room when it feels appropriate an I'll do it in various ways. But sometimes it's start staringly bloody honest, so that a couple come to me and they're discussing the stresses of failed IVF attempts, its 10s of 1000s of pounds, this is the last time they're allowed to do it, and you look at this girl thinking you're anorexic honey bunny, you are so clinically underweight I'm surprised your even bloody menstruating and so the intervention I used with her, I think in her case I actually upfronted it, I might have said something like, I think with her because it was so obvious I said something like so did they ever discuss you the impact of your eating disorder on your ability to get pregnant? Because it was in the first session but the rapport had built quite quickly, and it was a really moving moment and I don't do it justice when I relay it then because it was a lovely sort of moment of warmth and peace and quiet and tranquillity in the session, we'd been where are you guys out, and the tragedies and upset and I just, it was a very soft way of did they ever talk to you about your eating disorder problem? The effectiveness of the ability to get pregnant? And she said that they had never mentioned it. And I said OK, what's your BMI right now? What's your weight? And it was down at about 16, 16.5, 17, and it was really moving because there was a real sense that she had been betrayed and let down, that they'd never taken the time to address with her that until you fix the eating disorder hon, there is no point in spending £10,000, probably close to £30,000 on a treatment that was never going to work. And even if by some miracle she had actually got pregnant she could well have injured the baby because of her eating patterns. So yes it was kind of very moving and I had 6 sessions with them and they in fact were on the employment assistant programme</p>	<p>Contrasting own efficiacy</p> <p>Interest in body weight What gets talked about</p> <p>Using diagnostic labels Using medical terms Perceiving dishonest practice 'Reading' eating disorder 'Bringing it into the room' Practicing morally Failing IVF Gazing and assessing Categorising as clinically underweight Announcing by 'upfonting' Considering 'obviousness' Stating the 'obvious' Justifying the intervention in first session Needing to do intervention justice Stressing the warmth Highlighting the tragedy Softening the upfronting 'Effectiveness' of getting pregnant Using BMI to assess weight The moment being moving Sensing betrayal Addressing and fixing disorder Pointlessness in expenditure A miracle being necessary Casting the patient as potentially injurious Brief therapy</p>
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Appendix N

Extract of interview with Carla with initial line by line coding. Extract taken from beginning of interview.

Note: 'R' denotes the researcher. 'P' denotes the participant.

Interview transcript	Initial coding
<p>R: Could you tell me the approach you take in the service that you work in?</p>	<p>Asking about approach</p>
<p>P: I work either psychodynamically or I use IPT, although in reality it's probably more integrative and I originally trained psychodynamically.</p>	<p>Working psychodynamically or using IPT Distinguishing between separate models</p>
<p>R: Do you have any experiences where you've felt bodyweight has been significant?</p>	<p>Body weight being significant</p>
<p>P: Yes I used to work on an eating disorders unit and my training group was with people with people with eating disorders so I have done a lot of work with people with eating disorders so I would say that it's something that I am always aware of and still see quite a few people now who have been diagnosed with eating disorder</p>	<p>Recounting work experience with eating disorders Experienced in working with eating disorders Heightened awareness of eating disorders Working with people diagnosed with eating disorders</p>
<p>R: So when you are working now, since you have had that experience working with eating disorders have you worked with anyone that has had a weight that's been different from you in any way?</p>	
<p>P: Frequently</p>	
<p>R: How does that come about in your work?</p>	
<p>P: I see an awful lot of people who are obese, because my experience of working with eating disorders it is something that I would normally address as far as the assessment is asking about alcohol, drugs, that kind of self harm I would also ask people about food. Also because in IPT one of the things you are doing is you have to review the symptoms of depression</p>	<p>Labelling people as 'obese' Addressing obesity from a familiarity with eating disorders Assessing for self harm Asking about food in assessment Reviewing symptoms of depression</p>

<p>every week so in my head I am going through the PHQ-9 so I am asking every week about eating and also because one of the areas that I IPT is in the NICE guidelines for is binge eating so it is something that I would address with somebody. Likewise if someone is clearly underweight, so I think I'm someone who would always tentatively ask, although occasionally there might be somebody that you don't ask and then I'm thinking I'm wondering why I'm not asking. Because obviously if the person doesn't volunteer that information you have to somehow broach the subject and I think probably with men you are less likely to broach the subject with women. I think because we don't tend to address eating issues with men to the extent that we do with women, if a middle aged man is overweight we kind of often ignore it.</p> <p>R: So do you notice yourself ignoring it at the time or is it something you might think about later?</p> <p>P: Probably later. I'm aware that what I find is really hard if I am supervising somebody who is working with somebody who has had an eating issue and they are clearly overweight themselves. I think that's an area we don't, I'm not talking about a little bit (pauses) overweight, I am talking about what would clearly be you know, overweight. Cos I think we wouldn't, how would we, it's difficult to address that with colleagues even if you are supervising them.</p> <p>R: So there is this difficult dynamic between you and then how are you managing that and then how are they managing their work with their own client? What do you do with that issue?</p> <p>P: Well I've got that issue at the moment and I don't know, it's something that I'm aware of, I'm aware of, I'm not sure if the person is aware and I'm not sure how to kind of, I try to, kind of put something in there and sort of say when I work with people with eating disorders I think about my own issues about food as a way of sort of encouraging them to say something</p>	<p>Referring to the PHQ-9 Asking about eating Guided by NICE guidelines for binge eating Categorising someone as 'clearly underweight' Asking tentatively about eating Recognising that not everyone is asked Reflecting on not asking and questioning why not Identifying information not volunteered Broaching the subject of eating Distinguishing between genders Intersecting gender and age Ignoring the issue of men being 'overweight'</p> <p>Chronology of awareness</p> <p>Delayed awareness. Noticing herself ignoring it later Experiencing difficulties in supervisory role Comparing eating issues to being 'clearly overweight' Struggling to define the term overweight Attempting to find a shared perspective of 'overweight' Seeing a colleague's weight as significant in their work Finding it difficult to address a supervisee's weight.</p> <p>Acknowledging power dynamic</p> <p>Contrasting own awareness and supervisee's awareness Hierarchies in awareness Feeling hesitant but seeing a need for it to be said Contextualising need for disclosure Encouraging supervisee's self-disclosure</p>
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Appendix O

Extract of interview with Simone with focused coding.

Note: 'R' denotes the researcher. 'P' denotes the participant.

Interview transcript	Focused coding
<p>R: What do you do then when they say oh I know I am over weight, what do you do with that?</p> <p>P: That is the million dollar question that I haven't quite found the solution for but it depends if that is the issue they are bringing then I can work with them on that. It depends if it is just a comment, as a bit of part of all the problems. So sometimes I let it go and if it comes back then I will challenge it, because you can't challenge everything that comes out of their mouth, but if its something that is really getting them down, being overweight, and they believe themselves to be unhealthy. So I will ask questions and say so tell me more about your lifestyle, you seem to think you are unhealthy so tell me a but more about your lifestyle, so I get them to give me a bit more information so I can then say oh does that fit with your idea unhealthy, what is your idea of unhealthy, to get them to explore that definition really and to think about why they have put that term to themselves as being as unhealthy. As its so hard to go in and challenge this idea of weight, some clients would think I was a bit mad if I just dived in and said you know what that's not true. So its really hard to sit and collude but you can't dive in and challenge it. So it is difficult but what I try and get clients to think about how that word unhealthy has been attached to their body size, so I say who's telling you this and often they'll say oh my doctor and of course that's difficult because as we know doctors are the font of all knowledge (sarcastic laugh) so I say hold on a minute lets just think about this, so someone who weighs a lot can you think of a sports person who weighs a lot so I say hold on their BMI must be really high so what do we think about that, and they say oh yeh they can't be unhealthy, so I say, OK well we can't just attach weight to health automatically without thinking more about it, so that's the way I go in really. And I'll make comments if someone really wants to explore it and I will say ' don't we say things about people who seem to eat whatever they want and never gain weight – couldn't it be that some big people eat quite normally and still gain weight.' And people say oh that's a good point. So there are quite a few things like that that start to challenge it.</p>	<p>Knowing when to challenge</p> <p>Exploring definitions of health and weight</p> <p>Being seen as 'mad' for challenging meanings</p> <p>Deconstructing meanings of health and weight</p>

If its something that someone is bringing I think its worth spending all that time on, going quite gently, and help people challenge this idea that just a certain weight is unhealthy and I try to encourage them to look at the psychologically bad health of thinking bad about yourself. So even if a bit of body weight was bad for you, wouldn't it be worse to think so badly of yourself all the time. But it is difficult when clients say things but its not the point of the work so you can't really go there as its not what they are asking for, but it probably underpins their self esteem and self worth so it is hard, particularly in 6 session work. We can't go in to that. And I have said something to people and they have looked at me as if I was bonkers and I have thought God I am going to get struck off for this so I have just let it go. And I have had the other end of the spectrum where the client comes in and tells me about my weight. It comes up occasionally and only if people are talking about their bodyweight, and its only ever been done in a really nice way. I had this lady who was a similar size to me although she was really tall as well. She was really sweet but going on about how unhealthy she was so I was trying to challenge it and then I said do you look at me and think I'm unhealthy, be honest? And she said well its unhealthy for all of us but you carry it off well, so I get comments like that. So I say well what does that mean, what constitutes as carrying it off well and not carrying it off well so we explored that, and I've had people say but you are happy with it. They don't know, so they'll say that. But if its a way in, I don't mind people asking that, I will say do you want to know how I got to that stage, and what it would be like to feeling happy and would it be good enough. But I have had recently 2 clients being quite rude which is the first time with clients, I get it elsewhere all the time. I had this lady who came in I knew she was going to be trouble as soon as I saw her, you know when people are going to be awkward, and she came in and was telling me to shut the windows and all of this sort of stuff, and she said, (this was our first session) she said, it's a good day for me, I have lost 4 and a half stone and I said oh right. Obviously she was expecting me to say oh well done which I didn't. She said and I've been and been weighed, and I've maintained it so it's a big day for me. So I said, OK right so that makes you feel quite good. And she said well yes, you'll understand, and I said, oh will I? And she said well yes because you have a weight problem. So I said, oh do I? Inside thinking Oh god, no! It's OK I can deal with this. She said yes of course you do. And I said right. So you'll understand what an achievement it is to lose 4 and a half stone. And I said it's interesting that you think I would understand that more. And she said well you have a weight problem too so you'll understand. So I

Being limited to challenge meanings

Fearing being struck off for

Bringing in the therapist's body

'Obvious' expectations in the encounter

Presuming meanings of the therapist's body

Appendix P

Extract of interview with Jess with focused coding.

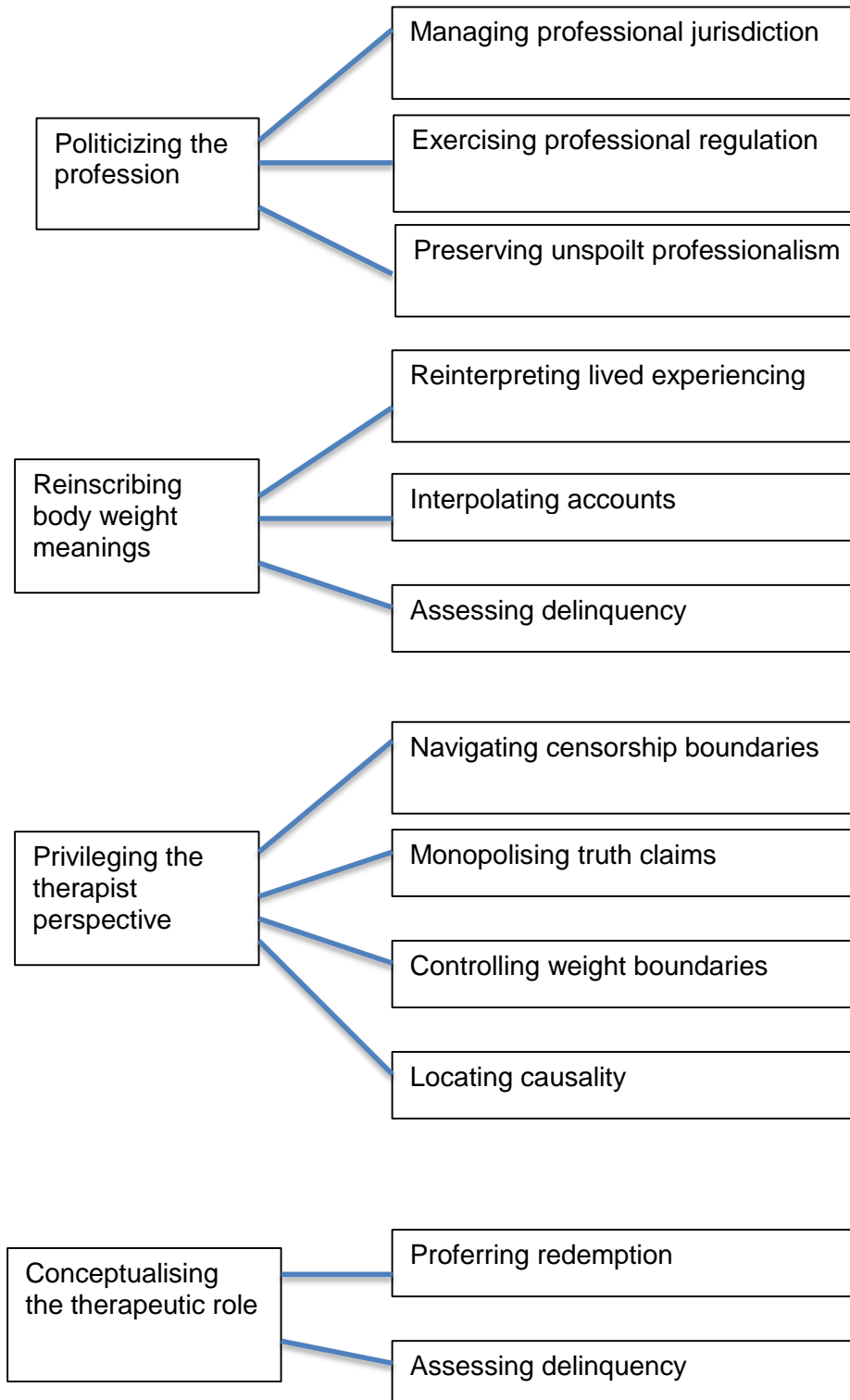
Note: 'R' denotes the researcher. 'P' denotes the participant.

Interview transcript	Focussed coding
<p>R: Do you use your own body in your work?</p> <p>P: Yes, the lady who I did a lot of my training with, my counselling supervisor, I relate to her very well and I practice, but I've worked underneath her the whole time , so I work very much on how I am feeling so if I feel very tired I might say to them, I'm feeling really really tired, are you tired, or if I feel anxiety I would just reflect that back at them. Because quite a lot of our clients aren't aware of how they are feeling and it depends on the client as we have quite a mix here but some of them have fallen out of mainstream life at such a young age they haven't developed as you and I developed, the social peer stuff, so its about working how, especially with our entrenched clients, where did you fall out of mainstream life and what have you missed out on because of that, in ways to relate. So we all go through certain phases, the beginning of life you are with mum and dad. Some of our most entrenched clients weren't with mum and dad they would have been born and probably placed in foster care and then moved from foster care, to foster care to foster care until they were adopted. So all that validity, and basic grounding that we would take for granted isn't there, so that trust and that early attachment, and that's really crucial if you have got someone who has fallen out at that part. And sometimes that's mirrored and made even worse if they act on some of those behaviours and they end up in a children's home rather than an adopted home, and that's more abandonment. One lady I worked with was really hard to engage, really hard and that was pretty much her history, she was adopted, she missed out on a huge amount of that touch phase, that early mothering phase that I think everyone needs, and some of our other clients when you look at it they feel out of if when they were</p>	<p>Using therapist's bodily felt experiencing</p> <p>Considering societal marginalisation and impact on development</p> <p>Lacking taken for granted validity and trust</p> <p>Viewing clients relationally</p>

<p>12 or 13, so they are out of the mainstream so they don't relate to peers, they might relate to people much older or with people who are controlling them, or they come from quite dysfunctional backgrounds where dad was beating mum up all the time, and they've seen that so that's reflected. I've worked with a couple of guys who have been on domestic violence courses but dad used to do that to mum and I only hit her once and in their eyes its fine because it's normal for them, so its about working out when did they get pushed our and how much were they pushed out. Because that's what I find quite difficult about some of the clients that I work with here, they have got no grasp, they don't even know how they feel because no one has ever asked them. So you are kind of doing psycho-education before you can even doing therapy because they have no way of verbalising some of their stuff.</p> <p>R: And then you have the words to start to get into your feelings and recognise them?</p> <p>P: I see one lady that I've finished with and she's gone to complex needs service, everytime I got in there I felt exhausted. I would literally switch off and I would be fighting myself and I kept saying, I'm just really feeling shut down, how are you feeling, and she has got 5 kids, none of them are with her, the 2 oldest are now because they are adults, 2 are fostered out she sees them once every 3 months, one is adopted and one died. And when she lost the last child when it was adopted out that was her point when I think she shut down and that was all I was getting from her. I'm quite proactive when I am at work and I would get in there and within 5 minutes I'd be like this (Mimes body crumpling in on itself). But she was the other way and she didn't eat and has actually put on weight, she has done quite well for herself, but she was very very thin and that came down to her kind of starving herself and not feeling worthy of food and she said I don't have an appetite, I don't want to eat it makes me feel sick. But small, small, small trickles she's started to build up.</p>	<p>Normal for the client</p> <p>Lacking words or understanding of self from being marginalised</p> <p>Disclosing own feelings and asking about client's</p> <p>Feeling shut down</p> <p>Not feeling worthy</p>
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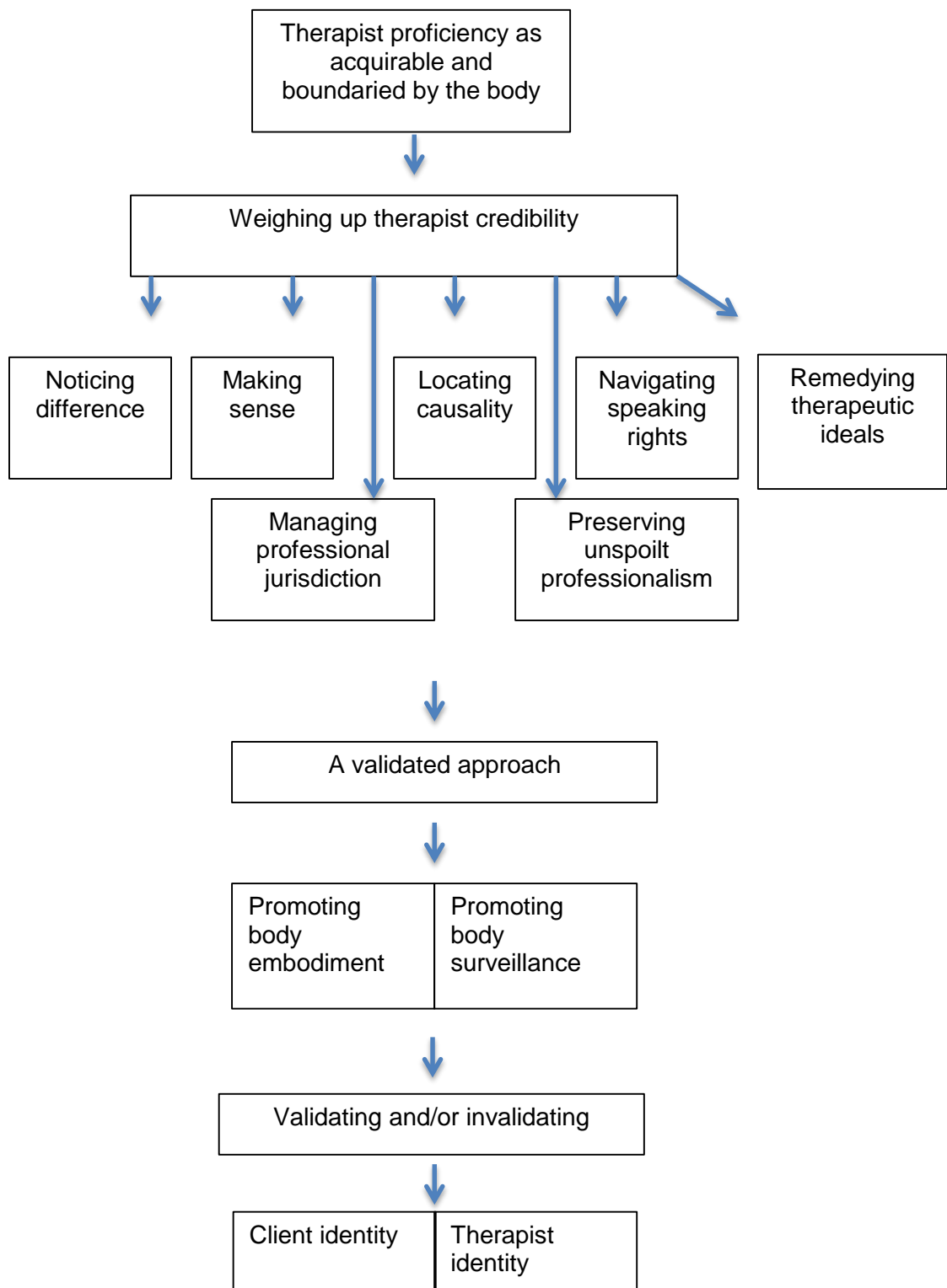
Appendix Q

Clustering exercise 1



Appendix R

Clustering exercise 2

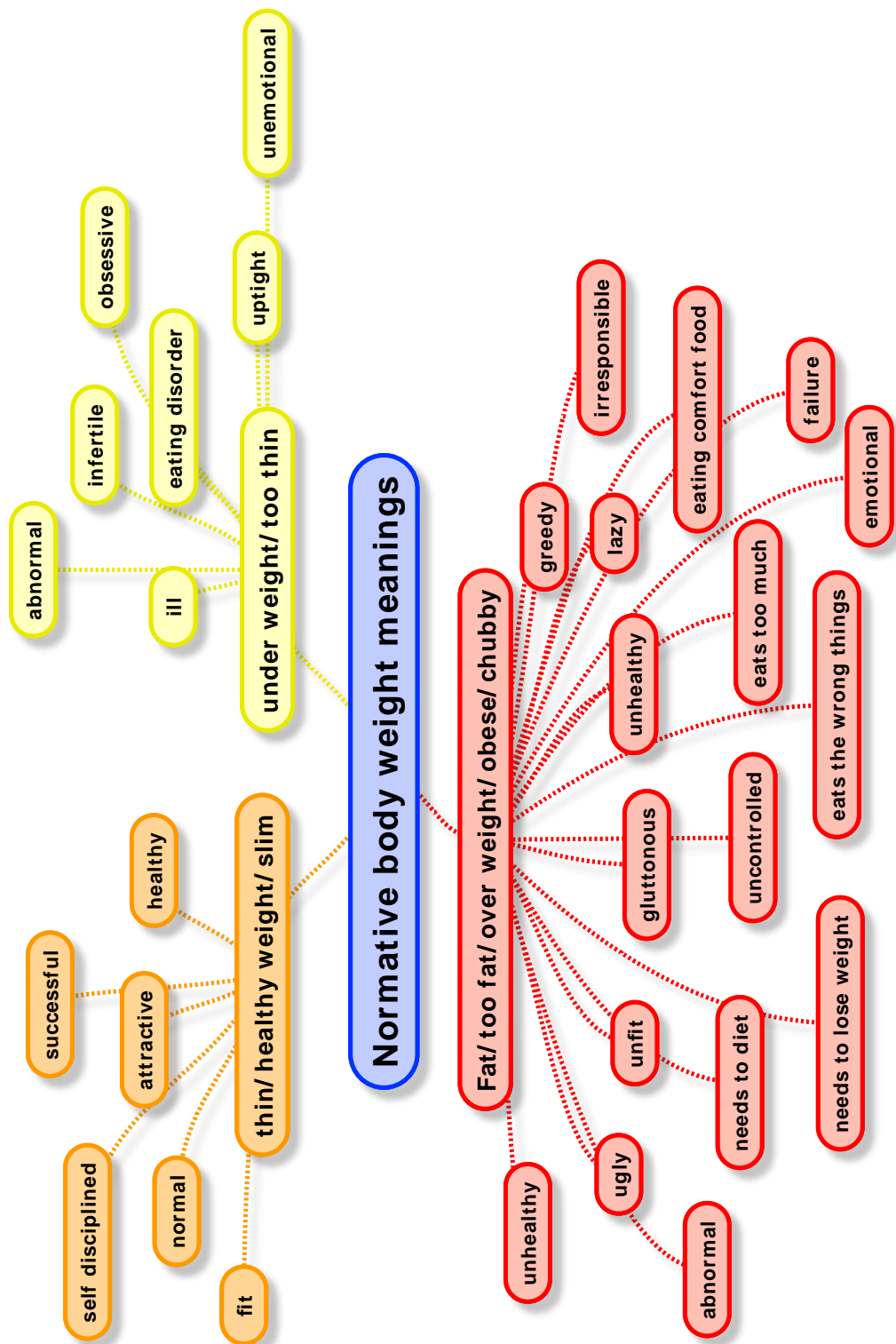


Appendix S

Table 1: Participant sample demographics and work context

Participant	Profession	Work place	Work pattern	Place of residence	Age bracket	Years of work experience	Gender	Disability	Nationality	Ethnicity	Religion	Sexuality
A	Counselling Psychologist	Drug and alcohol agency	Full-time	Berkshire	20-29	3	Female	No	British	White-British	Buddhist	Heterosexual
B	Counselling Psychologist	Self-employed	Full-time	Midlands	50-59	14	Trans-gender	Yes	British	White-British	Humanist	Lesbian
C	Psychotherapist	Self-employed	Full-time	Nottinghamshire	40-49	6	Trans-gender	No	British	White-British	No religion	Queer
D	Counselling Psychologist	CAMHS	Full-time	London	40-49	18	Female	No	British	White-British	No religion	Heterosexual
E	Psychotherapist	Psychology service	Full-time	Berkshire	50-59	23	Female	No	British	White-British	Christian	Heterosexual
F	Psychotherapist	Self-employed	Part-time	Dorset	40-49	11	Female	No	Russian	White-other	Russian Orthodox Christian	Heterosexual
G	Counselling Psychologist	University	Part-time	London	40-49	15	Female	No	British	White-other	No religion	Heterosexual
H	Counselling Psychologist	Psychology Service	Part-time	Oxfordshire	30-39	3	Female	No	Spanish	White-other	Christian	Heterosexual
I	Psychotherapist	Self-employed	Full-time	London	40-49	3	Female	Yes	British	White-British	No religion	Queer
J	Psychotherapist	Self-employed	Part-time	London	40-49	10	Female	No	British	White-British	Christian	Heterosexual
K	Psychotherapist	Self-employed	Full-time	Bristol	30-39	5	Female	No	British	White-British	No religion	Heterosexual
L	Clinical Psychologist	Self-employed	Full-time	USA	50-59	21	Female	No	American	White-other	No religion	Lesbian

Normative meanings of body weight



Alternative meanings of body weight



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