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Maisha N. Aza
What's the Skinny on Fat
Women in Psychotherapy:
Mental Health Clinicians'
Countertransference With
Women of Size

ABSTRACT

This qualitative study was conducted to explore mental health clinicians' possible countertransference with clients who are women of size. This study intends to contribute to the growing clinical literature on size bias in psychotherapy by focusing on clinicians' countertransference in depth. Twelve clinicians participated in this study, from various mental health backgrounds and degrees from licensed clinical social workers to clinical psychologists.

The data in this study suggests that clinicians experience intense, and often negative, countertransference with their clients who are women of size. Some clinicians were aware of their fat bias and prejudice out in the world, yet were not as aware of how this bias made its way into the countertransference with their fat female clients. Clinicians' narratives also suggest that cultural reinforcement of body aesthetics plays a significant role in countertransference, via an emphasis on health, disordered eating, and weight. Ambivalence was an overarching theme categorizing clinicians' experiences of their thoughts and feelings toward women of size. Other findings included affective reactions such as devaluation, fear, shame, and confusion around the topic of fat women, which can manifest in the form of microaggressions. This researcher concludes that size acceptance can be used as a way to manage clinicians' negative countertransference with women of size and can also be useful in treating fat women in psychotherapy.

WHAT'S THE SKINNY ON FAT WOMEN IN PSYCHOTHERAPY:
MENTAL HEALTH CLINICIANS' COUNTERTRANSFERENCE
WITH WOMEN OF SIZE

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

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2009

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CHAPTER I

INTRODUCTION

Countertransference is something all clinicians encounter when working with clients of all types. Clinicians are often seen as compassionate, empathetic, caring, giving, open minded and understanding people who seek to help others. People who possess these traits often enter the field of social work. Social Work clinicians are trained to examine their biases and become aware of how those biases might influence the therapeutic relationship through our countertransference. The countertransferential reactions that a therapist may have toward any client, if used properly can have “diagnostic and therapeutic relevance” and can “facilitate rather than inhibit treatment” (Betan, Heim, Conklin, & Westen, 2005). Although clinicians make great attempts to leave their biases at the door, their biases, values and beliefs do enter the room and may be different or similar to those of their clients. Most clinicians are aware of this and often take steps such as supervision and peer support to monitor and manage their countertransference related to social biases.

The purpose of this study is to address and discuss the potential countertransference that clinicians might experience with their fat female clients or women of size. Women of size may include women who have been labeled “overweight”, or “obese” and have experienced life as a fat person based on the way she has been perceived and treated by others in society. Fat experiences can consist of being called pejorative names, being discriminated against, not fitting comfortably into public structures made for smaller sizes, multiple stares, being the object of fat jokes, ridicule and judgment, and needing to shop at specialty clothing stores, to name a few. Women

of size may also include women who have been considered, by the medical establishment, to be obese or morbidly obese according to the Body Mass Index (BMI) scale, which calculates one's body mass index based on a person's weight and height. (Kwan, 2006) Although clinicians may not be aware of each client's BMI, there may be subjective visual cues and cultural perceptions that might potentially lead clinicians to believe a woman is fat or of size. Also, a woman's weight or BMI may have nothing to do with whether she is considered, by others or herself, to be fat or of size. Other ways a clinician might determine a woman of size is if their female client identifies as fat or as a woman of size and/or discloses that she has been discriminated against because of her large size; and/or has had significant discomfort or difficulty accessing public facilities and structures designed for smaller sizes.

Race, class and gender are categories that the mental health field has worked the longest and most diligently with regard to clinician bias (Eriksen & Kress, 2008; Javier & Herron, 2002; La Roche, 1999; Simon, et al., 1992). In addition to race, class and gender, there are a number of categories of "othered" groups that exist and are being studied in empirical research today. These include but are not limited to ethnicity, disability, age, religion, sexuality, sexual orientation, looks and size. Othering, is a social and psychological way of defining, stigmatizing, denigrating, and excluding another person or group in order to affirm one's self and secure one's own positive identity or a group's identity. The social differentiations that are made to 'other' a person or group can be based on ethnic, geographic, economic, ideological or any category which creates a meaning of 'us' and 'them' and marginalizes people (Ulrich, 2003). Size is a category of "otherness" that has multiple complexities and misunderstandings. Although there is a

modest amount of research about fat women, the literature pertaining to how clinicians deal with size bias with fat women in the therapeutic dyad is slowly picking up momentum.

According to Irvin Yalom, “Countertransference refers to the irrational feelings that the therapist has toward the patient”(1989, p.93). Biases, can inform the countertransference that one may experience and have the potential to impede the therapeutic process, particularly if one is not aware of her own biases or has not actively worked on her bias against any certain group of people. It may also be true that a clinician might not become acquainted with all of his biases until someone is sitting across from him in the therapeutic setting. Irvin Yalom’s (1989) book *Love’s Executioner and Other Tales of Psychotherapy* contains a psychotherapy story between Yalom and a client he calls the “*Fat Lady*”. In the story titled, “*Fat Lady*”, Yalom grapples with his countertransference with and bias toward his client of size. This is an honest and candid account of Yalom’s feelings toward fat women and this fat client. The following is an excerpt from Yalom’s *Fat Lady*.

The day Betty entered my office, the instant I saw her steering her ponderous two-hundred-fifty-pound, five-foot-two-inch frame toward my trim, high-tech office chair, I knew that a great trial of countertransference was in store for me. I have always been repelled by fat women. I find them disgusting... How dare they impose that body on the rest of us? The origins of these sorry feelings? I had never thought to inquire... So deep do they run that I never considered them prejudice... Of course, I am not alone in my bias. Cultural reinforcement is everywhere. Who ever has a kind word for the fat lady? But my contempt surpasses all cultural norms. Early in my career, I worked in a maximum security prison where the *least* heinous offense committed by any of my patients was a simple, single murder. Yet I had little difficulty accepting those patients, attempting to understand them, and finding ways to be supportive. But when I see a fat lady eat, I move down a couple of rungs on the ladder of human understanding. I want to tear the food away. To push her face into the ice cream.

‘Stop stuffing yourself! Haven’t you had enough, for Chrissakes?’ I’d like to wire her jaws Shut! (p.93-95)

The story continues on about Yalom’s struggle with this client and the barriers he faced sitting across from her and how it interfered with, as well as facilitated the therapeutic process. Yalom’s reflections are not far from the feelings many people in society share. Although he says that he believes his bias goes beyond that of cultural norms studies show that many people, in our society have general hostility toward fat women (Tripplett, 2007). Yet Yalom’s account stands alone as a mental health clinician’s personal exposition of countertransference toward fat female clients. How was his bias different or similar to the biases many have around race, ethnicity, gender and other groups? Should he have referred this patient to someone else since his feelings were so intense or could he have benefited from supervision or peer support? How did this affect his treatment plan and his therapeutic alliance with this fat client? Were his feelings ever truly resolved? Yalom’s bias-informed countertransference gives the researcher pause and invites the reader to do the same.

Yalom however, is not to blame. Negative value judgments and personality traits are often applied to fat women (Yalom 1989, Kwan, 2006 Tripplett, 2007) and research shows that medical standards such as the BMI, endorsed by the medical community and reinforced in the media, inform social norms and negative attitudes toward people of size (Cossrow, 2001). The medical terms overweight, obese, and morbidly obese can engender judgment and negative imagery. This can immediately instill concern, fear, arrogance, and even self-righteousness in people in the helping industries such as mental health clinicians, doctors, nurses and others. This could reverberate into

countertransference and has the potential to effect treatment goals and interventions that may not be in accordance with fat female clients' goals. Yalom's excerpt clearly depicts how these social standards may influence and shape clinicians' countertransference.

This study will seek to answer the following questions: Do clinicians experience countertransference related to women of size? What are some of the countertransference responses that can occur with clinicians who work with women of size? Are clinicians aware of the possible countertransference issues that may arise when working with these clients? Do those clinicians' who do experience countertransference with this population find that there is a difference in countertransference with those clients of size who accept their bodies versus those who do not accept their bodies? Does a woman's size and level of acceptance of their size influence the treatment plan and goals suggested by clinicians?

CHAPTER II

LITERATURE REVIEW

In order to provide a framework for this study on clinician's countertransference with women of size, this chapter focuses on the relevant literature pertaining to countertransference, cultural bias, and fat bias. The concept of countertransference is a central component to modern clinical practice accepted across many different psychotherapeutic disciplines (Southern, 2007). Due to this fact there is a wide body of literature on countertransference in the mental health field. It is well known that countertransference can be a significant aspect of the therapeutic process as most clinicians are taught early on in their careers about this phenomenon, particularly in psychodynamic theory classes or an equivalent, in graduate school (Betan, Heim, Conklin, & Westen, 2005; Southern, 2007). This necessary and unavoidable component to the therapeutic relationship must be considered when we talk about bias and how biases can inform countertransference. Bias toward fat women, specifically, has not been explored in depth, as it pertains to the countertransference clinicians may experience with these clients.

In terms of this study this researcher chooses to use the words "fat women", "fat female clients" or "women of size" as descriptors. To use the word "fat" is to de-stigmatize the derogatory use of the word fat and it is used as a descriptive term just as describing someone as tall or thin. Fat women or women of size is more accurate and more respectful than medical terms such as "overweight" or "obese", which are words

that socially constructed and are often used to pathologize fat women and can engender shame and blame. Using the word fat is a way to reclaim the word as this researcher identifies as a fat woman and a woman of size. It is also important to recognize that there are women of size who do not identify as fat or as women of size and who prefer the medical terms, overweight or obese. However, I am consciously choosing to create a paradigm shift and I recognize that it may not necessarily be a term that all fat women may be comfortable with. In order to simplify the literature review when I do use the words obese, obesity or overweight it will often be when referencing current research that uses that language, as to preserve the authors' original intent and meaning of the words in the particular context in which it was written.

There is a wide body of literature found in the medical field that discusses the issue of women's bodies and fat women's bodies via the vehicle of social constructs such as "obesity" and "overweight" as they relate to health factors and the process of losing weight. The mental health literature primarily focuses on psychological reasons and pathological behaviors associated with being fat. However, the majority of the research does not address size as a cultural difference and equally does not address size bias. Feminist literature attends to the societal pressure and cultural standards for women's bodies (Bordo, 1993) in general, with a strong emphasis on anorexia. Sociological and Social Psychology literature attends to more of the prejudice and stigma toward fat people (Crandall, 1994; Rothblum, 1999), whereas literature on size bias, fat phobia or size acceptance in the mental health field is modest but growing.

The extent to which these factors influence clinicians' perceptions of and countertransference toward, women of size remains an open question. And although

some noteworthy contributions (Yalom, 1989) address fat bias in countertransference, few empirical investigations tackle this question in depth.

The following chapter will introduce a review of the relevant literature organized as follows: The first section will provide a brief history of countertransference as a psychotherapeutic phenomenon. The second section will focus on the cultural production of fat including the ways that social stigma, size prejudice and discrimination can impact women of size. The next section will focus on countertransference in more depth including different ways clinicians can manage it, as well as the ways that it can be impacted by clinicians' biases. The last section will briefly review the concept of size acceptance as a possible way to manage countertransference.

The History of Countertransference

In the earliest incarnations of psychoanalysis, Sigmund Freud (1909) thought of countertransference as a “permanent problem” in the therapist that needed to be “dominated”. Freud was intuitive in his understanding of countertransference as a “blessing in disguise”, in his letter to Carl Jung (Freud, 1909). Many analysts of the time interpreted, from this, that countertransference is something to be avoided (Heimann, 1950).

Forty years later, Donald Winnicott (1949) expanded on the concept of countertransference and saw it as inevitable, just as all different kinds of emotions are inevitable in the therapeutic relationship. He made a major contribution to the psychoanalytic world by normalizing hate and aggression toward clients. In his well known paper, *Hate in the Countertransference* Winnicott (1949) points out the ambivalent nature of hate in the countertransference and the ways in which clinicians'

limits can be pushed. In 1950 Paula Heimann believed that many analysts of her time misinterpreted Freud's charge that countertransference must be 'recognized and mastered' (p. 81). These psychoanalysts went about this mastery by attempting to completely avoid feelings and emotional responses toward their clients to the point of becoming completely detached. According to Heimann (1950), this was not what Freud was trying to convey. She felt that Freud intended to communicate that psychoanalysts must constantly consult their feelings in order to make better interpretations (Heimann, 1950). Consequently, Heimann (1950) expanded upon Freud's definition of countertransference to include "all the feelings which the analyst experiences towards his patient" (p. 81). Countertransference should constantly be explored and analyzed by the therapist and mastered by way of constant insight and interpretation. Heimann concluded that, "if an analyst tries to work without consulting his feelings, his interpretations are poor." (p. 82)

Winnicott, Heimann and others researched ways in which countertransference could be more clearly seen as beneficial to the therapeutic relationship. Since Freud, clinicians have emphasized the clinical utility of countertransference helping clinicians understand it as a way to be more empathetic to clients (Roulolamin, 2007). These psychoanalytic contributions influence how many clinicians' situate themselves in the therapeutic relationship today. Countertransference is a common interaction that takes place in any given psychotherapeutic encounter and is a useful lens with which to look at women of size in psychotherapy.

Clinicians and their fat female clients live in a sociocultural milieu where obesity is talked about daily in our culture and heavily represented in the media (Boero, 2003;

Rothblum, 1999). The messages about fat therefore affect all individuals of this society, consciously and unconsciously, directly and indirectly. Psychotherapy, therefore, can never function completely independent from the cultural milieu in which we all live, particularly when anti-fat messages are delivered on a daily basis by multiple authoritative sources.

The Cultural Production of Fat

Since Victorian times, Western culture has attempted to tame and control women's bodies (Bordo, 1993). Body size is no less culturally produced than gender, race, and class (Bordo, 1993). The structure, form and size, of women's bodies, is reinforced by the culture in which women live. Unfortunately, in Western culture discrimination and bias against fat people are the norm (Bordo, 1993; Council on Size and Weight Discrimination, 2009; Gee, Ro, Gavin, & Takeuchi, 2008; K. Davis-Coelho, Waltz, & B. Davis-Coelho, 2000; National Association to Advance Fat Acceptance, 2009; Saguy, 2007). Due to the wide held belief that body size and weight is controllable, discrimination prejudice and bias toward fat people is common. Considering Western culture's history of bias against women as well as its bias against fat people, bias against fat women is a natural byproduct and needs to be acknowledged and addressed in so far as this bias can permeate through the confines of the psychotherapeutic relationship.

According to research conducted by the National Institutes of Health (NIH) (2009), obesity has reached epidemic proportions in the United States and is said to be a public health concern; and today, 64.5 percent of adults in the U.S. are overweight or obese. The United States government is concerned about obesity. There are many factors

that contribute to obesity, from genetics, to medical, socioeconomic, environmental and behavioral factors. (National Institutes of Health, 2009) The Weight-control information network (WIN), a part of the NIH's Obesity Research Task Force, reports that, "Overweight refers to an excess of body weight compared to set standards. The excess weight may come from muscle, bone, fat, and/or body water. Obesity refers specifically to having an 'abnormally' high proportion of body fat compared to the 'standard'." (Weight Control Information Network, 2007, p. 1). According to WIN (2007), the body mass index or BMI, is the most popular way to determine if someone has "too much" body fat and is overweight or obese. A BMI of 18.5 to 24.9 is considered healthy. A person with a BMI of 25 to 29.9 is considered overweight, and a person with a BMI of 30 or more is considered obese (WIN, 2007, p. 3).

However, according to research conducted by WIN, these numbers do not always accurately reflect whether or not someone is healthy. According to WIN, the BMI cutoff points are used as a guide for "comparative purposes across populations over time"(WIN, 2007, p. 3). WIN (2007) clearly states...

BMI, therefore, is useful as a screening tool for individuals and as a general guideline to monitor trends in the population, but by itself is not diagnostic of an individual patient's health status. Further assessment of patients should be performed to evaluate their weight status and associated health risks. (p.3)

Although the research conducted by the government points out that this tool has these limitations, health practitioners continue to use the BMI scale to associate levels of body fat with health risks in their individual patients; to the point of stigmatization. (Schwartz, et al.) This accessible information, is not highlighted in the media (Boero, 2003).

Notably, current research conducted by WIN and other researchers, continues to outline

the harmful health risks in being “obese” or “overweight” (NIH, 2007; WIN, 2007). This is an example of how bias against individuals can incorrectly inform the public via omission, and maintains the status quo. This can affect the over all views and treatment of fat individuals, from healthcare professionals to mental health clinicians, to the average person passing fat women on the street (Teachman et al., 2003).

Social Stigma, Size Prejudice & Discrimination

Social stigma, size prejudice and discrimination of fat women in U.S. culture potentially affects every interaction a fat woman has with others, this includes the relationship between the woman of size and her therapist. The effects of biased research coupled with heightened media attention serve to uphold societal views and values about weight and health and stigmatizes fat women (Boero, 2003). “Fat” is often equated to “bad” in this society. Being “fat” is associated with being a bad person, having lower intellect, and having no willpower or control. According to K. Davis-Coelho, Waltz, and B. Davis-Coelho (2000), “Fat oppression has been defined in clinical literature as the fear and hatred of fat people, particularly women, and the concomitant presence of oppressive and discriminatory practices aimed toward fat people (Brown, 1989, p.19)” (p.682). The BMI scale, used by doctors and the government contributes to fat oppression by setting social standards for individual bodies even though WIN admits that it is not an accurate tool to assess individual health outcomes (WIN, 2007). There is anti-fat, social bias and stigma associated with the terms overweight, obese or morbidly obese. These terms are socially constructed to identify an ideal weight and suggest that anything outside of that norm is a medical anomaly. Yet many people use these words as descriptors and as a way to define a person, for example, “you’re overweight”, “she’s obese”. When associated

with an individual, obese implies that a fat person is someone in need of medical attention, due to the fact that these are medical terms associated with the BMI scale. Public service announcements calling obesity an epidemic “indirectly promotes a thin body type” and denounces a fat body type (Kwan, 2006). As stated succinctly by Samantha Kwan (2006), “The medical frame, even while promoted neutrally by the government and medical community in the name of health, can essentially become a front for body oppression” (p.15). This gives rise to stereotypes and prejudices toward people of size in multiple arenas, including the helping professions such as with mental health practitioners.

Fat women’s bodies are often seen as deviant, pathological and in need of a cure. Research shows that some of the terms often used to describe fat women include, “lazy,” “ugly,” “stupid,” lacking willpower,” “incompetent,” and “indulgent” (Cossrow, Jeffery, & McGuire, 2001; Crandall 1994; Davis-Coehlo, et al., 2000; Dittman, 2004) . These stereotypes lead to discrimination in the job market, low work evaluations, and poor treatment of fat people in general. Statistics show that people of size are discriminated against in the workplace, in medical settings, when it comes to buying insurance and housing as well as in mental health settings (Brownell, 2005; CSWD, n.d Davis-Coehlo, et al. 2000; Dittman, 2004;.; NAAFA, 2009; Rothblum et al., 1988). Public places are also not accessible to people of “larger than average size” and it is looked upon as an individual problem rather than a societal problem (CSWD, n.d.). Children as young as five years, show a preference for photographs of average or thin children (Rothblum & Miller, 1988).

These strong societal messages can have harmful psychological, emotional and socioeconomic ramifications. It is likely that wide spread size-phobia is more detrimental to the health of fat people than their weight or size (Brownell, 2005; Puhl & Latner, 2007; Rothblum & Miller, 1988). Research shows that stigma and discrimination can cause women of size to avoid regular doctor visits, which can lead to health issues (Rothblum, et al., 1988). Also the discrimination experienced by them could lead to emotional feelings such as anger or hurt, which can cause physical symptoms such as high blood pressure. This illustrates that size in and of itself is not an indicator of health but that the treatment of individuals can adversely affect their health (Carlson & Chamberlain, 2004). This concept has been explained with regard to racism and health disparities among African Americans and can be extrapolated to include size and other groups discriminated against in the health field (Carlson & Chamberlain, 2004; Rothblum et al, 1988; Brownell, 2005). This is more evidence that clinicians need to be aware of the social climate around fat when a woman of size enters the room and be sure to notice their countertransference in relation to it.

It is also helpful for clinicians to be aware that often times the desire to be accepted in this society often negates the need to be truly healthy in a holistic way, which is demonstrated by the many unhealthy ways that women often try to lose weight. The stigma associated with being “overweight” or “obese” and being a woman in this society, can cause a range of behaviors geared at becoming visibly smaller rather than healthy (Bordo, 1993; Kwan, 2006; NAAFA, 2009). Yo-yo dieting, elective surgery, excessive exercise, and restrictive eating are some of the many unhealthy control mechanisms women have instituted to maintain an acceptable size (Kwan 2006; NAAFA, 2009; Puhl

& Latner, 2007). Multiple studies show that the results of these types of behaviors have proven to be much more harmful to people's bodies than the initial weight and in fact often lead to gaining more of the weight they were trying to lose. Many authority figures encourage this unhealthy obsession with weight and size including doctors, nurses, teachers, and even mental health clinicians (Puhl & Latner, 2007). This is evidence that the stigma associated with being fat is a powerful mechanism of oppression and heavily influences social interactions including diagnoses and treatments offered by mental health providers (Puhl & Latner, 2007).

Women of size are often seen as lazy, weak willed, sexless, unattractive, ignorant, poor, uneducated, unhealthy, extremely giddy, or extremely mean (Jennings, 2006). Recent research by Laura Triplet (2007) informs us that women seen as slender and healthy, by virtue of appearance, tend to feel justified in judging and blaming fat bodies. There is often a moral and punitive tone associated with this judgment. In one research article that instituted an anonymous survey of college students, when asked the question "Under what conditions is female fatness acceptable?" (p. 11), the responses were staggering. Most of the responses condemned women of size and blamed them for being deviant and there were very few reasons the students gave for fat to be acceptable. The overwhelming sentiment was that fat is not okay even when it is what they see as out of the person's control, as with pregnancy, an eating disorder, or a medical condition (Triplet, 2007).

Triplet's (2007) research study responses were good examples of how comfortable people are with expressing negative attitudes toward fat women's bodies. The responses were harsh, critical and blaming of women's bodies regardless of whether

the respondent was a male or female. A young woman's response to, "Under what conditions Is female fatness acceptable?" included this disclosure, "It makes sense if you're fat while you're pregnant but there aren't really any other legitimate conditions for a woman to be fat." (p. 13).

A young man's response to why fat bodies are not acceptable include, "Being fat is ugly and unhealthy...men look for beautiful women so it doesn't make sense for a woman to be fat. Maybe that explains why fat women are such an easy lay. They know they can't get a man any other way" (Triplett, 2007, p. 16). While these responses were given by undergraduate college-age students and might appear extreme, many of these students' sentiments reflect the sentiments of a multitude of people in our society regardless of age.

One only needs to review Yalom's (1989) *Fat Lady* story to see that societal prejudices and stereotypes, such as those expressed by the college students in the aforementioned study, have an influence on everyone in the society; including those in the mental health field. Therefore the more mental health clinicians become conscious about size-prejudice and the stigma associated with being fat, the better equipped they can be when working with fat female clients.

College students were not the only groups studied with regard to size prejudice. The National Association to Advance Size Acceptance (NAAFA) researchers conducted a survey in a hospital setting and found that, "doctors and nurses self-reports show that they view "obese" patients as "lazy, lacking in self control, non-compliant, un-intelligent, weak-willed, and dishonest." In a survey of nurses 24% felt repulsed by fat people and 31 % said they prefer not to care for "obese" patients, and 12% said they would not want

to touch these patients.” (NAAFA, 2009) “Psychologists ascribe more pathology, more negative and severe symptoms, and worse prognosis to obese patients compared to thinner patients presenting identical psychological profiles.”(NAAFA, 2009) The consequences of these attitudes and beliefs, expressed by these healthcare professionals results in some fat people not receiving proper care and some are reluctant to seek care because of the stigmatization and mistreatment they often receive (Cossrow et al., 2001; NAAFA, 2009). These above studies point to the ways in which weight is socially constructed and the ways that fat bias can be harmful and how easy it might be for mental health clinicians to inadvertently label their fat female clients before even seeing them, which would inevitably lead to countertransference in the therapeutic setting.

Countertransference

Irvin Yalom (1989) has been the only clinician to date whose work includes a countertransference dilemma with a fat woman as outlined in his story *Fat Lady*. Yalom stated clearly near the beginning of his essay,

Once I accept someone for treatment, I commit myself to stand by that person...most of all, to relate to the patient in an intimate, authentic manner. But could I relate to Betty? To be frank, she revolted me. It was an effort for me to locate her face, so layered and swathed in flesh as she was. Her silly commentary was equally offputting. By the end of our first hour I felt irritated and board. Could I be intimate with her? I could scarcely think of a single person with whom I *less* wished to be intimate. But this was *my* problem, not Betty's. It was time, after twenty-five years of practice, for me to change. Betty represented the ultimate countertransference challenge – and for that very reason, I offered then and there to be her therapist (1989, p. 97).

Yalom's account of Betty helps illustrate the sometimes, extreme emotions clinicians' may experience with their clients at one point or another. According to Donald Winnicott (1949), it is important that clinicians be aware of their own “fear and hate”, he

goes on to say about clinicians, “However much he loves his patients he cannot avoid hating them, and fearing them, and the better he knows this the less will hate and fear be the motive determining what he does to his patients.” This concept can be very important in understanding size bias or any other bias. Yalom (1989) displayed some intense affect with regard to Betty and at the same time he was aware of it and was excited about the opportunity to work through his countertransference with Betty because he knew it would help him grow as a person and as a clinician.

Although not all clinicians agree that countertransference exists or is relevant and there is some controversy in the field with regard to theoretical definitions of countertransference (Rosenberger & Hayes, 2002), empirical findings show that regardless of whether clinicians believe in the concept of countertransference or have been trained to notice it, patterns of countertransference responses consistently emerge in therapeutic relationships (Southern, 2007). In essence, clinicians of all disciplines have responses to their clients and if they are aware of their responses, can make use of that information, which can facilitate the therapeutic process and deepen the therapeutic alliance, assisting both client and therapist (Southern, 2007). However one defines countertransference, researchers agree that left unacknowledged and unresolved countertransference responses can impede the therapeutic process (Betan et al, 2005; DeVaris, 1994; H. London, 2007; Rosenberger & Hayes, 2002; Southern, 2007).

Managing countertransference

The extent to which countertransference responses are acknowledged by mental health clinicians varies and is dependent upon the level of awareness and insight of the individual therapist. Many view countertransference as something negative but many

more see it's intrinsic significance to the therapeutic working alliance. However, as it stands, there is always the potential for countertransference to have negative consequences (Betan et al, 2005; DeVaris, 1994; H. London, 2007; Rosenberger & Hayes, 2002; Southern, 2007). Therefore, it is necessary for clinicians to manage their countertransference, which empirical research shows, can be done in a number of ways (Geltner, 2007; Ligiero & Gelso, 2002; H. London; 2007, M. London (2006); Rosenberger & Hayes, 2002; Southern, 2007; Williams, 2007).

A few of the ways the therapist can identify countertransferential sensations is through: somatic awareness or tuning-in to the body's reaction to what is happening in sessions such as sleepiness, aches, pains, erotic or sexual feelings, coughing and other bodily responses (M. London, 2006). Some ways that clinicians' can manage countertransference include, "curative emotional communication" (Geltner, 2007) and management of affect or using particular expressive looks and sounds to show clients empathy; awareness of "conflict-relevant material" (Rosenberger & Hayes, 2002) between therapist and client; awareness and acknowledgment of power imbalances in the therapeutic dyad (DeVaris, 1994; Shahar, 2004); and the utilization of peer support and clinical supervision (DeVaris, 1994; H. London, 2007; Southern, 2007; Williams & Day, 2007).

The assumption implicit in the above ways of managing countertransference is that the clinician involved is self-aware, which may depend upon individual clinician's personal qualities. Rosenberger and Hayes (2002) found that,

Research has indicated that therapists who possess certain qualities, such as self-integration (i.e., less fragmented personalities and more stable boundaries) tend to have fewer countertransference reactions and more positive therapy outcomes. In

addition to self-integration, other therapist characteristics that have been found to be positively associated with countertransference management are empathy, self-insight, anxiety management, and conceptual skills. Related to the issue of conceptual skills, therapists' ability to apply theory to their cases seems to facilitate countertransference management, but only when therapists are self-aware. When a therapist lacks self-awareness, purely theoretical conceptualizations of one's clinical work appear to be insufficient for managing countertransference. In fact, theory without self-awareness seems to generate more countertransference behavior (p.222).

Irvin Yalom (1989), for instance, was self-aware enough to identify that he was experiencing countertransference reactions with his fat female client, Betty, in his essay, *Fat Lady*. It was important for him to acknowledge his feelings and begin to untangle the history and depth of his countertransference as he did. This is evidence that clinicians have multiple options in addressing their countertransference and to ignore it could be harmful if not unethical to their clients.

Countertransference and Clinical Supervision

One of the ways to manage countertransference is through clinical supervision. Researchers agree that clinical supervision can be a healthy and effective component to working through countertransference (DeVaris 1994; H. London, 2007; Southern, 2007; Williams & Day, 2007). Stephen Southern (2007) observes that, "Effective clinical supervision involves a balance of personal and professional issues, reflection and action, insight and behavior change" (p. 290). The clinical supervisor can bring clinicians' "unconscious countertransference" to the surface, by asking questions about the clinicians' feelings toward a client (H. London, 2007). This process can enable the clinician to explore the ways in which her or his, now, "conscious countertransference" might be affecting the client's treatment or give the clinician some insight into the client's inner world (H. London, 2006).

This kind of attuned clinical supervision can be particularly helpful when the countertransference relates to the client's trauma or mental illness, as well as with the clinician's biases based on social or cultural norms. Southern (2007) suggests that the relationship between the client and therapist is a co-creation by which the therapist's attitudes, behaviors and functioning is communicated to the client unconsciously and is then exhibited by the client's disclosures. The therapist can then disclose what has occurred with the supervisor. This phenomenon is important as it facilitates self-disclosure and vulnerability on the part of the therapist and the clinical supervisor. Looking at Yalom (1989) he may have benefited from this type of supervision. For instance at the end of Yalom's (1989) story we find out that had he listened to his own advice he may have had a different therapeutic relationship with Betty throughout the process had he been to supervision or had she been included in his countertransference process. Yalom points out the importance of this at the end of the Fat Lady excerpt when he and Betty are terminating therapy.

As we neared our final session, I felt a mounting relief and exhilaration – as though I had gotten away with something. One of the axioms of psychotherapy is that the important feelings one has for another always get communicated through one channel or another – if not verbally, then nonverbally. For as long as I can remember, I have taught my students that if something big in a relationship is not being talked about (by either patient or therapist), then nothing else of importance will be discussed either. Yet I had started therapy with intense negative feelings about Betty – feeling I had never discussed with her and that she had never recognized. Nevertheless, without doubt, we had discussed important issues. Without doubt, we had made progress in therapy. Had I disproven the catechism? Are there no “absolutes in psychotherapy?” (p. 122).

In this final session Yalom felt that he had essentially “gotten away with” not informing Betty of his feelings about her and did not reveal his feelings about how he felt about her size until the end. However, Betty surprised Yalom and reminded him of what he already

knew intellectually but failed to see because he was too close to it. Betty asserts herself in this final session as Yalom attempts to inform Betty of how his feelings were initially toward her and how his feelings had changed.

What I mean is that my attitude about obesity has changed a lot. When we started, I personally didn't feel comfortable with obese people..." In unusually feisty terms, Betty interrupted me. "Ho! Ho! Ho! 'Didn't feel comfortable' – that's putting it mildly. Do you know that for the first six months you hardly ever looked at me? And in a whole year and a half you've never – not once – touched me? Not even for a handshake!" My heart sank. My God, she's right! I *have* never touched her. I simply hadn't realized it. And I guess I didn't look at her very often, either. I hadn't expected her to notice! I stammered, "You know, psychiatrists don't ordinarily touch their..." "Let me interrupt you before you tell any more fibs and your nose gets longer and longer like Pinocchio." Betty seemed amused at my squirming. "I'll give you a hint. Remember I'm in the same group with Carlos and we often chat after the group about you. (1989, p. 123-124).

Yalom was surprised that Betty knew all along how he felt about her size without him saying a word about it to her and even more surprised that she knew that he had touched Carlos, his other client, in the form of shaking his hand, and holding him in his arms as he cried (Yalom 1989). This was an important lesson for Yalom and it demonstrated what he already knew about disclosing strong countertransference feelings, and how he unconsciously and inadvertently communicated his disgust for Betty through his behaviors, which he was unaware of. He was aware of his feelings but not the behaviors that accompanied those feelings, such as his inability to achieve eye contact with Betty or his inability to touch her (Constantine, 2007; Sue et al., 2007; Downes, 2001; Yalom, 1989). This is evidence that no matter how seasoned the therapist, clinical supervision can benefit everyone involved. Yalom's essay is a good example of the needed research in this area. Although there is a substantial amount of literature on supervision and countertransference in psychotherapy; there has not been enough research in the literature

or training in mental health education related to size bias and how it informs the countertransference in the psychotherapeutic relationship.

Bias and Psychotherapy

Research shows that countertransference can also include the way that clinicians respond to differences between themselves and their clients. From visible differences, to differences in communication style, biases can lead to negative countertransference particularly with disenfranchised populations (Javier & Herron, 2002). The majority of contemporary educational training and research on bias in the therapeutic dyad has been primarily with regard to gender, class, culture, ethnicity and race (Eriksen & Kress, 2008; Javier & Herron, 2002; La Roche, 1999; Simon, et al., 1992), leaving fat comparatively under analyzed. This cross-disciplinary research has sought to inform current and future clinicians about social and cultural biases and prejudices that may affect the therapeutic relationship. The research on sexual orientation, religion and disability bias in the field has been even more recent in the past few decades (Garnet, Hancock, Cochran, Goodchilds, Peplau, 1991; Lannert, 1991; May, 2005). In addition, in mental health research, size bias is a burgeoning concern (Carter, 2008; Davis-Coehlo, Waltz, & Davis-Coehlo, 2000; Downes, 2001; Jennings, 2006; McCardle, 2008; Muennig, Jia, Lee, & Lubetkin, 2008; Robinson & Bacon 1996; Schwartz, Chambliss, Brownell, Blair & Billington, 2003; Teachman, Gapinski, Brownell, Rawlins, & Jeyaram, 2003) and is beginning to receive more attention as a form of prejudice that may impact the clinical relationship. The following section will introduce a current socio-cultural issue that faces therapists and clients today and research will show how inferences can be made with relation to the research on size bias.

A socio-cultural issue that faces therapists today is race. Due in part to the history of racism in the United States, race is one of the more common themes written about with regard to bias and countertransference in psychotherapy (Constantine, 2007; Javier & Herron, 2002; La Roche, 1999; Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Esquilin, 2007). These studies serve as a model for looking at countertransference in relation to bias with fat women. A present day concern most recently associated with the topic of race in mental health research, is the concept of racial microaggressions (Constantine, 2007; Sue et al, 2007). Derald Wing Sue and colleagues (2007) describe racial microaggressions as, “brief and commonplace daily, verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative, racial slights and insults toward people of color” (p. 271). Racial discrimination is a daily part of the lives of people of color and racial microaggressions are one of the subtle forms that occur daily, often without the perpetrator’s awareness of its occurrence (Constantine, 2007; Sue et al., 2007; Rosenberger & Hayes, 2002). An example of a racial microaggression includes the concept of “colorblindness” (Constantine, 2007; Sue et al., 2007) whereby the white clinician informs his or her client that he or she does not see color. This frequently used statement invalidates, minimizes and denies the racial experience of the person of color, and in effect blames the victim and denies the existence of white privilege (Constantine, 2007; Sue et al., 2007).

Fat microaggressions can look similar in structure to racial microaggressions, as the repercussions of disregarding, invalidating and blaming the victim for societal discrimination and oppression exist (Downes, 2001; Gee, et. al., 2008; McCardle, 2008; Schwartz et al., 2003). This concept of microaggressions can be extrapolated to include

the invalidation that many fat women experience on a regular basis, when clinicians and others feel compelled to suggest that fat women lose weight (Davis-Coelho et al., 2000; Downes, 2001; Robinson & Bacon, 2007; Schwartz et. al., 2003).

It is pertinent and useful to include size microaggressions as a behavioral enactment of bias or negative countertransference when thinking about fat women in psychotherapy. Research shows that the impact of microaggressions is often greater when enacted by a therapist rather than with someone who is not in a helping profession, because of the power implicit in the dynamics of the therapeutic relationship (Constantine 2007; Devaris, 1994; Shahar, 2004).

That size has not been researched fully as an area of difference points to the fact that more research is needed regarding fat women as an oppressed group. However microaggressions provide a relevant framework with which to address size bias and the ways in which clinicians may engage in size related microaggressions with their fat female clients. This is depicted well in Yalom's (1989) essay when Betty reported that she noticed his limited to non-existent eye contact and his inability to touch her even in the form of a handshake. These acts are demonstrations of microaggressions (Constantine 2007; Downes, 2001; Sue et al, 2007).

Research has shown that clinicians can unintentionally exhibit fat bias without conscious awareness of the process (Robinson & Bacon, 1996; Teachman et al., 2003). From this research it can be deduced that microaggressions also can occur when it comes to women of size. In Anne Downes' (2001) qualitative study of fat women in psychotherapy, a fat female client lost trust in her therapist when her therapist suggested that she lose weight. This is a primary example of a microaggression toward someone

who is fat. This suggestion that a fat woman lose weight can serve to alienate the fat woman in psychotherapy, impacting the therapeutic alliance negatively (Downes, 2001). The assumptions implicit in this suggestion is that women of size want to lose weight, or that losing weight will solve a fat woman's problem. These assumptions are based on cultural aesthetics of body size (Jennings, 2006). After clinicians' suggest that clients lose weight a suggestion of a diet often follows. Then size becomes associated with the cultural construction that food-intake is a determinant of weight and that a woman's weight is a determinant of her health (Jennings, 2006; Muennig, et al., 2008).

A recent survey conducted in Melissa McCardle's (2008) study about weight bias in social work practice, showed that clinicians do have negatively biased attitudes toward fat people and beliefs that weight can be controlled. When clinicians assume that weight can be controlled this can create an atmosphere that is not conducive to the fat clients needs (Downes, 2001; McCardle, 2008).

Size-Acceptance

Can size acceptance serve as a way to manage clinicians' countertransference with fat women? The following literature focuses on the efforts made over the years to improve acceptance of women's bodies including the idea of size acceptance.

According to Abigail Saguy, Ph.D. (2007), an assistant professor at UCLA, the early feminist, scholarly, literature initially focused on women's bodies and the pressure to conform to social standards via the vehicle of anorexia and bulimia. This literature created a foundation for the acceptance of women's bodies (Bordo, 1993). However, what was missing from this early feminist literature was the notion of rejecting or accepting fat bodies and the role society plays in the lives of fat women (Saguy, 2007).

Bordo (1993) was one of the first feminists to write scholarly works on the societal pressures on women's bodies. Through her book, *Unbearable Weight, Feminism, Western Culture and the Body*, Bordo sought to reverse the negative effects and stigma related to socially constructed views about women's bodies and to counter the harmful things women do to their bodies, such as bingeing, purging and excessive dieting, in order to fit into the socially constructed norms. This important part of feminist literature, and the ideas regarding Western culture's view of the woman's body, is helpful in understanding the stigma of being fat. In effect, the reason Bordo (1993) and early feminist scholars wrote about women and weight was because anorexia and bulimia was the result of women trying to conform to social standards and women who did not want to be seen as fat. What these early feminist scholars did was begin the academic conversation about women's bodies. While this scholarly work was going on in academia more work was being done on the grass roots level to actively oppose fat phobia; literally meaning fear and hatred of fat people, or fear of being fat (CSWD, n.d.; McKinley, 2004; NAAFA, 2009; Rothblum 1999; Rothblum & Miller 1998).

There are several individuals and organizations that contribute to the research on weight, size and health outcomes as well as size acceptance. Some of this research has come out of the size acceptance movement, also known as fat acceptance, size positive, fat liberation, fat positive, and fat power movement (CSWD, 2009; Hayes, 1995; Health Weight Network, 2009.; NAAFA, 2009; Rothblum, 1999; Rothblum & Miller 1998; Saguy, 2007). This grassroots movement was started by various individuals and organizations in the late 1960's through the 1990's and still exists today.

There is not a comprehensive history of how the size acceptance movement began, due to its grassroots origins. However, the oldest and most well-documented, non-profit human rights organization within the fat-positive movement is the National Association to Advance Size Acceptance (NAAFA). NAAFA was founded in 1969 to end discrimination and protect the rights of fat people (CSWD, n.d; NAAFA, 2009 Weitze, 2006). NAAFA was one of the early fat-activist organizations to encourage Health At Every Size (HAES).

HAES is a paradigm shift where the focus is on the acceptance and respect of all body sizes and a more holistic approach to health and wellbeing, rather than a focus on weight loss (CSWD, n.d; Hayes, 1995; HWN, 2009; NAAFA, 2009). What would happen if clinicians were able to use this approach in working with their fat female clients? An essential principal of size acceptance is “recognizing that health and wellbeing are multi-dimensional and that they include physical, social, spiritual, occupational, emotional, and intellectual aspects” (NAAFA, 2009). NAAFA and other size acceptance organizations view the BMI as a means to label, stigmatize and discriminate against fat bodies rather than as a predictor of good or poor health (Body Positive, 1999; CSWD, n.d.; Healthy Weight Network; 2009; International Size Acceptance Association, n.d.; Kwan, 2006, National Organization for Lesbians of Size website, 2007; The Fat Experience Project, 2008). Some of the research that comes out of this movement as well as the informative websites that each of these organizations have, may serve as a way to normalize size acceptance and as a way for clinicians to manage their countertransference with fat women.

Summary

There has been an extensive amount of research on the topic of countertransference since the early days of psychoanalysis (Freud, 1909; Heimann, 1950; Rosenberger & Hayes, 2002; Southern, 2007; Winnicott, 1949; Yalom 1989). The above review of the literature on size and countertransference provides a foundation with which the researcher can address the question of clinicians' countertransference with women of size. In order to add to the existing literature, the researcher will seek to explore the following questions: Do clinicians experience countertransference related to women of size? What are some of the countertransference responses that can occur with clinicians who work with women of size? Are clinicians aware of the possible countertransference issues that may arise when working with these clients? Do those clinicians' who do experience countertransference with this population find that there is a difference in countertransference with those fat women who accept their bodies versus those who do not accept their bodies? Does a woman's size and level of acceptance of their size influence the treatment plan and goals suggested by clinicians? These questions will be explored using qualitative methods as outlined in the next chapter.

The ways in which the researcher seeks to obtain this data is outlined in the methodology section.

CHAPTER III

METHODOLOGY

The purpose of this qualitative study is to explore whether clinicians experience countertransference with their clients who are women of size and what kind of countertransferential responses they might experience if any. Women of size include women who have been labeled medically obese or morbidly obese according to the BMI scale, which calculates one's body mass index based on a person's weight and height. Although clinicians may not be aware of each client's BMI, there may be visual, subjective cues and cultural perceptions that lead clinicians to believe a woman is obese or morbidly obese. Another way a clinician might determine a woman of size is if the client discloses her weight status in relation to her size and describes that she has been discriminated against because of her size; and/or has difficulty accessing public facilities and structures. Also, the word "fat" used in the title of this study requires a working-definition, as it will also be used in this research. The word "fat" is a word that has been reclaimed, as a way to take the power away from its derogatory use, by a number of people in the "size-acceptance" and "anti-weight discrimination" movements. In these movements the word "fat" is used as a descriptive term. These terms are used throughout the paper either in the researchers own language, as quotes from the literature or perhaps even in some of the clinicians' responses.

Research Design

A flexible, inductive, qualitative research design was used to conduct this study. This design allowed for an exploration of clinician's experiences working with fat women, using narrative and exploratory measures. Much research has been conducted on bias and countertransference between clinicians and their clients. There is also empirical research on bias and countertransference with groups of people such as: people of color, women, gay, lesbian, bisexual, transgender, people with low socioeconomic statuses, and so on. This study is being conducted to focus on a group that has received little attention as a group that people may have biases against - particularly in the mental health field. Although there is growing research in the mental health field on fat women in psychotherapy, as well as size bias and psychotherapy, little research has been conducted with regard to clinicians' possible countertransferential responses to women of size. The majority of research found has been quantitative and most of the qualitative studies found, interviewed the clients rather than the clinicians.

Sample

This exploratory research was conducted using non-probability snowball sampling of convenience using professional connections. The sample was composed of 12 clinicians from various mental health backgrounds and degree's from licensed clinical social workers to clinical psychologists. These clinicians reported working with people of various socioeconomic, ethnic and cultural backgrounds. The participants included people who self identified as women, as men; as African American, as white; as lesbian, gay and heterosexual; and people who identify as being women of size, people who identify as being thin, and people who identify as having a disability.

To be included in the research the participants must have been licensed clinicians currently in direct practice in the state of Georgia, in the field of mental health and included licensed clinical social workers, licensed professional counselors and clinical psychologists. The participants were also required to have a minimum of one year of direct practice experience so that they may reflect on past and current cases. There was no requirement that any clinician be of any particular body size, racial, ethnic, cultural, socio-economic background, sexual orientation, gender, age, or ability status, although efforts were made to include a diverse sample of clinicians. Most importantly, at the time the interview was conducted the clinicians must have worked with at least one fat female client, in the past or presently.

The exclusion criteria included the following: participants could not be bachelor level social workers, case managers or people other who work indirectly with clients seeking psychotherapy, as the focus of this study pertained to the psychotherapeutic dyad. The participants were not to be clinicians with less than one year of practice in order to allow for enough experience with fat women in psychotherapy. At the time of the interviews the participants were not to be practicing in any state other than Georgia, as the in-person interviews took place in Georgia. If clinicians never worked with at least one client who is a woman of size they would have been excluded from the study.

Procedures

The recruitment process took place via email and Internet list-serves, as well as in-person and telephone phone conversations. There were various clinicians in the metropolitan Atlanta area that were recruited via snowball sampling. A letter to potential participants was distributed, via email, to clinicians with whom this researcher was

acquainted (Appendix A). These clinicians in turn sent the announcement to their colleagues via email, as well as to any professional list-serves in which they were members. When clinicians notified the researcher of their interest of becoming a participant in the study, each clinician was screened via the telephone to be sure that they fulfilled the inclusion criteria.

A diverse group of clinicians was desirable and participants were recruited with that in mind. Professional and personal contacts were used strategically based on knowledge of the diversity of individuals' professional affiliations, in order to diversify recruitment efforts. Demographic data was collected from the participants in order to reflect the diversity of the sample and to ascertain how that diversity affected the results of the study. Clinicians were asked to fill out a brief demographic questionnaire before the interview (Appendix B).

Following approval of the research design, by the Human Subjects Review Board of the Smith College School for Social Work (Appendix C), participants were asked to sign an informed consent form at the time of the interview, which is in Appendix D. Participants were asked if they wanted to receive the form via email, in order to preview it before the interview. Participants were also given the opportunity to ask questions of the researcher before signing the informed consent. Participants signed the informed consent before the interview and any audio recording took place. Along with the researcher's contact information participants also received the chair of the Human Subject Review Committee, Dr. Ann Hartmann's contact information in the event of any questions, concerns or complaints. Research participants were not minors. All participants were fluent in English and did not need a translated informed consent form.

Participants were individually interviewed at their job setting or another mutually agreed upon location that was conducive to conducting a recorded interview. They provided their professional opinions and personal reflections with regard to countertransference, bias and size as they related to the therapeutic dyad. The interview consisted of semi-structured questions that focused on the experience, skills, and strategies clinicians utilized in the treatment process. Clinicians were asked about treatment plans and goals, as well as personal feelings, values and beliefs associated with their female clients of size in a clinical setting. The interview guide is provided in Appendix E. A list of working definitions (Appendix F) and a resource list (Appendix G) were made available to clinicians, who wanted them. The working definition handout was provided if a participant wanted clarification of certain terms, particularly the term “women of size”. The resource list was provided at the end of the interviews if the participant was interested in learning more about the subject matter.

Participants’ confidentiality was protected in a number of ways. Clinicians’ participation in this research was anonymous and confidential; no part of the research was conducted in a group format. All names were removed from transcriptions and all other written materials. Participants were assigned code numbers, which appear in place of names on written materials. The participants were not asked to identify their names while the recording device was running, and were asked not to include any identifying information in any examples of case material they provided. Identifying information about the participants was disguised, when illustrative vignettes and quoted comments were used.

Volunteer transcription assistants signed a confidentiality agreement (Appendix H). The signed informed consents, notes and transcripts, will be stored separately from audio recordings and transcriptions. Data will be stored in a locked file box in a secure location. Electronically stored data will be password protected. All data will be kept secure for three years as required by Federal regulations after which point they will be destroyed, unless the researcher is still using it for publication, in which case it will be destroyed when no longer needed.

Data Collection

All interviews were digitally recorded and transcribed. Each interview was coded with a number to ensure confidentiality. Data from each interview was analyzed based on content and theme. Demographic data was collected and analyzed manually. All responses were separated and highlighted based on common themes that emerged when analyzing the narrative responses. The clinicians' race and gender was noted next to their narratives so that differences or similarities could be noted more easily. Summaries of the themes are reported in the Findings chapter.

CHAPTER IV

FINDINGS

The data in this study show that clinicians experience significant countertransference with their clients who are women of size. Some clinicians were aware of their fat bias and prejudice out in the world yet were not as aware of how this bias made its way into the countertransference with their fat female clients. Clinicians' narratives also suggest that cultural reinforcement of body aesthetics plays a significant role in countertransference. Ambivalence was an overarching theme categorizing clinicians' experiences of their thoughts and feelings toward women of size. Other themes that emerged, in addition to ambivalence, were microaggressions, as well as affective reactions such as devaluation, fear, shame, and confusion around the topic of fat women. Thematically, clinicians' narratives resounded in their emphasis on health, disordered eating, and weight. Three clinicians' narratives stressed a "Fat positive and Size Acceptance" approach to managing bias, negative affect, and cultural pressures when working with women of size. Due to the fact that there is limited literature with regard to clinicians' biases and countertransferences with women of size, this study highlights the need for more research in this area.

The sample was composed of 12 clinicians from various mental health backgrounds and degree's from Licensed Clinical Social Workers, to LPC's to PHD in psychology to PsyD's. These clinicians work with people of various socioeconomic, ethnic and cultural backgrounds. The participants included people who self identify as

women, as men, of African descent, of European descent, as lesbian, gay and heterosexual, and people who identify as being women of size, people who identify as being thin, and people who identify as having a disability.

Bias Prejudice and Discrimination

One somewhat surprising finding is the number of clinicians who have biases or prejudices toward fat people, including those clinicians who consider themselves women of size. Nine participants indicated some form of bias toward women of size. Five out of these nine clinicians explicitly reported that they were aware that they experienced prejudiced attitudes toward women of size. The other four out of these nine participants, indicated bias as evidenced by their affect, and in interactions that occurred with women of size, outside of the therapeutic setting. Participant 2 stated, “I have prejudice also with people with weight and I will notice and think, ‘poor thing I wish they could...figure it out. I have my own weight issues that I can’t figure it out, you know? I’m 40 pounds overweight.”

Participant 3 stated, “I could see the idea of countertransference because I definitely have countertransference issues about size. I know that I do...I would say that it’s a big issue for me...I would say that I’m prejudiced.”

Initial Responses to Yalom Excerpt

Nine of the clinicians in this study agreed with Yalom, that cultural reinforcement of fat bias is everywhere. Although one clinician, participant 10, said that she did not agree with what Yalom said about cultural reinforcement due to the fact that she is African American and grew up with family and friends who are of size. She explained how in her community the women make disparaging remarks about her size because she

is smaller than they are. She reported that she felt because Yalom was a white male that it must be different for him. Though her view stands alone among the African American clinicians interviewed as the other African American clinicians interviewed, agreed with Yalom, that social reinforcement is everywhere. Though three other clinicians agreed that cultural reinforcement does play an important role in fat bias they also agree that Yalom's being a white male may have been a factor in his extreme response to 'Betty' in his excerpt. Five other clinicians however, felt that cultural reinforcement does play a role in fat bias in general. Participant 9 an African American participant stated, "It's true that he's probably not alone in his bias you know, and that cultural reinforcement, it is sort of everywhere...but that cultural reinforcement is most often coming from, you know, White America. I mean anything that's not thin and blue eyed and blond hair is not reinforced really."

Participant 5 however, responded to Yalom's excerpt in this way: "I have always been repelled by fat women." I guess I would have to agree with that...and that 'I find them disgusting'. Yeah I would have to agree with that. She then went on to explain an incident in which she treated a person of size in her life in a cruel way that ridiculed and shamed this person by way of openly laughing at this person in his presence. She commented that she felt bad about the incident but could not help herself.

Eight out of 12 clinicians reacted with anger or were offended by Yalom's description of and feelings toward Betty, the fat lady, in Yalom's story. They indicated astonishment at Yalom's choice of words in describing his client. The words, "shocked", "horrified", "angry", "disgusted" and "surprised" were some of the expressions used by

the participants. For instance participant 11 responded with, “I’m just...I’m horrified! That’s just mean!” Participant 2 replied,

I have to tell you, I’ve been a lifelong feminist and I’ve done a lot of work around women and eating and prejudice so that’s going to color my views too. I’m mad at him! I appreciate his honesty but I do think it’s possible that men have a harder time with this than women. I think the fact that he didn’t mention fat men makes me mad! Um and I’m disgusted with him!

An interesting finding however, is that participant 6, a white male clinician, and participant 10 a black female clinician immediately identified feeling shame in feeling similarly toward fat women as Yalom in response to the question, “What kinds of feelings did that excerpt elicit in you?” They both reported that they felt shame that they also struggled with similar feelings toward women of size. Participant 10 an African American female clinician stated, “My shame comes in with having had unkind thoughts about folks who are overweight. Not to that extreme um but my thoughts are shaming for me so when I read his I think ‘wow’, you know?” Although other clinicians agreed that they had bias and prejudice toward fat women they did not mention it in response to identifying with Yalom’s description of Betty. At the same time participant 6, a white male clinician who reported that he felt shame about struggling with fat bias also stated that he did not agree with Yalom’s statement, “How dare they impose that body on the rest of us.” Participant 6 also talked about how worried Yalom was about his “trim high tech office chair,” and said that, “he came across as being arrogant and ostentatious.” He thought Yalom was, “rude and crass” when Yalom stated that he wanted to say, “stop stuffing yourself and have you had enough for Christ’s sake!” This clinician along with four of the other participants thought that Yalom should have had more “compassion” and “empathy” toward Betty. Participant 11 an African American clinician stated, “part

of me says boy it's really sort of nice that he would be willing to put himself out there like that but...that's just hateful. I don't even consider this countertransference I just consider this straight up oppression personally." She also stated that, "In a therapist, this is just kind of dangerous, because it's just like, what options, if I sit with you, would I have, for that immediately to become the focus of the therapist...that I've got to get your weight down. Many clinicians had a reaction to Yalom stating, "How dare they impose that body on the rest of us." Three women, participants, 8, stated that his "male privilege" might have had something to do with the extremity of his response.

Almost every clinician suggested that Yalom receive supervision of some kind whether it was peer supervision, colleague support, or even therapy. Although there were a few who said that he should just refer the client to someone else due to the fact that his feelings were so strong. Many said that they would want to find out more about why he feels so strongly toward Betty. Others said that although it was commendable that Yalom was aware of his feelings and wanted to explore them, the language that he used was "disrespectful" and "dehumanizing". Participant 11 stated that she would ask Yalom, "How did you immediately manage to strip that person of her humanity?" Participant 12 stated that due to his "male privilege and power", that both "gender and size" seemed to play a part in his bias. She states, "Does he have this same reaction to men who are overweight, or is that a gender issue and a size issue?"

A couple of clinicians suggested that this was Yalom's dark side and mentioned that we all have this "shadow side" or "dark side". One clinician specifically said that he would do, "shadow work" with Yalom. He said that, "Shadow work is what you find repulsive or annoying in someone else. How is that a part of yourself that you try to

suppress?” Participant 6 stated that he would explore that with Yalom and also expressed some empathy for Yalom.

Part of it was because he’s such a well-known therapist and author it was like uh, some one else has this too? Someone else struggles with countertransference? So um, I guess, gives me permission giving to look at my own biases and be gentle with myself during that process and knowing that in the end we are human. A good therapist is one that works on it not just ignores it but that works on it. So, it was like okay good. I’m not the only one that struggles with stuff sometimes.

These clinician responses were important in understanding where they initially stood at the beginning of the interview and helped see where their views lie toward the latter part of the interview. Were their views the same, how did their response to Yalom’s excerpt conflict with their values or how did it mesh with their current values and beliefs? Did the clinicians’ feelings truly differ from Yalom’s affective response, once they explored them more? Had they ever explored them in depth before?

Ambivalence

A particularly striking finding was that most participants, 10 out of 12 had ambivalent feelings toward women of size. Sometimes this took place in the form of feeling one way toward women of size outside of the therapeutic setting and feeling another way toward women of size within the therapeutic setting. Other ways ambivalence was expressed was with clinicians’ biased feelings or negative affect toward women of size and their attempts to treat and have empathy for these clients. Other forms of ambivalence occurred when clinicians of size worked with women of size who were larger than themselves and the feelings that came up for them versus working with women who were of the same size or smaller than them. Another form of ambivalence

emerged with regard to clinicians who were once of size and no longer were of size and how they exhibited bias toward their clients who were women of size.

Participant 7 disclosed that she used to be a woman of size many years ago so therefore she indicated that she had no prejudice, bias or countertransference with regard to fat women yet reported that, “It’s not something that people who have a problem with weight have learned how to control...and they may get the only attention they get by being overweight, they may be protecting themselves from being approached sexually, by being overweight.” Participant 2 stated that she felt prejudice toward people of size in the general population but not in her office, for instance, she reported that if a woman of size walked into her office, “I would notice it and say, ‘hmm well, there’s my prejudice against people with weight, that’s interesting and then go right to, ‘who is this person besides that.’” This clinician stated that although she feels this way she would just “notice it and go on to see who the person is besides being a fat woman. “I’m different with clients...nonjudgmental. Yeah, I probably put that aside.” This clinician reported that she had the ability to be judgmental outside of practice and turn off the judgment when she is in her practice. Participant 7, a white female clinician, in talking about her level of comfort in working with women of size stated that...

I mean I have been annoyed on an airplane when a larger person, male or female, has sat down and their body size sort of seeped over into my seat. It’s like, ‘I don’t like that.’ You know but that’s a whole different thing. That’s a physical comfort thing. ‘You’re invading my space.’ But I feel real comfortable talking to people [of size] because I have a lot of information. I’ve done a lot of study and uh...data and I know how hard it is. Been there done that.

This clinician was illustrating that she is comfortable working with women of size but out in the world she gets “annoyed” with people of size in certain circumstances. This same

clinician also stated that because of the training she has had in acquiring information on weight and health she feels as though she does not, “get hooked into the countertransference, and fat doesn’t do it to me.” Her words in the latter statement seem to contradict some of her earlier conclusions that “extra weight” makes one unhealthy.

Participant 12, an African American self-identified woman of size stated,

“It’s kind of a thorny issue, not unlike some others. So, basically we just don’t talk about weight. I don’t treat my patients any differently in regards to weight or whatever. But I mean, occasionally the thought crosses my mind. What do they see when they look into the mirror?”

This clinician seemed to struggle with talking about size even though she does have private thoughts about the way women of size look and weigh. This was a striking finding as this woman was also a woman of size.

Affective Reactions

Context and Affective Reactions

As stated earlier although some clinicians did not explicitly state that they were aware of their bias or prejudice toward women of size they expressed some intense affective reactions when talking about their fat female clients or fat women in society. Less surprisingly, clinicians who did express clearly that they were biased also had some intense affective responses or negative emotions regarding women of size. Ambivalence can account for much of the discrepancy in clinicians’ reports. However, some clinicians reported that these reactions were context dependent. Clinicians acknowledged feeling negatively toward women of size out of clinical contexts more rather than while in session with their clients. Other clinicians consistently experienced

strong negative reactions regardless of the context of their encounters with women of size.

Judgment and Devaluation

Intense negative affect most commonly manifested in clinicians' expressions of judgment and devaluation toward women of size. For example, participant 5 reported that when she is in session with women of size she sometimes has punitive thoughts such as, "No wonder that happened, because if you were smaller that wouldn't have happened." This same clinician indicated that she experiences devaluing feelings and thoughts when she comes across women of size in general, "I'm like, man get your stomach stapled or you know do something to take care of yourself and then I immediately think, sexual abuse." She also reported an incident that occurred in a movie theater that illustrates her feelings even more:

I went to a show one time at a casino and there was this lady who was already seated with her family in the auditorium. I mean she was just...like she filled up the chair and it had to have been terribly uncomfortable for her, but she smelled and you know I had to sit there like that and you know, you had to sit in the seat that you were assigned to and I was just like "Ohhhh my god!" I mean I couldn't ENJOY it! And I don't know what the feeling was....I was...I was MAD at her! For making it so I couldn't enjoy the movie and then she just sat there when everybody got up to leave and I thought that is just a horrible way to live...you know that's just horrible!

These highly charged, negative reactions, bear some similarity to Yalom's, and ultimately seem overly critical in observing a woman of size. If these feelings and thoughts were put into actions like averting their glance they would be considered microaggressions.

Fear

Another, disproportionate affective response was that of fear. One clinician who identified as a woman of size, while referring to one of her fat clients who was bedridden, said,

“It was challenging for me...it brought up a lot of feelings about fear of where I could end up, being a woman of size myself. I see people out, who I perceive as being heavier than I am and it takes me back for a second and I think, ‘Oh God please don’t let me get to that point’...I certainly have great fear about getting to the point of being completely bedridden.”

This participant was able to state her countertransference with a client as well as having those same feelings outside of the clinical setting. This clinician was one of the participants who did not clearly state that she was biased or prejudiced toward women of size in the beginning, however her disclosure of fear of becoming bedridden is another indicator of bias.

Shame

Some clinicians expressed an element of shame either directly or indirectly. For example, one clinician reported that he felt shame about feeling biased with regard to women of size even though he has done a lot of personal and professional work on changing his outlook on size. He stated that as a therapist he felt that he should not have a bias like that. This clinician also stated that he was a child of size and used to be teased and called names about his size. He indicated that his history increases the shame he feels about having size bias, due to the fact that he knows how much it hurt him to feel discriminated against when he was younger. Participant 2, a white female clinician stated that she felt “helpless” and participant 3, also a white female clinician stated that she felt

embarrassed and as though she was “walking on egg shells” when she was working with one fat female client. Participant 3 said, about this client,

She came in one day and said that she lost 10 pounds and you know I mean I couldn't tell! And I didn't say anything. I was kind of embarrassed because I thought I couldn't tell that she lost 10 pounds. You know is that bad you know should I have said something?

Confusion, Helplessness and Repression

Some participants felt confused or helpless about how to work with fat women and others surprised themselves about their feelings toward fat women and their decision to consciously or unconsciously ignore the fact that their clients were women of size. Four clinicians stated that perhaps they overcompensated for their negative countertransference with women of size. Participant 10 stated, “Maybe I've overcompensated for my negative response, my negative internal responses by ignoring maybe issues that are pertinent to the treatment.” Participant 3 said that she goes to the other extreme of Yalom by being overly nice to her fat female clients whom she feels intense negative feelings toward. Perhaps these negative intense feelings, which are being repressed, may be aggressive in nature.

Participant 9 stated that she had never considered being biased toward people of size due to the fact that she is an African American woman and women of size is a cultural norm in her community, however she did recall a moment with one of her clients in which she attempted to find a more comfortable chair for her due to her size. This action alone did not indicate bias per se, however the interaction that occurred between herself and a colleague shed some light on perhaps the internal shame she felt about size. The following shows her process with regard to her internal conflict.

There was one situation in which I had a woman who was very large and I was um I saw her at intake um, in another office and I was...when she returned I was seeing her in my office and I was concerned about her being embarrassed if she couldn't...sit in the chair, um so it was this whole thing about trying to find a chair but being kind of...um...I don't know there's this feeling that you want to be accommodating because you don't want...I didn't want her to be embarrassed but the whole idea of my looking for a big chair for my client seemed, I don't know like um...you know I was just, I was just guessing. I don't...you know I didn't know if this chair was too small or whatever but she's...she's a large woman so I have to make sure that I have a really big chair. And so I was looking for a chair and someone said, "what are you doing?" 'Nothing.' I didn't tell them that I was looking for a really big chair you know what I mean? Because there's something about that process that I was uncomfortable with...and I don't know how to describe it...like I was making a bigger deal about it than maybe it was you know? When my friend asked me, "what are you doing" and I said, 'Nothing.' Why did I say, 'nothing'? Why didn't I just say, 'oh I'm looking for a bigger chair'? You know I don't know what that was about...transference of some type...you know, so. I don't know.

Participant 2 felt some confusion and helplessness working with her fat female clients. "I don't know how to help people, sometimes who are extremely overweight. So, you know that's some of my countertransference, is like helplessness. And when my supervisor said, "yeah I have a hard time with it too" I thought, "Oh! Oh no!" This type of confusion coupled with shame and helplessness around how to deal with women of size was illustrated in exactly half, of the clinicians' interviews.

In contrast to the other clinicians participant 11 spoke of how shame was detrimental to the healing process in any given situation and specifically talks about the concept of shaming women of size.

Because one thing is, I've never seen people heal from anything if there's shame. I don't do better if people shame me. You know, "bad, bad woman for having a fucking cookie, or a row of cookies", you know? Or you know whatever. So, for me in my work it's like how to help people disconnect from shame period, 'so *you* can decide [what's best for you].' you know? And walk through these [size] standards because it's crazy making.

Microaggressions

Some of the affective responses manifested into actions in some cases. This interviewer found 3 specific therapist-client interactions that included microaggressions toward fat women in the form of microinvalidations and microinsults. For instance participant 10 reported that during a group session, unrelated to size, one of her fat female clients came to group in tears because, “A man said something really cruel about her size” on her way into the building. When I asked the clinician how she and the group handled that incident she replied.

We just gave her some support and tried to validate her self worth apart from her physical appearance, ‘that’s not who you are, no, that’s just the container’, so we tried to highlight all of her strengths. You know, let her know that there are a lot of jerks in the world and people say unkind things and kind of brought her back to the group we’re here now trying to develop the skills to deal with...we can’t control the world and what others say and do but that we can control our response.

Although, the clinician and participants of the group had the client’s best interest in mind, if deconstructed, this intervention could be considered a microaggression known as a microinvalidation (Sue et. al, 2007). Another account of a fat microaggression enacted by a therapist was when participant 7 informed me of some of the information she often gives her fat female clients:

I look at it as a health issue, not as a weight issue. For instance, one of the things I learned along the way is that it takes a mile of blood vessels to support a pound of fat, so your heart is pumping blood through many, many more miles than it needs to as you’re over weight and so that’s part of why heart problems are connected to overweight. You know your heart was only designed to do so much pumping and you’re putting stress on it just by...just by being overweight. You know It seems from what I’ve read and I’m not a doctor...seems that there’s a high correlation between estrogen and fat and high levels of estrogen can induce cancers so that’s why obesity is sometimes linked with cancer, especially in women. So, I try to point out things that help them see it’s not just about how you look. It’s about, ‘Do you want to live healthy and for a happy length of time?’ Diabetes is related to belly fat, hard belly fat causes diabetes. And it’s the worst disease you’ve ever

seen. I've treated clients who were blind because of diabetes I've treated clients who were disabled because of diabetes. I've known people to lose their feet and hands because of diabetes, it is just such an ugly disease, um...and it's one of those things that you're...as you're overweight you're going to likely to be diabetic.

This kind of interaction with a fat client would be considered a microinsult (Sue et. al, 2007). When asked if she brought up the subject of her clients' health and weight to them even if they did not ask, this clinician emphatically replied, "Yes!"

A third clinician, participant 9 had an epiphanic moment, at the end of the interview, when she suddenly realized that her choice not to see size was equated with incidents she has experienced when people say to her, "I don't see Color." Her account continues:

...So of course that made me think, you know I'm like, 'oh have I just been totally ignoring size?' Like, "I don't see size, I accept everybody." Am I doing the same thing that some white people do? You know, 'I don't see color.' It makes me think...Yeah, 'I don't see size. I just accept all of my patients', which of course is ridiculous.

Health, Eating Disorders and Losing Weight

Although all the clinicians stated that the reason most of their women of size come in is for depression, anxiety and other mental health concerns that most people come in for. Issues of size, weight, health, and eating disorders emerge and appear to become conflated when they may not necessarily go together and may or may not be related to a client's mental health status or progress in therapy.

Exactly half of the clinicians mentioned feeling "mystified" or "confused" about what to do with their fat female clients and it was often with regard to real or perceived weight and health issues as well as eating disorders. Although I did not ask questions about eating disorders or weight loss each clinician mentioned one of these issues when

talking about their fat female clients. Many felt that they did not know how to help women of size with their weight, whether the client asked them for help with their weight or not. Some clinicians stated that the sessions were “difficult”, that their sessions, “didn’t go well”, and they seemed to measure success by how much weight their clients lost. Although participant 7 stated, “I look at it as a health issue, not as a weight issue.”

Participant 6 spoke of the messages that arise when working with women of size. He stated, “there’s the added message of okay well what can I do with you if you have chosen all of this, if you don’t have the quote ‘willpower’ to overcome it, what kind of willpower will you bring into therapy too?” This overlapping of concepts include having the assumption that will power is required to lose weight, that weight needs to be lost and that willpower is needed in therapy and that clinicians feel at a loss when this occurs in sessions where the goal for the clinicians or the client or both is to lose weight. This is not an isolated incident or concern of one clinician. Participant 2 stated the following.

I guess I know how to work with people who say, ‘I’m depressed.’ I go a-b-c-d, boom, boom... ‘I have anxiety’...here, well go to da, duh duh, da duh... ‘I have a weight problem’...I kind of go hmmm I have a general idea because I’ve been to workshops and have read everything Janine Roth has written and I know about OA and but somehow I don’t have as good a handle on it. So I kind of go hmmm okay well, ‘we’ll do what we can.’ There was a sense of feeling incompetent. You know? Not totally incompetent but not totally confident to handle what was going on. Feeling like I didn’t have the right words.

Although her client did ask this clinician to help her with her weight, the clinician indicated that she did not know how to help women of size. This clinician asked me if I knew of places that helped women of size lose weight. Her confusion seemed to primarily be about eating disorders and/or losing weight.

Participant 7 felt that she was able to adequately handle working with her clients who were women of size due to her own experience with weight watchers. She concluded that, “if you’re overweight you’re going to likely be diabetic.” Interestingly this clinician also reported that she routinely gives her fat female clients medical information about the way fat works in their bodies and how it affects the heart and blood sugar levels. This clinician stated that she usually tells clients what diets and programs worked for her because she was once fat and is no longer fat. She reports,

I think it helps me give them some ideas about what they can do. What I prefer to do is to give them information about things that have been helpful for me...objective kinds of information. I refer people to real age dot com for an objective evaluation of their age versus their chronological age and if people are extremely overweight, that’s going to impact their age, and then that website will tell them what they can do. There are nutritional analysis websites as well.

Although this clinician’s approach was the most action oriented of the responses, four other clinicians concluded that they were “worried” or “concerned” for the health of their clients who were women of size.

Size Positive Language & Size Acceptance

When clinicians were asked how many of the women of size they treated were accepting of their bodies most clinicians responded quickly and emphatically that there were no women they treated who were accepting of their bodies. There were four clinicians, however, who stated that they experienced women of size who were accepting and happy with their bodies and that they were women of color, primarily African American women.

Half of the clinicians used some type of size-positive language when interviewed although some of these same clinicians used fat biased language in other parts of their

interviews. Only one clinician, participant 11, out of 12 used only size-positive language when referring to women of size and women's bodies in general. Participant 11 was not a woman of size but considered herself a feminist as well as an activist, unrelated to size, in other parts of her life. Although her feminist affiliation in and of itself does not constitute that one would use size-positive language this clinician intuitively used this language even though she may not have acquainted with the term size-positive.

Participant 2 also considers herself a feminist, however she did use some biased, fat phobic, language and admittedly experienced prejudice toward women of size.

Three clinicians were the most consistent in using size-positive language with the least amount of ambivalence, when referring to women of size. Participant 11 stated,

It's not about what your normal is or anybody else's but what is my normal and how do I sit with someone around their definition of normal and satisfying for them...because feeding into these cultural standards about how we all have to look, creates a distortion about what is normal...That someone can be perfectly happy in the body that they have, have a quality of health that they feel good about...size is not an immediate flag, and it's important to stay clear about that.

I identified this way of speaking as size positive language. Participant 6, a white male clinician revealed what he felt was important:

I honor the beauty within all body shapes and sizes. I see a shapely body as a symbol of goddess, a symbol of giving birth and creation, so not necessarily that you have to have a baby but to create and to nurture and comfort and compassion. So, I choose to take those images when I see a woman of size.

This clinician, though reporting that he struggled with bias also was able to hold this image of women of size.

The above findings were obtained from interviews with 12 clinicians with regard to countertransference with women of size. The above responses indicate that clinicians

do experience countertransference with women of size. The implications will be discussed in the discussion chapter.

CHAPTER V

DISCUSSION

This qualitative study was conducted to explore mental health clinicians' possible countertransference with clients who are women of size. In order to contribute to the current literature on size bias in the therapeutic relationship and to understand how fat comes out in the countertransference with women of size, the interview questions were designed to answer the following questions: Do clinicians experience countertransference related to women of size? What are some of the countertransference responses that can occur with clinicians who work with women of size? Are clinicians aware of the possible countertransference issues that may arise when working with these clients? Do those clinicians' who do experience countertransference with this population find that there is a difference in countertransference with those fat women who accept their bodies versus those who do not accept their bodies? Does a woman's size and level of acceptance of her size influence the treatment plan and goals suggested by clinicians? This chapter will summarize the findings and relate it to the literature, discuss the strengths and limitations of the study and discuss its clinical implications for social work and further research.

Countertransference has explored dimensions of race, ethnicity, class, sexual orientation, gender, religion and more over the last few decades (Constantine, 2007; Eriksen & Kress, 2008; Garnets et.al., 1991; Javier & Herron, 2002; La Roche, 1999; Lannert, 1991; May, 2005; Simon, et al., 1992; Sue, et al., 2007). Research shows that

mental health clinicians can and do experience bias and countertransference toward fat people (Carter, 2008; Davis-Coelho et al., 2000; Downes, 2001; McCardle, 2008; Schwartz et al, 2003). There are multiple ways in which the countertransference responses of most of the clinicians in this study exhibited their biases toward fat women.

Summary of the Findings

The findings of this study show that mental health clinicians experience substantial countertransference with their fat female clients. An overarching theme that prevailed was that of clinicians' ambivalent feelings towards women of size. Due to this ambivalence some clinicians' often expressed confusion or helplessness when it comes to working with women of size. This in large part has to do with the cultural production and stigmatization of fat bodies in the United States (Bordo, 1993; CSWD, n.d.; Davis-Coelho, 2000; Hirsch, 2007; Kwan, 2006; NAAFA, n.d; NIH, 2009; Saguy, 2007; WIN, 2007). The cultural production of fat has been known to induce fear and shame in many individuals, including those whose job it is to be nonjudgmental, as evidenced by the clinicians' testimonies. This nonjudgmental role clinicians attempt to play, seems to engender a conflict between what clinicians' as members of society have been taught about fat, weight and health and the mental health expertise they are there to provide. This conflict can often show up in the form of microaggressions (Constantine, 2007; Sue et al, 2007; Yalom, 1989). When this conflict occurs in the mental health clinician, there is more potential for the use of ineffective treatment modalities and for potential harm to the woman of size client. (Downes, 2001; McCardle 2008).

The phenomenon of countertransference is an inevitable part of the therapeutic relationship (Betan, 2007; Freud, 1909; Heimann, 1950; Winnicott; 1949).

Consequently, it is important for clinicians to recognize when bias and prejudice about a particular group, gets infused into the countertransference material. These findings show that some of the clinicians, though aware that they had some bias toward fat women, were not aware of the ways in which their prejudices influenced their countertransference. For instance the “confusion” and “helplessness” expressed by one of the clinicians and the “walking on egg shells” expressed by another clinician created impasses with some of their fat female clients. Some of these impasses occurred with the fat female clients whom the clinicians reported had eating disorders or those fat women who informed the clinicians that they wanted to lose weight. However, this does not negate the fact that these clinicians felt helpless, confused and mystified, about how to treat or work with their fat female clients. It also begs the question, did their fat female clients truly have an eating disorder or did the fact that they were fat lead the client and their clinicians’ to believe that they had an eating disorder, namely overeating? Another way to also look at the idea of eating disorders is in the way that our society has constructed and conflated, fat, weight, health and food choices. Due to these blurring of these lines, it not surprising that many clinicians believe that fat women all have eating disorders by nature of their size (Saguy, 2007) This way of thinking is heavily influenced and maintained by the main stream U.S. culture by way of the medical establishment, the government, and the media (Bordo, 1993; CSWD, n.d.; Davis-Coehlo et al., 2000; Hirsch, 2007; Kwan, 2006; NAAFA, n.d; NIH, 2009; Saguy, 2007; WIN, 2007). This makes it more challenging for clinicians because they have to sift through all of these messages when a woman of size enters the room.

Another example of bias manifesting itself in the countertransference was with the participants who felt it was important that their fat female clients lose weight for health reasons, keeping up with societal notions that fat equals unhealthy and thin equals healthy (Davis-Coehlo et al., 2000). This is not to say that some of the fat female clients did not have health issues, as some of these clinicians' clients did. However, the clinicians who had fat women clients with health issues, like diabetes, concluded that their weight was the reason for their circumstances. However, they did not take into account societal issues of prejudice and discrimination. Size phobia – fear of fat – in this society can often result in some fat women avoiding routine doctor visits, out of shame and fear of ridicule brought on by aesthetic societal standards of size. This reluctance to visit the doctor, though understandable given the social climate, can exacerbate minor health issues that may have been preventable (Brownell, 2005; NAAFA, n.d.; Rothblum & Miller, 1988; Schwartz et al., 2003; Yalom, 1989). It also relevant to mention that research has also shown that oppression and structural inequalities can and often does lead to illness due to psychological and emotional stress (Carlson & Chamberlain, 2004; Puhl & Latner, 2007).

What is being pointed out is that some of the participants, regardless, of their fat female clients' issues, offered help and assistance in the area of losing weight when it was not necessarily incumbent upon them to do so. This seemed to be particularly prevalent in the clinicians who were not women of size and did not identify as women of size, but expressed that they had “problems” with their weight currently or in the past, were “overweight” or not “at their ideal weight.” It could be deduced that some of the

clinicians' concerns about their own weight influenced their concern about their fat clients' weight, which lead to microaggressions perpetrated by some of these clinicians.

An unexpected finding was that regardless of race, ethnicity, size and other sociocultural factors almost all of the clinicians had bias or prejudice and some negative countertransference (Betan, et al., 2007) toward women of size. The level to which that bias influenced their countertransference varied but the fact remains that they still exhibited some form of biased values about weight and in turn size. The African American clinicians in this study had differing values around size, and one even admitted to being prejudiced toward women of size, but they all referenced their community in regard to being more accepting of size. This highlights the fact that in U.S. American culture size prejudice and discrimination is the norm as well as a specific type of body aesthetic. The thin body aesthetic has been circulated through the media and other sources of authority (Boero, 2003; Crandall, 1994), over time and has permeated its way into communities that may not have always held these same values.

The devaluing, judgment, shaming and blaming of fat women was prevalent in the findings to an extent that surprised this researcher. Some participants felt very strongly about fat women's bodies and how much physical space they took up. These negative countertransferential feelings were palpable in the room and were useful in understanding some of the anger and hostility projected in response to a general feeling of fear of fat (Javier & Herron, 2002).

Participant 5, in particular had some extremely strong negative feelings about fat women's bodies and her responses were heavily associated with the concept of fat women's bodies as deviant from the norm (Puhl & Latner, 2007; Triplett, 2007). This

participant's comments harkens to Laura Triplett's study of college age students' harsh, critical and blaming responses to the question of, "Under what conditions is female fatness acceptable?" (Triplett, 2007). This particular clinician's response echoed these students' strong feelings that fat bodies are essentially not acceptable. Her notion that her fat female clients' problems all stem from them being fat and that if they lost weight the rest of their problems would melt away is false and could be harmful to her clients who are women of size. Her heavily charged reactions to fat women's bodies in general took this researcher aback and begs the question how many more clinicians out there feel the same way she does? Perhaps she and Irvin Yalom were the only two clinicians brave enough to say exactly what they feel regardless of the blatant bigotry associated with their comments (Yalom, 1989).

When these kinds of strong negative reactions, to fat women, occur in clinicians' lives outside of the therapeutic setting there is nothing to stop these same feelings from occurring within the therapeutic setting and entering into the countertransference. This researcher believes that for clinicians, there is a thin line between what happens inside of therapy and what happens outside of therapy. Therefore, it is highly unlikely that clinicians can turn off their biases and prejudices just because they have put their clinicians' hat on. When it comes to working with fat women clinicians must take that into account their feelings and values outside of the office when they enter into a therapeutic contract with these women. If they don't these hidden feelings can play out in the form of microaggressions (Constantine, 2007; Sue et al. 2007).

Microaggressions

Derald Wing Sue and colleagues (2007) define microaggressions as, “brief and commonplace daily, verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative, racial slights and insults toward people of color” (p. 271). Though more research is needed it can be deduced that women of size experience size bias in the form of microaggressions, from people in helping professions such as mental health clinicians (Constantine, 2007; NAAFA, 2009; Schwartz, et al., Sue et al., 2007; 2003; Yalom, 1989). Some of the clinicians in this study unknowingly committed microaggressions with their fat female clients.

For example, participant 12, along with her therapy group may have committed a collective microaggression when she and the group told the fat woman in her story, “that is not who you are, that’s just a container” and then insisted that the person who said something mean to her was a “jerk”. Though, on the surface, this type of intervention seems like it might be comforting, it could potentially be invalidating to this fat woman. The ways in which it can be invalidating are two fold. One, the fact that they reduced this fat woman’s body to “just a container” could have invalidated her experience (Sue, et al., 2007), as someone who, regardless of how she feels about herself, is experienced by society as deviant; based on cultural body aesthetics. Two, they may have also invalidated her experience by unintentionally conveying to her that this was an isolated incident, when they said the man who called her a name was a “jerk.” The way this invalidation can happen is that when microaggressions occur, the experience is often one of many which suggests that society, not an individual has a problem. Granted the

clinician was in a group clinical setting where the focus was on a completely different topic so there was not much time to process it fully. However the concept of microaggressions in the forms of invalidations (Sue et al., 2007) can certainly be useful when the desire of a clinician is to respond in an empathic way.

Another example of a microaggression was when participant 7 reported that she suggests to her fat female clients that they should lose weight and begins to site all of the medical data associated with fatness in her sessions with women of size, this is also considered a microaggression in the form of an insult, due to the level of rudeness and insensitivity conveyed in those unintentionally hurtful remarks (Sue, et al. 2007). Lastly, participant 9 noticed her microaggression, within the interview, without having known the terminology for it, and stated it clearly when she said that her choosing not to notice size is the same as when someone says to her, “I don’t see color.” This is the kind of empathy that can create a strong therapeutic alliance between client and therapist.

These experiences are considered microaggressions because these fat women may experience these kinds of well meaning sometimes, hurtful incidents on a regular basis (Constantine, 2007; Sue, et al., 2007). A woman of size who experiences microaggressions in the therapeutic setting where she feels safe, may experience the effects of it on a deeper level because of the delicate nature of the therapeutic relationship (Constantine, 2007; Downes, 2001; McCardle, 2008; Sue et al., 2007). This kind of interaction, if left unnoticed by the clinician, can lead a woman of size to self-terminate with the clinician who perpetrated the microaggression (Constantine, 2007; Downes, 2001; Sue, et al., 2007). However, if a clinician is aware that she has committed a microaggression she can then attend to it and to her client.

Size Acceptance

Size Acceptance, according to this researcher, is the conscious acceptance of ones body size and shape despite the society's cultural standards, values and norms of beauty. It includes loving ones body no matter what size it is and still taking care of ones body and staying active by doing what the body needs and what the person loves to do, without the obsessive compulsion to literally lose pounds and without the component of self loathing and body hatred. This is acceptance with an overarching theme of self-love. Size-positive language is that which by virtue of its content is accepting of all the various sizes and shapes of people rather than pathologizing, blaming or othering people because of their size (Rothblum & Miller, 1988; Saguy, 2007; Triplett, 2007; Ulrich, 2003).

Size acceptance was a theme that showed up among a small number of the participants. Content included positive images and feelings that come up around women of size such as “nurturing” and “comfort”, as goddesses, “honoring the beauty in all shapes and sizes” letting the client decide what her “normal” is; the importance of letting the client tell you what they need rather than focusing on their weight, if the client does not see it as an issue; and the importance of not shaming women of size or any woman (Downes, 2001; McCardle, 2008).

Some of the positive images of fat women as goddesses and nurturers can become stereotypes and could be problematic for some fat women. This labeling can perhaps serve to put some fat women in a box that they do not feel they belong, as every person has different personalities and not everyone is nurturing. It was however a more positive association with fat women than the common devaluing, harsh judgments, blaming and shaming of fat women that some of the other therapists exhibited which is indicative of

the larger society. However it should be noted that at the same time these positive images occur for some clinicians it is still possible, even likely, for them to have negative value judgments toward women of size.

The notion of “honoring all shapes and sizes” that one participant had, is more aligned with size-positive sentiments and can be used therapeutically with fat female clients in the countertransference (Body Positive, 1999; CSWD, n.d.; Healthy Weight Network; 2009; International Size Acceptance Association, n.d.; Kwan, 2006, NAAFA, 2009; National Organization for Lesbians of Size website, 2007; The Fat Experience Project, 2008). If clinicians were able to adopt some of the values of the size-positive movement, then perhaps it would assist them when working with fat women in the therapeutic setting. With all of the conflicting messages in the media about weight and health it is no wonder some clinicians are confused when a woman of size enters their office (Boero, 2003; Rothblum, 1999). Clinicians could perhaps keep these size-positive values in mind when they feel the urge to suggest that a woman of size lose weight or when they are working with fat female clients who do present with weight concerns.

The Size Acceptance Movement and Social Work Practice

Size acceptance organizations’ primary focus is to change societal attitudes about fat individuals and to dispel the myths and misinformation about weight, obesity, size and the relationship of fat to bad health (CSWD, n.d.; HWN, 2009; NAAFA, 2009). Their message is essentially, to “love your body the way it is now” and to focus on health instead of weight (Hayes, 1995, HWN, 2009, NAAFA, 2009, CSWD 2009).

According to Bill Weitze, a member of NAAFA since 1989, one of NAAFA’s main tenets is,

‘Fat is not a four-letter word’. It is an adjective, like short, tall, thin, or blonde. While society has given it a derogatory meaning, we find that identifying ourselves as ‘fat’ is an important step in casting off the shame we have been taught to feel about our bodies. (Weitz, 2006)

The movement has had an increase in focus on fat men’s and fat, as well as fat transgender people, as the medical community and the media has been bringing these concerns to the forefront more lately, and society has shifted to look more negatively upon all fat bodies (Carter, 2008; NoLose, 2007; Puhl, 2007). There are now organizations within the movement that specifically focuses on children, for instance, Bodypositve.com (1999) is specifically related to raising awareness and combating the negative effects of fat phobia on children.

Since NAAFA began, many other size-positive organizations have blossomed. Some fat activist organizations include, the Council on Size and Weight Discrimination (CSWD), the Healthy Weight Network (HWN), The International Size Acceptance Association (ISAA), National Organization for Lesbians of Size (NoLose) and so on. (CSWD, n.d.; HWN, 2009; ISAA, 2009; NoLose, 2007). There has been a rise in organizations, literature and initiatives to end size discrimination and promote size acceptance. These organizations can provide helpful resources to social workers and their clients of size. Though the work that these organizations do is not highlighted in the mainstream media, they have made some recent headway. One of the size acceptance movement’s accomplishments is that the state of Michigan has added weight and height to their anti-discrimination policies, in employment, public schools, and state colleges and universities (CSWD, n.d.; NAAFA, 2009.). The CSWD, other fat-activist organizations, as well as scholars and researchers, are still working toward making this

type of anti-fat discrimination legislation a federal law (CSWD, n.d.; Gee, Ro, Gavin, & Takeuchi, 2008; NAAFA, 2009).

The size acceptance movement and HAES organizations and scholars have been working toward ending size discrimination and debunking the myths about weight and health. These organizations value and appreciate people of size for their difference and seek to create social change, in similar ways that members of other oppressed and stigmatized groups appreciate and value their differences and seek social change.

Psychotherapists are not immune from bias and often are taught to avoid moral judgments when working with clients. This is particularly true for social workers. Although awareness of biases is something that is taught in social work training and most clinicians attempt to do this, there are still subtle ways in which bias against fat women can play itself out in therapy, particularly because size is often left out of the conversations about difference. Robinson and Bacon (1996) agree when they state that, “psychologists are not exempt from these societal trends; researchers have documented the presence of fat phobia among mental health professionals” (p. 175). For instance, “psychologists frequently recommend dieting to their fat patients because of their assumption that the major cause of obesity is overeating.” (Robinson & Bacon, 1996, p. 175)

Women’s Size Acceptance and Social Activism

McKinley (2004) noted that there are different types of body acceptance depending on the individual and their worldview. McKinley’s (2004) research on fat women and size acceptance shows that there was a difference between the women in the survey who accepted their bodies but thought it would look better if they changed them,

and the women in the survey who accepted their bodies while advocating for social change around “cultural attitudes toward” body size (McKinley, 2004, p.214). In Nita McKinley’s (2004) study on fat women who endorse fat acceptance, the research data indicated the following:

The data suggest women can and do re-sist negative prescriptions for their body experience. These data also suggest working for social change, rather than personal acceptance only, may improve body experience and psychological well-being. This is consistent with feminist arguments that activism is a more effective means to improving women’s lives than simply working on personal acceptance (p. 218).

According to McKinley (2004) people of size and allies who belong to social justice groups such as NAAFA, ISAA, and CSWD, are most likely to be more accepting of their bodies than those who may not have access to or have ever heard of fat acceptance. It is therefore vital to the mental health field, particularly clinical social workers, due to their commitment to social justice, that clinicians be made aware that some women of size have this belief system. Also, if clinicians can be more positive and open to the various factors associated with wellness and health and recognize that size is not necessarily a determinant of health then they can begin to make different connections with their fat female clients in a more informed way. In addition to this it would be helpful for clinicians to be aware of the fact that not all women of size desire to be thinner or to lose weight, not out of denial, but out of a conscious choice to be healthy and fat rather than unhealthily thin.

Strengths and Limitations

This study was about the nature and tone and quality of countertransference in clinicians working with women of size. There was a lack of generalizability due to the

small sample size of 12 participants. Also, some participants may have been excluded due to the nature of the snowball sampling employed in recruiting. However, the diversity of my sample is quite remarkable and yields rich data with multiple perspectives, as it crossed multiple identity dimensions of the clinicians from race to gender. The questions presented in this study needed to be explored, at this qualitative level, due to the intimate nature of the interviews. In many respects these interviews replicated certain aspects of the clinical process. It was possible to press people to find out what elements of countertransference were taking place especially the specific tone of the countertransferences.

A strength and possible limitation of this study is that I am a woman of size who ascribes to size-positive values. Although this may be viewed, by some, as a limitation, I believe that due to my subject position as person who experiences multiple oppressions - as I also belong two other groups that have been historically oppressed - I am more attuned to issues of microaggressions. I am able to detect and have a greater sensitivity to the issues and concerns clinically at hand. This sensitivity and level of awareness was used to guide this research. Though the possible limitation of this is that clinicians may in an attempt to give responses that were more socially desirable did sometimes seek my approval by asking me questions like, "Is that bad?" or "Am I kidding myself?" Though this may have limited some clinicians, to an extent, it did not inhibit others and I was able to pick up rich material with regard to all of the participants' countertransference with women of size. When clinicians stuttered and stumbled over their words and had a difficult time managing some of their responses, I was able to notice that as a symptom of bias on one hand; and on the other hand I was also able to hold that due to the fact that fat

has not been talked about in this way, clinicians may have been thinking about and discussing the concept of fat and countertransference for the first time.

The rich data in the findings illustrates the need for further qualitative and quantitative research with larger sample sizes of clinicians, in order to further address clinicians' countertransference. This study only skimmed the surface of the multiple ways in which size can be analyzed. However since the focus of this study was on clinicians' countertransference with women of size, the following areas were not addressed: 1) The ways that race, class, gender, age, culture, sexual orientation, disability status and size may intersect. It is important to study how multiple oppressions can compound the ways that women of size are received and treated by others and the ways in which fat women move through the world. 2) Another important area that was only briefly addressed and deserves to be researched further is how a fat woman's level of size acceptance can affect the way she utilizes therapy. If a woman of size has made a conscious choice to accept her size and be positive about her size she may have different beliefs and values from a woman of size who has not consciously chosen to accept her size or was not aware that size-acceptance was an option.

Clinical Implications and Recommendations

This researcher recommends that size acceptance or a size-positive approach might be a useful way to mitigate countertransference. There are three ways that size acceptance can be utilized clinically: 1) one way, is by preventing negative countertransference. If clinicians utilize a size-positive approach and they begin to take on more size-positive values, their perceptions of women of size have the potential to change. This can lead to a stronger therapeutic alliance with more respectful and

empathic undertones. The countertransference, then, could become more conscious and can at least be addressed in more positive and productive ways. This can be transformative for both the clinician and the client as this approach can be more respectful and empathic to the client who is a woman of size; 2) A size-positive approach can also be used to mediate against negative affect and defenses. While having a size-positive approach may not change negative affect that clinicians feel, clinicians can begin to restructure their thinking around the negative feelings they experience. For instance, instead of feeling shame or guilt about negative feelings of anger and fear, the clinician can consciously work through the feelings while keeping in the back of their mind the social construction of fat, and the ways in which fat women have been discriminated against in our culture. They can begin to think about how the construction of fat has played out in their own lives and perhaps be able to talk about this in supervision or with peers. If clinicians' belief systems around fat change, the negative affect has the potential to decrease in intensity and lessen over time. Consequently, clinicians can begin to validate the experiences of women of size without unintentionally insulting them or shutting them down; 3) Clinicians can begin to see size as a socio-cultural issue and concern. Fat, usually highlighted in the form of weight and health, is socially constructed along the same lines as race, gender, disability, age, class and other constructions of difference. If clinicians begin to see that size is something that can also be looked at through a sociocultural lens, then that means there is a way to become more culturally competent about it and begin to incorporate it into the therapeutic session in a way that is respectful. Clinicians can begin to seek out the tools they need to deconstruct these societal notions of fat as "bad", which means that they can move from feelings of

confusion and helplessness to feelings of competence and hopefulness when working with fat women. So, from a social justice standpoint clinicians could take a more active role by researching and reviewing articles and websites focused on size-positive social change. Also with this information, clinicians and future clinicians' can demand more from educational institutions and mental health conferences that size and fat be included in the discussion within the context of difference and sociocultural concerns.

Summary

It is incumbent upon clinicians to do the research and become aware of societal assumptions and misconceptions about fat people and the role that these social factors might play in some of the mental health concerns of women of size. Discrimination and prejudice are likely to effect levels of self-esteem, body satisfaction, and social interactions in some women of size and could inhibit clients from working on issues unrelated to their size (Robinson & Bacon 1996). It is particularly harmful if clinicians immediately believe that size, eating, or inactivity are the main problems of every fat woman. It is also important for clinicians to realize that some of their fat clients may never have an issue with their weight, eating habits, exercise habits, their health or low self-esteem related to their body. Although, these may be the concerns of some fat women, due to the fat phobic sociocultural milieu that clinicians and clients live, these may not be the concerns of all women of size.

It must be stressed how important it is for clinicians to manage their countertransference in a way that will be respectful of women of size who come in for therapy. If clinicians choose to consciously be aware of the size-phobic society in which we all live, they can begin to untangle the myths and realities of size, weight and health,

which can reduce some of the negative affect and countertransference responses toward fat women. Clinicians can then, begin to truly honor the diversity of sizes among all bodies, while promoting change and acceptance in a culture that seeks to undermine fat female bodies and female bodies in general. This stands to benefit clinicians when they are out in the world and facing fat women in public as well as when a woman of size enters their office space. Sizism must be addressed in both personal and professional settings, in public and private arenas, in order for real change to occur.

Ultimately, mental health clinicians typically desire to support their clients and facilitate their healing in a way that is nonjudgmental and therapeutic. That can be challenging with all of the often harmful and judgmental messages clinicians and clients receive from society on a daily basis. As clinicians' become more socially conscious about the issues facing women of size, including the intersections of oppressions, a size-positive approach can effectively be a healing way for clinicians to be more thoughtful, intentional and expansive. This can be a powerful way for clinicians to begin the process of liberating themselves and their fat female clients from these social binds.

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APPENDIX A

Recruitment Letter

January 26, 2009

Dear Prospective Participant,

Hello, my name is Maisha Najuma Aza and I am a graduate student at the Smith College School for Social Work. I am conducting a study on clinicians' potential countertransference responses to their clients who are women of size. I am currently looking for mental health clinicians to interview. The interview will take between 45-60 minutes.

In order to participate in this study the following criteria must be met:

- You must be a licensed clinician currently in direct practice in the mental health field.
- You must have a Master's level degree or higher.
- You must have a minimum of one year of direct practice experience.
- You must speak English in order to participate in this study.
- You must practice psychotherapy in the state of Georgia, as I am conducting in person, individual interviews.
- You must currently have at least one client who is a woman of size or have had a client who is a woman of size in the past.

I am conducting a research project designed to explore clinicians' experiences with their clients who are women of size. I will be asking clinicians' about their current values and beliefs about weight and size, as well as any potential countertransference issues and concerns that may be related to women of size. Additionally, I will ask that each participant provide demographic information about her or himself for this study.

With your consent, I will be audio recording the interview and then transcribing it myself with the help of two volunteers. The names and identifying information of each participant will be held in confidence and the volunteers will have signed a confidentiality agreement. I will label all interview notes and audio recordings with coded numbers instead of real names.

Upon request, I will be happy to send you a finalized copy of the summary of my findings. In addition, if you are able to suggest other eligible colleagues that I might interview I would appreciate it. If you are interested in participating in this study, please contact me at maza@smith.edu.

Thank you for your time and I look forward to hearing from you.

Sincerely,

Maisha Najuma Aza, MSW Student
Smith College School for Social Work

APPENDIX B

Demographic Questionnaire:

Age: _____

Gender/Gender Identification: _____

Race: _____

Ethnicity: _____

Sexual Orientation: _____

Ability status: _____

Height: _____

Weight: _____

Degree: _____

Licensing credentials: _____

Length of time in practice: _____

State in which you are licensed to practice: _____

APPENDIX C

Informed Consent

Dear Research Participant,

My name is Maisha Najuma Aza and I am a graduate student at the Smith College School for Social Work. I am conducting a research project designed to explore clinicians' experiences with their clients who are women of size. This exploratory study will investigate the lessons learned by experienced clinicians, in the mental health field, who might be a witness to the effects that discrimination and bias may have on women of size. It will also investigate clinicians' current values and beliefs about weight and size and any countertransference issues and concerns related to women of size. You have been asked to participate in this study because, as an experienced clinician you have working knowledge of countertransference and bias and how it may effect the therapeutic relationship. This study will be presented as a thesis, and is being conducted in partial fulfillment of the Master's of Social Work degree at Smith College School for Social Work, and may be used in possible future presentation or publication on the topic.

As a participant, it is understood that you are a mental health clinician, currently licensed to practice in the state of Georgia. You have at least 1 year of direct practice experience and have a Master's level degree or higher, in a mental health profession. In addition, you must have worked with a minimum of one woman of size currently or in the past. If you choose to participate, I will ask you to sit for a recorded, individual interview that will last approximately 45-60 minutes. Prior to the interview you will be asked to fill out a brief demographic questionnaire. The interview itself will consist of semi-structured questions focusing on the experience, skills, and strategies you use when faced with countertransference. I will travel to your job site to conduct the interview or will meet you at some other mutually agreed-upon location that is private, relatively quiet, and convenient for you.

Participation in this study may trigger strong personal feelings or some degree of discomfort related to a sometimes controversial and socially uncomfortable topic such as personal feelings about weight and size. This could bring up feelings about your own weight and size or reveal new information that you may not have known about your values and beliefs around size. You may have to divulge personal feelings and beliefs that may not be in accordance with the values of the researcher's and you may therefore feel exposed and vulnerable. If you are a person of size, your own previous experiences of discrimination or bias may surface.

If you would like more information on the subject matter, I will provide a list of references at the end of the interview.

While there will be no financial benefit for taking part in the study, participation will allow you to share your knowledge and experience of the therapeutic dyad and working through countertransference. Your contributions will provide important information that may be helpful in furthering the knowledge of countertransference with women of size, in both the professional and educational spheres. While there is a chance you may not receive any personal gains from participation, it is hoped that the benefits of participation include gaining a new perspective on working with clients who are women of size. You will be able to share your personal and professional opinion and add to the research of a relatively new area of exploration in the mental health field.

Your confidentiality will be protected in a number of ways. The demographic questionnaire and the audio recording of the interview will be assigned a number for identification. You will not be asked to identify your name while the recorder is running, and you will be asked not to include any identifying information in any examples of case material you may provide. Some illustrative quotes will be used in the thesis, but will be reported without identifying information and disguised if necessary. I will be the primary handler of all data including recordings and any transcripts created.

My research advisor will have access to the data collected, only after any identifying information has been removed, and may assist in the analysis of the data. In addition, any person assisting in transcription will be required to sign a confidentiality agreement. I will keep the demographic questionnaires, electronic password protected recordings, transcripts, and other data in a locked and secure environment for three years following the completion of the research, consistent with Federal regulations. After that time, all material will be kept secured or destroyed unless I am still using it for publication, in which case it will be destroyed when no longer needed.

As a voluntary participant, you have the right to withdraw from the study at any time up until April 15, 2009. If you choose to withdraw from the study all materials related to your participation will be immediately destroyed. You also have the right to decline to answer any question and if you wish, you may end the interview at any time.

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

Signature of Participant

Date

Signature of Researcher

Date

Thank you for participating in this study. If you have any questions, concerns or complaints please contact:

The researcher, Maisha Najuma Aza at maza@smith.edu or the chair of the Human Subjects Review Committee, Dr. Ann Hartmann, at (413) 585-7974.

Please keep a copy of this consent form for your records.

APPENDIX D

Human Subjects Review Approval

January 24, 2009

Dear Maisha,

Your amended materials have been reviewed. You have done an excellent job in clarifying your purpose and in the further development of your research. Your title is great and you have done a very creative job in the enhancement of your questionnaire. I'm glad that you found our suggestions useful. We are happy to give final approval to your study.

Please note the following requirements:

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

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

In addition, these requirements may also be applicable:

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

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

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

Good luck with your project. In thinking about this topic, I know one of the ways I would react as a therapist to the clients you describe is with concern about the health issues, heart disease, diabetes, etc. It will be interesting to see if this comes up.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Stefanie Speanburg, Research Advisor

APPENDIX E

Interview Guide

1. What is your academic background?
2. What population do you generally work with?
3. How many of them are women of Size current or Past.

Please read this excerpt from Yalom's story entitled "Fat Lady", from his book Love's Executioner:

The day Betty entered my office, the instant I saw her steering her ponderous two-hundred-fifty-pound, five-foot-two-inch frame toward my trim, high-tech office chair, I knew that a great trial of countertransference was in store for me. I have always been repelled by fat women. I find them disgusting... How dare they impose that body on the rest of us? The origins of these sorry feelings? I had never thought to inquire... So deep do they run that I never considered them prejudice... Of course, I am not alone in my bias. Cultural reinforcement is everywhere. Who ever has a kind word for the fat lady? But my contempt surpasses all cultural norms. Early in my career, I worked in a maximum security prison where the *least* heinous offense committed by any of my patients was a simple, single murder. Yet I had little difficulty accepting those patients, attempting to understand them, and finding ways to be supportive. But when I see a fat lady eat, I move down a couple of rungs on the ladder of human understanding. I want to tear the food away. To push her face into the ice cream. 'Stop stuffing yourself! Haven't you had enough, for Chrissakes?' I'd like to wire her jaws Shut! (Yalom, 1989 p.93-95)

4. What kind of feelings does the above excerpt illicit in you?
5. If you were Yalom's clinical supervisor what would you say to him?
6. What are some things Yalom says, in this excerpt, that you found you agree with or disagree with?
7. If you were in this same situation as Yalom with these same feelings, what are some ways you might deal with your own countertransference?
8. What is your level of comfort in working with women of size? Please share an experience that may have been either easy, challenging, or both, for you when working with these women.
9. Has anyone who has come to you that you feel was extremely overweight brought up their weight or health as a concern?
10. Have you ever brought up their health or weight to them if they didn't bring it up?
11. What kinds of challenges did or do they face in their lives? How did or do their challenges affect your treatment plan, goals and interventions?

12. Have you ever worked with any woman of size who has considered themselves to be accepting of their size? If so what seemed to be different from them versus your other clients who are women of size?

13. When in a session with a client who is a woman of size how might you identify any possible countertransferential responses (both positive and/or negative)?

14. Please share any positive or negative countertransference issues you may have had in the past when working with women of size. How do you think this might have affected your treatment goals and interventions then, and what would you do differently now?

APPENDIX F

Working Definitions for Participants

Women of size - include women who have been labeled medically obese, morbidly obese or overweight according to the BMI scale, developed by the NIH, which calculates one's body mass index based on a person's weight and height. Although clinicians may not be aware of each client's BMI, there may be visual, subjective cues and cultural perceptions that lead clinicians to believe a woman is of substantial size and might be considered overweight, obese or morbidly obese. Another way a clinician might determine a woman of size is if the client discloses her weight status, is discriminated against because of her size, and/or has difficulty accessing certain public facilities and structures based on her size.

Fat – a term that many women of size have reclaimed. Fat is used as a descriptive term rather than as a pejorative term by some, although it may still be used, by others, in a derogatory way.

BMI Scale - the body mass index (BMI) scale is the most popular way to determine if someone has too much body fat and is overweight or obese. (see Appendix G) A BMI of 18.5 to 24.9 is considered healthy. A person with a BMI of 25 to 29.9 is considered overweight, and a person with a BMI of 30 or more is considered obese (retrieved from Weight Information Network website 2008 <http://win.niddk.nih.gov/statistics/>). This is from a medical perspective.

Bias - prejudice in favor of or against one person or group compared with another, usually in a way considered to be unfair, especially when the tendency interferes with the ability to be “impartial, unprejudiced, or objective.” (Merriam Webster online 2008)

Countertransference - The patient's influence on the clinicians unconscious feelings which can interfere with treatment. (Freud, S. 1910) Clinician's reactions to the patient (conscious and unconscious, emotional and cognitive, intrapsychic and behavioral) may have diagnostic and therapeutic relevance and can, if properly used, facilitate rather than inhibit treatment (Betan, E. et al 2005).

APPENDIX G

Resource List for Participants

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Sue, D.W., Capodilupo, C.M. & Torino, G.C., et al. (2007) Racial Microaggressions in everyday life: Implications for clinical practice. *American Psychologist*. 56(4) 271-286.

Triplett, Laura. "The blame game: A first glimpse at the socially acceptable causes of female Fatness." Paper presented at the annual meeting of the International Communication Association, TBA, San Francisco, CA, May 23, 2007 Online PDF. 2008-09-13 http://www.allacademic.com/meta/p172822_index.html

Weight Discrimination. Retrieved August 13, 2008, from the Council on Size and Weight Discrimination (CSWD) website. <http://www.cswd.org/docs/discrimination.html>

Yalom, I. D. (1989) *Love's Execution and Other Tales of Psychotherapy*. Perennial Classics. New York, NY.

APPENDIX H

Volunteer Confidentiality Agreements


Volunteer Transcriber's Assurance of Research Confidentiality


This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

- All volunteer transcribers for this project shall sign this assurance of confidentiality.
- A volunteer transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.
- The researcher for this project, *Maisha Najuma Aza*, shall be responsible for ensuring that all volunteer transcribers handling data are instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines .

PLEDGE

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, *Maisha Najuma Aza*, for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

 Signature

3-22-09 Date
 *Maisha Najuma Aza*

3/22/09 Date

Volunteer Transcriber's Assurance of Research Confidentiality

This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

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_____Wendie Peterson_____	Name
_____ <i>Wendie Peterson</i> _____	Signature
_____ June 23, 2009 _____	Date
_____ <i>Maisha Aza</i> _____	<i>Maisha Najuma Aza</i>
_____ 6/23/09 _____	Date