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Lauren Polly Hanson
Do you see what I see?
Making the invisible visible
through an exploration of the
intersubjective experience of
social work clinicians
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ABSTRACT

This qualitative study was designed with flexible research methods to explore experiences of clinical social workers in sitting with and developing relationships with fat clients. Using an intersubjective theoretical lens, this research investigates clinicians' countertransference or beliefs about fatness in the relationship building process with fat clients. An analysis of the literature revealed multiple meanings for fat, complex dynamics in therapeutic relationships and potential parallels between some racial oppressions and fat oppression using the concept of visible difference.

This exploratory study presents findings based on nine semi-structured interviews with clinical social workers who see fat clients. Participants were asked about their relationship to their own bodies, their countertransference experiences with their fat clients and about the relationship building process with their fat clients.

Findings show that clinicians do harbor biases and judgments about fat clients. This research points to the fact that social work clinicians may benefit from more cultural competence training around their work with fat clients. Other findings include a clearer understanding of how bodies—both clinicians' and fat clients'—enter and occupy the therapeutic space; as well as a greater awareness of the role that terminology and language around size plays within relationship building between client and clinician. Through increased attention to bodies in the room, attending to language that we use

around fatness and acknowledging bias and judgments leveled against fat people, the hope is that the profession can bring size oppression out of the shadows, where it has been rendered invisible, and make it visible.

DO YOU SEE WHAT I SEE? MAKING THE INVISIBLE VISIBLE THROUGH AN
EXPLORATION OF THE INTERSUBJECTIVE EXPERIENCE OF SOCIAL WORK
CLINICIANS WORKING WITH FAT CLIENTS

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

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2009

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CHAPTER 1

INTRODUCTION

Over the past decade there has been increased media, political and medical attention given to a reportedly growing number of children and adults who are labeled overweight or obese. There is much controversy over multiple aspects of “America's expanding waistline” (Boero, 2007). Doctors, scientists, politicians, journalists, lawyers, advertisers, and mental health professionals disagree on what or who is to blame, what solutions are most effective, whether this is even is a problem and whether the statistics pointing to increases in weight are accurate. Conflicting research and opinions abound; yet what is promulgated through mainstream media is generally portrayed as a public health epidemic.

At an obesity summit in 2004 sponsored by Time magazine, ABC news and the Robert Wood Johnson Foundation, a gathering of government officials and diet, nutrition and health advocates, U.S. Surgeon General Richard Carmona took the stage and declared that

As we look to the future and where childhood obesity will be in 20 years ... it is every bit as threatening to us as is the terrorist threat we face today. It is the threat from within (Wallis, 2004).

An informal search using the Google search engine elicited 35,000 hits for the phrase “war on obesity.” The burgeoning use of this phrase may point to the presence of a cultural understanding of fatness as problematic. From blogs to news articles to the

government-run National Institutes of Health investing \$1.2 billion into a strategy to combat obesity, the threatening enemy, battles are being waged on fatness (Boero, 2007).

With such strong language and powerful images yet still so many unanswered questions and so much confusion over this issue, what is the role of the social work clinician? What does this cultural phenomenon mean for the profession of social work? What kind of effect does this war-like relationship to fat have on our fat clients and on our work with fat clients? How, if at all, is the therapeutic work different from our work with non-fat clients? Questions such as these are the underpinning and inspiration for this research. So much attention is given to the issues of fatness, overweight and obesity in our everyday existence yet, significantly, very little attention is given to the subject in social work training, practice and research.

As clinicians who practice from a 'person in environment' perspective, social workers must consider the impact that this cultural phenomenon of the 'obesity epidemic' may be having on our clients. The language of the National Association of Social Worker's code of ethics indicates that social workers should understand culture and its function in human behavior and society (NASW, 2006). This research project was designed to give voice to the dilemmas or issues that clinicians may face when they are working with their fat clients. Beyond this, the research explores the ways in which social work clinicians experience fatness and how this plays out in the therapy relationship.

As a point of clarification, I use the word 'fat' as a descriptive term as opposed to 'overweight' or 'obese,' as these words imply abnormality and aberration. The terms implicitly assume size exceeding the "ideal" weight and point to a pathological perspective. The notion that we can make assumptions based on how someone looks is a

prejudice. Therefore for the purposes of this paper, the word fat has been stripped of its negative and pejorative attributions and is meant to be a descriptor devoid of judgment.

This qualitative thesis addresses the gap in the research around clinicians work with fat clients. The project endeavors to explore the experience of social work clinicians sitting with fat clients. Using semi-structured interviews with nine participants, narrative data was collected. The research investigates the therapeutic interaction between clinicians and their fat clients. This work is predicated on an intersubjective theoretical frame. This 'third-space' conceptualization of therapeutic work helps to reveal the role of a clinician's countertransference or beliefs about fatness in the relationship building process with fat clients.

The findings from this research can be used to improve social work practice with fat clients. Social work clinicians may gain more cultural competence about the issues that face fat clients. Another potential benefit to social work clinicians might be that this work can inspire self-reflection around a clinician's relationship to their own body and beliefs or possible prejudices about fat people. This project will hopefully contribute to laying a foundation upon which to develop further social work research on fat oppression, building and maintaining relationships with fat clients and the effect of a clinician's relationship to their own body on the therapeutic relationship. Lastly, the findings from this research point up the need to add fatness and body size to conversations we have within training programs and as part of the curriculums within social work education environments.

CHAPTER II

LITERATURE REVIEW

Literature on clinical social workers and their work with fat clients is hard to come by. There has been some research in other fields such as psychology, medicine and public health. Specific to social work literature, only one research project – an unpublished social work dissertation completed in 2004 entitled “Fat in the countertransference: Clinical social workers reactions to fat clients” (Dennis, 2004) was found. Dennis interviewed nine psychodynamically oriented clinical social workers and in her data analysis determined that there are “a great number of meanings of the word [fat].” In her findings, she discusses the various categories of meaning that the word 'fat' elicited in conversations with participants. Fat seems to act as a nexus for a number of immensely complicated issues within our culture and, in order to ground my research, I feel it is important to address this complexity. For the purpose of this literature review, I will, in a similar vein as Dennis, explore fat from a multitude of perspectives and identify themes in the literature around the meaning of fat and the various 'ways of seeing fatness'. More specifically, I will explore the extensive ways in which we as a culture perceive, react, think and feel about the fat body and present them on a spectrum from 'pathology' to 'acceptance' or 'celebration.' I also briefly review literature on transference and countertransference in therapeutic relationships and how these inform and affect – if at all – the quality of therapeutic alliance. Lastly, as a means of comparison and contrast to fat and weight stigma and oppression, I will review research on race and racism in the

context of psychodynamic therapy. This will include a look at the role of 'visible otherness' and ways in which race and weight manifest as prejudice based on skin color and body size.

Ways of seeing fatness

Fatness as Pathology or Illness

Within the framework of the medical profession the pathology of fat has been documented copiously. Obesity has been linked to hypertension, coronary heart disease, stroke and diabetes (U.S. Department of Health and Human Services, 2000)¹. In mainstream media, numerous articles and news reports ring the alarm of the obesity epidemic. Reports indicate that rates of obesity are ballooning much like America's waistline (Mokdad, Ford, Bowman, Dietz, Vinicor, Bales & Marks 2001). Some claim an epidemic is upon us and fatness is poised to take over tobacco use as the leading cause for preventable death in America (Mokdad, Marks, Stroup & Gerberding, 2004). Others predict an overall decline in U.S. life expectancy as a result of obesity (Olshansky, Passaro, Hershow, Layden, Carnes, Brody, Hayflick, Butler, Allison & Ludwig, 2005). Inherent in this research is the assumption that weight-loss will help ameliorate negative health implications of obesity.

Within the research community there is question as to the research methods used to determine these dire numbers. A 2004 study in the *American journal of public health* indicated that previous research had not adequately adjusted for confounding factors.

¹ Some researchers would argue that this link is exaggerated and that the focus should be eating healthy foods and exercise – not weight (Gaesser, 2002, Ernsberger & Haskew, 1986).

Researchers found the number of deaths correlated to obesity to be about one third (~100,000) the number previously reported (~300,000) (Flegal, Williamson, Pamuk & Rosenberg, 2004). Beyond this, some argue that the stress related to weight stigmatization could also be a culprit for the rise in illnesses such as hypertension, coronary heart disease, stroke and diabetes – all medical problems exacerbated by stress (Muennig, Jia, Lee & Lubetkin, 2008).

Anne Marie Jutel conducted a content analysis of all articles contained in the Pub Med database since its inception. Themes and patterns emerged around references to the term ‘overweight.’ A shift was observed in the connotation of the term ‘overweight’ from a sign or a symptom to being a disease entity (Jutel, 2006). More recently there has been an upsurge in medical ‘treatment’ and ‘prevention’ plans for those who are overweight. Terms such as ‘treatment’ and ‘prevention’ evoke images of pathology and disease.

Disability

Related to the medicalized view of fatness and obesity is the idea that fatness is a disability. By redefining the locus of responsibility for fatness from poor lifestyle choices by a fat patient into a medical problem inflicted *on* the patient, we invite further opportunities for interventions and treatments. Fat becomes something to contend with - a liability. Viewed in this light, fatness also represents potential for financial gain by pharmaceutical industries and bariatric surgery centers (Kirkland, 2008). Whenever there is potential for financial gain there is increased publicity, awareness and power behind the ideas.

This idea runs into trouble however when we examine it from a legal perspective. As defined in the court case *EEOC v. Watkins Motor Lines*, legally defining fatness as a

form of disability requires proof of an underlying cause such as a thyroid condition or a genetic condition (Kirkland 2008). Not all fat people have a readily-identifiable, underlying cause for their fatness. Some fat advocates argue that if all fat people had access to disability accommodations such as fat-appropriate seating, or office accommodations their rights would be legitimized. This in turn would diminish the power and privilege that comes with thinness. Thus the trade-off for labeling fatness as disability – which does imply medicalized deficit – is equal access to a previously off-limits environment (Garland-Thomson, 2005).

Morality and Fat

In Merriam-Webster's 2008 online dictionary morality is defined as “of or relating to principles of right and wrong in behavior.” Oftentimes in conversations over meals, we hear people talk about how 'good' they were today when they avoided the doughnuts at a morning meeting or how they 'were bad' and 'gave in' to the 'sinful' chocolate desert at dinner. 'Good,' 'bad,' 'sinful,' these words are laden with morality. The prevailing assumption that fatness is a result of over consumption – especially of 'bad' foods – results in the conclusion that fatness must indicate morally wrong behavior.

Religion and morality often go hand in hand. In the Christian faith, it is believed that those who are fat have a propensity towards gluttonous and slothful behavior; gluttony and sloth are considered one of the seven deadly sins. Based in America's puritanical religious roots, self-denial and discipline continue to be held in high regard. There is a general understanding that those who are fat display the outward appearance of lacking restraint. This fatness can be seen as a something akin to a scarlet 'O' for obesity – inferring a sort of spiritual inferiority. In many religions fasting is a means to purify

both the body and the spirit. Fasting is often associated with loss of weight or a thinner body. If fasting and loss of weight conveys purity, then fatness at the very least indicates less purity (Smith, 2004). As far back as the 12th century, Buddhists were known to stigmatize fatness as a karmic representation of a moral failing (Stunkard, LaFleur & Wadden 1998).

Fatness is often equated with overeating. In this vein, it is interesting to consider the way in which Overeaters Anonymous (OA), a twelve-step program for compulsive eaters presents food addiction. In OA, recovery from the disease of overeating is achieved by turning one's compulsions (eating) over to a higher power. Unlike other diseases however, compulsive eating is "primarily an emotional and spiritual disease" (Lester, 1999). One complication that Lester addresses is how to abstain from food when our bodies need to eat to survive.

Lastly, we see fat and morality coincide when fatness is framed as moral panic. It appears that fat people are getting lost in the panic to fix the obesity problem. The concept of 'moral' fatness carries with it an air of repugnance and disgust, as if obesity is a filthy pestilence or disease that can be eradicated. The following quote from an interview with Michael Fumento, author of "The Fat of the Land: The Obesity Epidemic and How Overweight Americans Can Help Themselves," sounds a distinctly moralizing tone: "When somebody shows prejudice to an obese person, they are showing prejudice toward overeating and what used to be called laziness. It's a helpful and healthful prejudice for society to have" (Lasalandra, 1998). This statement is tantamount to condoning prejudice. The social work profession does not condone prejudice against others based on the color or their skin, their sexual orientation or their religious

preference, to name a few. In fact, social workers are expected to practice activism, extending their practice to address issues of social justice. As the statement above suggests, there are people who sanction prejudicial behavior towards fat people, I would argue that these efforts for social justice work should be extended to people of all sizes. That being said, there is no mention in the code of ethics about how to respond to fatness or people with different body sizes nor is their identifiable discourse in the profession about size discrimination.

Fat as Politics

As our concerns about fatness and public health have become something government would like to manage, the importance of defining fatness and its impact becomes central to legislation and to the creation and implementation of policies. Eric Oliver author of the 2006 book, *Fat Politics*, acknowledges the complexity of fat politics. He speaks to his own process in writing his book. When started his book he assumed that the obesity epidemic was undeniably a concern – especially for our country's health and wellbeing. His original intent for the book was to come up with solutions so that Americans would stop gaining weight. As he dug into the evidence, however, he found that this 'epidemic' and the 'mortal danger' around obesity-related health concerns turned out to be more of a 'politically orchestrated campaign' that profits and prospers on America's growing weight” (Oliver, 2006). Drug companies, scientists, weight-loss programs, bariatric surgeons all stand to gain financially from America's mandate to lose weight.

A congressional bill introduced in 2005 – *The personal responsibility in consumption of food act* – affectionately known as the 'cheeseburger act' was intended to

protect food manufacturers, marketers, distributors, advertisers, sellers, and trade associations from lawsuits claiming injury related to a person's weight gain, obesity, or any health condition associated with weight gain or obesity (GovTrack.us, 2005). This bill was passed in the house but stalled in the senate. At the same time that the federal government is pushing to place the onus of fatness on the individual, many city and state governments are attempting to legislate limits to junk food and sodas in schools. In the end, however, these efforts become mere shadows of their original intent. Schools often depend on contracts with beverage companies to pay for some of their art and physical education programs. Beyond that, there is tremendous push back from lobbyists such as the Grocery Manufacturers Association or the National Soft Drink Association which keep politicians torn as to what and whom they need to protect. Fatness as a political issue points up the various interest groups that have a stake in controlling fatness (Oliver, 2006).

When we talk about obesity as an 'epidemic' it transforms into a public health concern that involves our local, state and federal government. One prominent politician sounding the alarm of obesity is the recent presidential candidate and former Governor of Arkansas, Mike Huckabee. In a campaign for a 'Healthy Arkansas' program, Huckabee used weekly radio announcements to extol the virtues of losing weight, exercising and eating more healthfully. The healthy Arkansas program is primarily about health incentives – giving benefits to those that eat healthy, exercise and also who lose weight. (Healthy Arkansas: For a Better State of Health, n.d.). In 2006, referring to obesity, Huckabee was quoted as saying, "There is no greater issue driving the U.S. economy than this." He notes that obesity's drain on the economy can be attributed to rising medical and

insurance costs and worker absences, among other things (Leibovich, 2006). To Huckabee obesity and fatness need to be addressed to help keep people healthy but he also sees the economic and political benefit to lowering healthcare costs and increasing worker productivity. This has proven to be a potent and persuasive political argument.

Fat as a Feminist Issue

In the introduction to the second edition of “Fat is a Feminist Issue,” Susie Orbach (1990) states that “We need to challenge the idea that women should be a particular size and shape, and that happiness or contentment is contingent on attaining it” (p. xxv). She calls feminists to arms and impels them to stop buying into the magazine advertisements intended only to profit the advertisers. Women are fed imperatives and invectives as to what they should wear, how they should look, and how they should eat.

This sort of feminist activism and defiance against cultural norms and expectations is echoed in works such as “The Beauty Myth” by Naomi Wolf (1990) and “The Obsession” (1981) and “The Hungry Self” (1986) by Kim Chernin. Wolf and Chernin question the underpinning behind these fixed beauty standards and both authors contend that the roots belong in feminism. Wolf argues that fat is seen as “demonic,” “female filth,” “cancerous matter” and “nauseating bulk waste” (p. 192). She points out that these characterizations are not founded in their physical properties but rather in misogyny (p.192). Wolf also posits that as long as women remain concerned about their fatness, they relinquish much of their power in the workplace. The desire for dieting and for 'thinness' - getting rid of fatness – keeps women hungry and weak. Chernin discusses parallels of women's need to 'control' their eating and their bodies and their fatness, much like they are being controlled by the socially-sanctioned obsession with thinness.

These feminists still have a complicated relationship with fat. Orbach struggles with a tension between fat as something undesirable but on the other hand as something comforting. In her chapter on “What is Fat About,” she argues that fat is used to protect from emotion, to ameliorate anxiety about competition and sexuality and to express anger. Finally, Orbach's closing statement of the chapter alludes to the power of fat. She posits that as we access and operate from our intrinsic power as opposed to having our fat act for us (as protector etc.), women can “give up” their fat. Here, even though Orbach encourages women to find their power, she still elevates the normative expectation of thinness.

In Laura Brown's fat oppression and feminist psychotherapy research she has found that much of the fat bias in therapeutic relationships is based in internalized fat oppression experienced by the clinicians themselves (Brown, 1989). For many clinicians the work involved in challenging their own internalized fat oppression is very painful and risky and for many is avoided at all costs. Those clinicians who are scared or uncomfortable thinking about or examining their relationship to their own body may do a disservice to their clients. This blindness around their own body concerns may lead to road blocks for clients who want to work on their own body concerns (Brown, 1989).

Oppressed Persons

Fat occupies a distinctly unprivileged position in our society. Some would claim it is the last form of 'acceptable' prejudice (Stunkard et al., 1998). Discrimination against fat people includes negative stereotypes and attributions such as fat people are unattractive, a-sexual, weak willed and unlikable (Crandall, 1994; Puhl & Brownell, 2001). Very often fat people internalize these prejudices and hold them against themselves as internalized

oppression. In a 1999 study by Myers & Rosen, the authors surveyed two different groups of fat people using an open-ended questionnaire about stigmatizing situations and the participants' coping responses. In one case they surveyed 445 members of the National Association to Advance Fat Acceptance (NAAFA) and found that 98% reported their family and friends teased, criticized or harassed them and 75% reported teasing and harassing on the job. The authors also surveyed 492 readers of Weight Watchers magazine and found that 40% of respondents reported nasty comments about their weight from co-workers. The results also indicated that 25% of respondents were self-employed to avoid these denigrating situations (Myers & Rosen, 1999). Evidenced in this study, fat people's lives, relationships, jobs and well being are compromised based on the size of their body. This stigma and discrimination leads to oppression.

Fat as Identity, Acceptable and Celebrated

Fat acceptance began back in the late 1960s with the founding of the National Association to Aid Fat American later renamed the National Association to Advance Fat Acceptance (National Association to Advance Fat Acceptance, n.d; Fishman, 1998). About three years after the founding of NAAFA, a radical activist group – the Fat Underground - separated from NAAFA and took the movement in a more extreme direction. The fat acceptance movement is founded on the notion of fat pride, advocacy for fat rights, public education and support. A very large number of blogs online openly, vociferously and actively beg to disagree with anti-fat sentiment (Rabin, 2008). The fat acceptance social movement is gaining notoriety as academicians, authors and activists ask the public to rethink the war on obesity –including our definition of healthy. “Fat-

acceptance activists insist you can't assume someone is unhealthy just because he's fat, any more than you can assume someone is healthy just because he's slim” (Henig, 2008).

Historically, fat identity has been viewed as deviant or even spoiled (LeBesco, 2004). Often fatness will take on a master status identity - that is some status that supersedes all other identifications that might be made by outside observers. Because fatness is obvious, it trumps other identifying signifiers (Becker, 1963). If fatness is chosen for them by outside observers as their primary identity, this strips a fat person of the choice as to how he or she might define his or her primary identity. This kind of identity attribution to fat people has strong implications around oppression. At the same time the emergence of fat as a self-determined identity allows for acceptance, pride or even celebration around people's fat size identity.

In her writing, Kathleen LeBesco (2004), a feminist researcher with specific interests in queer theory, social constructionism and the body, argues that as fatness moves from the realm of science and nature into the arena of social and cultural criticism, its meaning is being reconstructed. As discourse grows around fatness, groups of affinity are created. Eventually, out of this process of new definition, fat groups arise. Eventually, fat as an identity is defined by the fat person as opposed to being defined by the outside world (LeBesco, 2004).

Intersubjective Psychodynamic Therapeutic Work

As social workers subscribe to a 'person in environment' perspective on therapeutic work with clients, we aim to understand and respect meanings ascribed to many cultural contexts and identities – fatness should be no exception. As clinicians, fundamental to our work in developing relationships with cultural competence, is an

awareness of our own culture and identity-schema. The next step is to address the interaction between our cultural schema and our client's cultural schema.

Modern psychodynamic theory is predicated on the relational model. Much of the growth that happens in therapy is directly related to the relationship between the clinician and the client (Kahn, 1997). Transference, originally described by Sigmund Freud and subsequently well documented in the literature, is the idea that a client's history, understanding of the world and previous relationships often manifest in the therapeutic relationship. Our understanding of countertransference has evolved significantly from Freud's early conceptualization. The updated definition of countertransference, at its most basic is similar to transference but refers to the *therapist's* history, understanding of the world and previous relationships and how these fundamental experiences of the therapist may be triggered by sitting with different clients. Whereas countertransference was previously understood to be an impediment to therapy we now accept it as unavoidable and use it to build therapeutic alliance and strengthen our relationship building (Winnicott, 1956).

Beyond the idea that transference and countertransference can be used to strengthen a relationship, we now know that denying, avoiding or repressing countertransference feelings interferes with the therapeutic process. In order to explore our feelings, reactions and responses to a client within the relationship requires honesty, vigilance and self-knowledge (Berzoff, Flanagan & Hertz, 2002). Therapeutic relationship is defined by the quality of the intersubjective space – or third space – between client and clinician. According to Stephen Mitchell's work, within the context of constructivist, relational psychotherapy, clinicians understand that there is a 'patient-

analyst' unit in which the patient and the therapist construct a co-authored experience (Mitchell & Aron, 1999). The thoughts, beliefs, assumptions and biases with which both the clinician and the client come to the relationship are sure to inform the work that the 'patient-analyst' dyad do together. As mentioned previously, the role that fat bodies play in this co-authored space it is not documented in the literature. As we look to consider the experience of clinical social workers and their experience in sitting with fat clients, these patient-analyst dyads will yield specific experiences based on what the fat client brings to the relationship and what the clinician brings to the relationship.

Race, Racism, Fat and Visible Difference in Therapy

A developing therapeutic relationship which is co-created requires an assessment of the different assumptions both client and clinician bring to therapy. In particular, social identities – primarily 'visible otherness' – and the role these play in the development of a therapeutic alliance should be investigated. Social identities are not only ways in which we define ourselves but they also can represent externally, socially-constructed iniquities founded in power, privilege and oppression (Miller, Donner & Fraser, 2004). One assumption social workers make in the psychodynamic view of the work is that these oppressive social structures are often internalized and ultimately shape the intra-psychic experience of people who identify as an 'othered' status (Hamilton-Mason, 2004).

For the purposes of this paper I will focus specifically on the experience practitioners have sitting with of clients of color. I choose to do this because the literature on race and therapy provides a solid case for both comparing and contrasting the experience of the fat client in therapy. Charles Ridley (2005) argues that transference and

countertransference around race and culture cannot be avoided. Literature on ethnicity and race within clinical practice has been framed according to a co-constructed interaction of constantly shifting social identities by both the client and the practitioner (Miller & Garran, 2008).

Miller and Garran go on to say that in the context of an intersubjective space, both members of the client-clinician dyad are evolving and reconstructing their social identity in the presence of each other. This evolution leads ultimately to a critical social awareness. Roselle Kurland (2002) addresses this evolution as she discusses her work as a white social work clinician. She writes about the process by which her ability to address race in the therapeutic context has progressed over time:

From thinking it did not matter, to wondering whether it did, to knowing that it did but being fearful of talking about it, to talking about it immediately and prematurely, to becoming comfortable enough to wait to raise it until it comes up in a way that flows naturally in the work with clients. In addition... I have learned that racial difference can be talked about. It needs to be (p.118).

The process Kurland discusses in her development as a white clinician involves growing awareness and knowledge. She brings her evolving racial identity into the room with her client. She acknowledges the importance of consciously being present as white woman while working with clients of color. A parallel to the way in which Kurland works across difference with her clients of color could be applied to clinicians working across difference of size.

Oftentimes white clinicians working with clients of color may be unaware of assumptions related to race that they bring to a therapeutic encounter. In some cases the unconscious assumptions may be based in internalized racism. This could manifest either as “feelings of superiority and privilege or as feelings of being less worthy or responsible

for one own social oppression (Miller and Garran, 2008). The less clinicians are aware of their own internalized racism, the more likely they are to miss or even corroborate a client's internalized racism. Other ways that clinicians may erect barriers to effective work with clients of color may include: choosing to remain “blind” to difference, being hyper-aware of color, lacking curiosity about cultural difference or disrespecting cultural differences (Ridley, 2005) or more subtle forms of racism known as microaggressions – such as snubs or dismissive looks, gestures, and tones. These exchanges are often unconscious and automatic but overtime, the effect is palpable. They can affect performance and often deplete energy of the recipients by creating small but significant, and repeated inequities (Sue, 2004; Sue, Capodilupo, Torino, Bucceri, Holder, Nadal & Esquilin, 2007) or out right denial that being white carries privileges unavailable to people of color(Ancis & Szymanski, 2001).

Dominic Pulera author of the 2002 book, *Visible Differences: Why Race Will Matter to Americans in the Twenty-First Century*, posits that observable distinctions in physical appearance which indicate difference between the races greatly influence intergroup relations. He also argues that there are social, cultural, economic and political ramifications to this visible difference between races. Intergroup relations across visible differences inevitably fuel struggles for power, recognition and resources (Pulera, 2002). Skin color is an identifier of an individual and signifies belonging to group, privileged or oppressed and exploited. This oppression and exploitation is born out of the social construction of race. These constructions have changed over time but white people continue to hold power based on a construction of whiteness (Miller & Garran, 2008) and skin color continues to be the most obvious and visible symbol to indicate difference.

Fatness – An Oppressed Identity in Psychotherapy

Similar to skin color, fatness is readily identifiable. When people see fat, they typically conjure negative stereotypes such as fat people are unattractive, a-sexual, weak willed and unlikable (Crandall, 1994). This sort of visible difference whether based on the color of one's skin or the size of their body will inevitably make its way into the therapeutic relationship. Research has shown that practicing psychologists are not immune to these types of biases (Agell & Rothblum, 1991). Fat clients are more likely to be negatively judged and treated (clinically) with poorer expected prognosis – especially by younger female psychologists (Davis-Coelho, Waltz & Davis-Coelho, 2000). This study published in *Professional Psychology: Research and Practice* set out to empirically research the role of fat bias in clinical judgment and treatment planning for fat clients. 500 clinicians were sent the same case formulation and either a picture of a 'thin' client or a 'fat' client. 200 clinicians returned the questionnaire. The thin and the fat client were the same person but with the aid of theatrical makeup and padding, she was made to look fat. A questionnaire was administered which assessed the psychologist's perception of the client's provisional diagnosis, prognosis, client effort, motivation and overall functioning based on the case formulation and the photograph. The results indicated that differing judgments, treatment plans and prognoses were found based on the visible difference of fatness indicated in the photograph. This bias can be attributed to the visible difference of fatness because the case formulation was the same.

Summary

The literature reveals a great deal of information about the many ways to make meaning of 'fat'. We ascribe fat with meanings such as pathology, disability, morality,

political importance and as ways of identification. As social workers we work to create a therapeutic alliance and acknowledge the importance of transference and countertransference. Beyond this, social work requires that we are vigilant about listening for what our clients bring to the relationship, being cognizant of what we carry with us into the work, understanding our own potential for being triggered by what our clients bring and finally, a respect for the intersubjective space that is created between client and clinician. Social work clinicians are specifically trained to honor what it means to work across difference and acknowledge the oppressive forces at play in the world and also in their therapeutic work.

What remains to be more deeply explored however is the specific role that fat plays in the therapeutic alliance and in relationship building between clients and clinicians. If, as social workers our work is in service to our clients, what do we need to know in order to do this work? As social workers we are not immune to the biases, beliefs and assumptions our culture holds. What do clinicians bring to the therapeutic relationship as we work together with their fat clients and create a third space? These questions guide this exploratory study with the intent to learn more about social work clinicians and their experience in working with fat clients.

CHAPTER III
METHODOLOGY

Problem Formation

This qualitative study was designed to explore clinical social workers' experiences of sitting with fat clients. Compared to the extraordinary amount of media attention and medical or public health research on fat and obesity, there is notably little research on clinical social work with fat clients. It is hard to ignore the impact of this 'war' being waged on obesity on clients – especially fat clients. It is incumbent upon social work clinicians to be aware of what effect this social phenomenon might have for our clients and the work we do with them.

Research Participants and Recruitment

Participants were recruited through a snowballing technique. Exclusion criteria for participation required that participants be licensed clinical social workers with at least 2 years of experience working with clients post graduation from a MSW program. This was requested to be sure that all the research participants graduated with the same level of social work education and had time in the field to develop caseloads. Participants were expected to have experience working with at least two fat clients on their caseload because this would offer access to clinical case material and first hand experience. The definition of 'fat' was left up to the participants' discretion. Potential participants were screened by phone to ensure that they met the study's criteria and to schedule interviews. Nine clinicians were interviewed. This small sample size meant it was not possible to

ensure diversity among the participants regarding gender, age, race/ethnicity, religious affiliation, sexual orientation and size.

The sample size was smaller than expected. During the recruitment process, the initial nine participants were found very quickly but subsequent efforts to round out the sample size to twelve were met with significant challenges. Many potential participants expressed discomfort with the subject material. Some clinicians felt they did not have the expertise to talk about the subject, others seemed wary and unsure about the purpose of the research and opted out. A number of inquiries to leads given by colleagues went unanswered. Some potential participants did not meet exclusionary criteria because they practiced psychotherapy with degrees other than social work degrees. In one case, contact was made with a colleague at a local eating disorders association to see about disseminating recruitment materials. She requested that the recruitment materials be changed to say that the research was on “overweight or obese clients who struggle with compulsive eating or binge eating disorder.” As compulsive eating and binge eating disorder were not the subject of this particular research project, and with further explication of the project, the colleague expressed discomfort in forwarding the recruitment email to her contacts and kindly refused. One participant verbally agreed to participate but stopped responding to communications so an interview was never scheduled.

A certain amount of discomfort with the subject matter was expected but the researcher was surprised by the amount of discomfort that surfaced during the recruitment process. A number of the participants interviewed noted how aware there were that the researcher had used the word 'fat' in the letter of consent. One participant

referred to the use of the term 'fat' as a 'bold' choice of words and other participants noted that they were 'surprised' by it. It is possible that a number of potential participants were disinclined to participate based on the use of this terminology.

The recruitment process included dissemination of both emails and handbills (Appendix B) to personal and professional acquaintances. Contacts were asked to share the recruitment materials with their network of colleagues and friends. The recruitment materials asked interested participants to contact the researcher either by email or by phone in order to set up a screening phone call. The screening process entailed a series of questions confirming that they are licensed clinical social workers who have at least two years clinical experience post graduation from a MSW program and that they have had at least two fat clients in their caseload. Once eligibility was determined, contact information was gathered followed by verbal agreement to participate in the research study. It was explained to each participant that contact information would be used to mail copies of the informed consent letter. At this time an interview time and place was determined.

Motivation for Participants Work with Fat Clients

In recruitment of social work clinicians, participants typically fell into two categories. The first category included clinicians who were 'obesity specialists' or clinicians who specialize in helping clients lose weight. The other category included clinicians who happened to have fat clients in their caseload but did not have a particular focus in their practice on weight management.

Obesity specialists. Three of the participants, Margot, Patricia and Karen, consider themselves to be obesity specialists or clinicians who specialize in working with people around weight management. Clients come to see them specifically around body issues and weight. On their way to becoming obesity specialists, all three worked with or studied to work with clients who suffered from eating disorders – specifically anorexia and bulimia. Margot spent seven years at a major metropolitan teaching hospital in the northeast working in an eating disorders clinic. After this, she established a private practice, originally planning to specialize in eating disorders, but “what I ended up getting was a lot of referrals of overweight people.” Patricia went into private practice to treat clients suffering from anorexia and bulimia as she saw a great need for these services. She also had a strong desire to work with clients around nutrition. After much training in eating disorders and work with peer support groups to prepare for this work she “found a lot of reasons why I really don't like working with anorexics but am very interested in the other side [obesity].” Karen now works in a nutrition and endocrinology clinic at major metropolitan teaching hospital in the northeast where she counsels patients around nutrition, diabetes management and assessment, planning and preparation for weight-loss surgery – an option that is offered at the clinic where she works. She started out doing research about anorexia and bulimia but has since changed her focus to working with obese clients.

All three participants having started with a focus on the eating disorders of anorexia and bulimia chose to pursue specialty work with obese clients. In all three cases, the participants noted that there is a great need for obesity specialists and both Margot and Patricia acknowledged that they really enjoyed working with the population of obese

clients. It is interesting to note that all three of these participants have struggled with their own history of eating disorders or disorder relationships to food.

Non-specialized caseload. The other six participants Greg, Jill, Connie, Laura, Mary, and Jana don't describe their work with obese clients as a specialty. They are all in private practice with varied caseloads that happen to have at least two or more fat clients on their caseload. Jana's work is distinct from Greg, Jill, Connie, Laura and Mary because she works in a community mental health center in the outpatient clinic. Her case load is primarily a population of persistently and chronically mentally ill adults. She notes that so many of her clients are big, but she has a few who are “really big.”

Potential Risks to Study Participants

Participants were asked to give 60 minutes of their time to talk about their work experience with fat clients. Participants discussed their historical and current relationship to their bodies. Some of the material discussed in the interviews had potential to be triggering and could bring up difficult or painful feelings. The researcher also asked about counter-transferential feelings towards fat clients. This had potential to make participants feel uncomfortable as they sometimes talked about their negative feelings about fat people to a fat interviewer.

Potential Benefits to Study Participants

While there was no financial benefit for participation in this study, participants were able to share their experience working with fat clients. Their involvement provided information that contributes to furthering the knowledge of clinical practice with fat people. Most participants also remarked that they gained new perspective in developing therapeutic relationships and alliances with fat clients through the interview.

Precautions Taken to Safeguard Confidentiality and Identifiable Information

Concerns of confidentiality were taken seriously, as consistent with federal regulations and mandates of the social work profession. All interviews have been, and will continue to be, kept confidential with data in this thesis and professional publications or presentations presented in the aggregate without reference to identifying information. Illustrative quotes have been used in this thesis but are reported without identifying information and disguised when necessary. After the interviews, audio-taped conversations were coded with numbers. All references to the participants in this report use pseudonyms. Participants were informed that they could refuse to answer any question and also that they could withdraw from the research project at any time up until April 15, 2009. If they had chosen to withdraw, all materials related to them would be immediately destroyed. Tapes, transcripts and other data will remain 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 continue to be kept secured or will be destroyed.

Data Collection

Participants were asked to sit for one 60-minute, tape-recorded interview. Interviews took place in participants' office space or personal residence. At the beginning of the interview the researcher briefly reviewed and answered questions about the content of the informed consent (Appendix A) with the participants. Both parties signed the consent. Demographic data such as gender, sexual orientation, race and size identity was also collected. Data was obtained using semi-structured interview questions, which encouraged case examples and extensive narrative data. The interview guide (Appendix

C) was designed to leave room for free associations and for themes to arise spontaneously. The research instrument focused on concepts such as clinicians' relationship to their own bodies; perceptions of fat clients' presenting concerns; clinicians' experience in building and maintaining relationship with fat clients and themes of countertransference in work with fat clients.

Data Analysis

Interviews, field notes and demographic data were manually transcribed by the researcher. Themes were identified using open coding. Data was reviewed and examined to identify similarities and differences among participants regarding specific subject areas. Data analysis for this project is based in the grounded theory method. Clearly identifiable themes emerged around social work clinicians and their work with fat clients. These themes were revealed in the descriptions, stories and case material that each participant brought to the interview.

CHAPTER IV

FINDINGS

The intention of this exploratory investigation was to determine more about the experience that social work clinicians have sitting with fat clients. The interviews focused on various aspects in the development of relationship between clinicians and their fat clients. Nine social work clinicians were interviewed. Using an open-ended interview question I asked the participants “how do you choose to identify yourself?” In response to this question, I came away with the following demographic statistics from the sample. Eight of the participants identified as women and one identified as a man. Two identified as Jewish and one additional clinician had a Jewish name. One identified as older. Three chose to identify as married, one specifically notes she is currently in a heterosexual marriage, one as partnered, one as divorced, one as single and another as engaged.

Specific demographic information about participants including years in practice; self-identification; body size identity and clinical orientation is presented in Table 1. All participants are referred to using a pseudonym in order to protect their identity and their client's identity. Participants were given latitude to define their own identity without being asked 'check off' specific boxes according to race, gender, sexual orientation, religious affiliation, age, disability and size. The identities presented in the table are expressed in the participant's own words.

Table I

Self-Identified Demographic Information of Participants

Participant	Years in Practice	Self-Identity	Body Size Identity	Clinical Orientation
Margot	26	White, Jewish woman	Small	Psychodynamic, self psychology, cognitive behavioral therapy
Jill	24	Jewish, mom, divorced, straight with strong lesbian identification, feminist	Curvy, zaftig	Body-oriented, bio-energetic, Freudian roots, self psychology
Patricia	18	Older woman	Chunky, short, wide, wears large sizes, in transition, used to be a tiny thing	n/a
Greg	4.5	Mexican-Caucasian male, over-educated, upper-middle class, partnered, American	Fat	Analytically trained, psychodynamic, getting EMDR certificate
Connie	24	Therapist with Jewish name, works with issues of infertility & adoption, in a heterosexual marriage	No	Integrative, psychodynamic, relational, behavioral, using mindfulness
Laura	11	Single woman, not in a relationship	Loaded question, distorted	Feminist
Mary	14	Psychotherapist in private practice, married, mother of 2 young boys	Don't think about it, average, size 8/10, middle of the road	Psychodynamic, psychoanalytic, cognitive behavioral therapy slant, flexible, eclectic
Jana	2.5	Child of immigrants, Italian-Armenian American, straight, white, engaged	Presents as thin or fine, struggles personally with being a bit overweight & trying to lose a few pounds	Psychodynamic, eclectic
Karen	2	White, female, individual therapist working with eating disorders	Small, petite, not overweight	Psychodynamic, cognitive behavioral therapy, developing coping skills

The overarching themes from the findings that I plan discuss include: Bodies in a room – together; the physical aspects of fatness in therapy; fatness as a problem; references and terminology around fatness; fatness as protection and fat bias and oppression.

Bodies in a room – together

Fatness in the Room

All participants acknowledged that they were aware of their client's fatness in the room while doing their therapeutic work together. In some cases participants acknowledged this explicitly to their clients and other times the fatness remained unnamed or expressed until it came up naturally by the client. Sometimes the first mention of weight or body concerns would take years to surface. Greg has a client who has been living with repercussions of weight loss surgery which was performed forty years ago. Greg has seen her for six years and says:

She was not willing to talk about those [weight issues and surgery] for a couple of years and dismissed any attempt I had of even asking her experience of having that kind of surgery is like...now six years later is something very much something she talks about.

Margot, Patricia and Karen typically are referred clients specifically because they are fat. As Margot puts it “that takes away the whole question of how much do you bring up weight...because that is what they are here for.” Karen, as a psychotherapist in the nutrition and endocrinology department has a different experience with her client's initial presentation to therapy. Clients are most often referred to Karen by nutritionists or medical weight management doctors. Karen's patients know that they are seeing the nutritionists and doctors because of their weight but their reason for seeing Karen seems less clear to them.

[They] come in initially...I ask a lot of questions – maybe they don't really know why they are there. Maybe they know a little bit, they were told, but it is uncomfortable, they really don't want to be there.

Karen was clear to point out that she sees her work as starting where the client is – so

“[The client's] main concern...might be very different from the RD [Registered Dietician].” So if a client comes in and states their initial concern as anxiety, then she will start the therapy with addressing the client's anxiety.

Greg was different from all the other clinicians in that he actively brought body size into the therapeutic space within the first two sessions of meeting a fat client, or any client for that matter, regardless of presenting problem. In his initial assessment or intake, Greg asks clients about their eating habits to have an idea if they are eating healthfully and also inquiring about their food behaviors such as restriction or purging. In his words “I don't leave much room for the imagination and so if somebody is fat I will say, 'Is your weight a concern for you?' 'Is it something that we are going to want to talk about here?’” He also noted that typically this is the last time weight or body issues are discussed until the client brings it up again.

Clinician's Body in the Room

As noticed by the client. Every participant talked about how aware they have been of their own body in the room as they worked with their fat clients. Sometimes this was illuminated by a client's acknowledgment of the therapist's body. One theme around this arose from fat clients questioning how the clinician could 'understand' what it is like to be fat when they aren't fat themselves. Margot talked about how this subject came up with clients saying 'how can you understand me - you are so small?' Jill also mentioned that “sometimes I will say something and they will say, well you aren't fat.” Karen, Jana,

Laura and Mary also expressed similar experiences. Laura remarked about her concern that her client “can't imagine that I would know what it is like for her to struggle.” Mary also talked about an unspoken but palpable sense that her client feels more envious of Mary when her weight is 'down', but when her weight is 'up', her client seems to feel more comfortable talking about her own body. Mary also noted that another client commented “about my arms...and that I probably go to the gym.” This client also will often compare Mary to “her beautiful boss who is in amazing shape.”

Patricia, Greg, Jana and Jill all talked about their personal frustrations and stresses with weight. Greg, however, is both the only male participant and the only one who self-identifies as 'fat.' He spoke about how he is “so very aware of my own body in sessions.” He acknowledged that he “would be willing to bet that if any of them were asked to describe me physically none of them would use the term 'fat.’”

He goes on to talk about how this is hard for him in a way because his frustration with *his* weight is diminished in the face of his client's suffering around their weight. As he put it: “So, in a way it feels as if I don't get to lay claim to my own sort of suffering in their presence.” Greg felt that it is important to leave a space for clients to have their own ideas about his body without knowing his own identity so “that they be able to decide the degree to which they would like to identify with me or reject me or for that matter, my body.” In a similar vein, Patricia acknowledged that her clients may perceive her reality differently than she does. In regards to her clients she noted that they

Probably think that I don't know how hard it is for them...I certainly believe I can imagine how hard it is. Because while it isn't as hard as it is for me as it is for them, there are things that have been very, very hard for me in my life. So it is easy for me to know what difficult feels like.

Both Greg and Patricia acknowledged the strong presence of pain and suffering their fat clients bring into the room. Beyond this they expressed their own reactions to the intense presentation by their clients.

Similar to Greg, Connie has an awareness of her body in the room, only she identifies as 'thin.' She expressly noted that she makes a conscious effort not to speak in a pejorative manner to her clients who are fat. She did say that in certain cases she may allude to the fact that fatness has not been her struggle and that she would “typically invite somebody to talk more about how they do feel talking to me [as a thin person].” In response to a question about how she builds her relationships with her fat clients, she expressed some contradictory ideas. Her initial reply was “I don't feel it has been any different [from non-fat clients].” When prompted further to explore the role of countertransference on relationship building she struggled to answer the question.

Um, [*silence*] well, I guess I would just say, I am aware of, um, I am just aware of being, you know what, needing to be and feeling very respectful and sensitive um, being that I am visibly not fat [*pauses*] that if somebody is going to trust me enough to discuss it with me, they have to feel safe.

Connie's initial response is size-blind, in that she doesn't see a difference in the way she builds relationships with fat clients, thin clients or anyone in between. She goes on however to reveal her awareness of working across a visible difference of her thinness and her client's fatness.

Clinician's relationship and perception of their own body. To varying degrees, seven of the nine participants have a history of disordered eating, body issues and eating disorders. Greg believes that his own judgments about himself are unconsciously at play in his

therapeutic work with fat clients. He acknowledges however that he has no idea how this actually affects the work.

But my role as their therapist and the ways in which I think about people that I am sitting with, I can't tell you if it represses, suppresses, creates a reaction formation, I can't actually tell you what psychic process is at work.

Margot stated that “I had an eating disorder as a kid...and I had been fat as an adolescent.” Margot's clients see her history with being fat and having an eating disorder as making her 'the expert' on how to lose weight. Because she is thin now, her clients assume that Margot must have the secret for how to successfully maintain her weight loss. Patricia's eating history comes into the therapeutic relationship because as she noted, “I understand emotional eating, I am lucky, for the way I have eaten in my life, I should weight four hundred pounds.” Though Patricia did not mention specifically having an eating disorder, she often spoke of 'restricting,' 'binging' and expressed great rigidity about her food and exercise regimen. Patricia sees her own experience with restricting and binging, as well as her health problems, as a way to join with her clients around their challenges with food and health. Though vague about the details, Karen did share that as a teenager she struggled with an eating disorder “at the other end of that spectrum [from obesity].” Karen acknowledged that she would feel reticent to share too much with her clients about her eating disorder history.

Both Jill and Patricia talked about the fact that as they have aged, their relationship to their bodies has become more complicated. Patricia, who is in her early seventies, expressed great frustration over the changes happening to her body due to wear and tear, illness and metabolism changes that come with age. She is finding that she has to shop at new stores because not all stores have clothing in her size. Beyond that, she

really doesn't like what is available in her size. She has been forced to pay more attention to her body's needs and to adjust to the amount of time and attention that it requires to attend to her body. She has even had to cut back on her caseload because of it. Jill noted that it wasn't until college that she “got down” on her body. Since then she has been “uptight” about her weight. Jill explained that with menopause, she gained a significant amount of weight – around thirty pounds or so. She speculated that one of her “very petite” clients “stopped seeing me because I, before her eyes, I got heavier.” She doesn't believe this was necessarily a conscious decision by her client. She concluded this part of the conversation by saying,

To be an American woman is to have an eating disorder ...[but] I have some my meat on my bones...[so] I am not...this ideal of starvation...[I am] modeling 'real woman-ness.'

Both Greg and Jana conveyed significant harshness about their own bodies. At the same time they both acknowledged that they have been frustrated by weight gain, they recognized that compared to their clients they undoubtedly present as thin. Greg stated that he does not have neutral feelings about this present weight, he expressed frustration over his inability to “get it [fat] off of me. He observed that, “I think because I have had problems with my own weight there is maybe more judgment of fat people in general.” Jana also spoke to her aggravation at her inability to lose the five or ten pounds that she has recently gained. She went on to talk about her feelings of hopelessness about losing weight. She chastised herself:

I don't try hard enough but I work out, you know I don't think I eat really badly, I guess I eat too much, you know, whatever, but...I do love food.

Jana acknowledged she has a sense of hopelessness for her clients and it may come from the hopelessness that she feels around her own weight gain subsequent to a knee injury and her difficulty losing the weight due to changes in her metabolism.

Mary and Connie didn't express any concerns about their size at the outset of the interview but as the conversation progressed, Mary did talk about her body and her fluctuating weight due to pregnancy and other things. She noted that some clients make her more aware of her body than others. In this case it is a client who is not fat.

So there's a patient who is um, a yoga instructor and very petite, very beautiful and um, and talks a lot about how beautiful she is. [laughter] And she talks about other people and she induces a lot of envy in me and makes me think ah, 'gosh, I wish I could lose weight' or maybe 'I should do yoga' in a way that I don't usually really think about myself in that way.

Connie also expressed some dissatisfaction with her body and discussed the ways in which this plays out in therapy with her fat clients.

I am aware of how subjective it all is cause I am aware of things I don't like about my body...and how powerful those issues are even though that xyz person would look at me and think 'are you out of your mind?' You know I am aware of how I suffer in my own ways.

Even clinicians who don't identify as having body concerns or a history of an eating disorder, clearly struggle with their body. Both Connie and Mary talked about how this body struggle makes its way into their therapeutic work.

Physical Aspects of Fatness in the Therapeutic Relationship

Throughout all the interviews I conducted with the participants, the theme of health concerns related to fatness arose in our conversations. In some cases the health concerns were raised by the clients themselves, sometimes by the social work clinician,

and other times from doctors or nutritionists operating outside the therapeutic relationship.

A number of participants mentioned that clients tend to come in feeling very anxious about their doctor's reprimands to lose weight. Patricia expressed an ambivalent way of thinking about health and fatness. She acknowledges that many of her clients will probably never lose weight and end up successfully keeping it off. She sees her role as someone to encourage health and a healthy lifestyle. At the same time, she expressed alarm and great concern over what she sees as very serious health ramifications of fatness. In reference to one of her clients whom she refers to as a “heart attack waiting to happen” she said:

He makes bad jokes like if he wanted to commit suicide he'd just eat another Twinkie...Cause that is how far away he is...from a heart attack, in fact he had a pulmonary embolism, um, that landed him in the hospital. When he came to – when he started seeing me, he didn't even have a physician, he didn't have a primary care doctor...and his wife was trying to get him to see a doctor and I just pressured on him. You know, I said, a person, everybody has to have a primary doctor. I have one, everybody has one, unless you want to make your wife a widow and your kids orphaned - I had to really be very blunt with him and he wasn't happy with it. But he got himself a doctor who didn't mention his weight!...He has doctors who doesn't mention his weight and it's *such* [italics added] a health hazard.

Patricia goes on to talk about the fact that he hasn't lost any weight but he did start walking and this seems to be having positive effects on his health and also on his marriage. She expressed a specific interest in doing nutrition work with her fat clients. Patricia “wanted to educate people in what was food and what was not food.” She sees that “food is medicine but...[some food] it's poison...you become what you eat.”

Though not every participant spoke about the health ramifications of fat with the same amount of distress, several expressed beliefs about fatness and its detrimental effect

on people's health. Greg, Connie and Jana were all of the opinion that fat is a serious health concern. As Greg notes: "I have a bias. My bias is that being in a really big body is not so healthy physically." This sentiment is echoed by both Connie and Jana. Jana feels there is a distinct medical concern related to being fat. "We are talking about people that really probably are putting their hearts and risk and other things like that."

Client Concerns About Health

In sharing case vignettes, every participant said that at least one of their clients brought up specific health concerns. These fat clients expressed worry that their fatness was to blame for the health concerns. Some participants talked about their clients' concern that their fatness is fatal. Here Margot talks about her clients expressing these worries, "Yeah, patients come in...who say, I am afraid I am going to die and leave my kids orphans." Jill as well has a client who brings her medical concerns into therapy a lot: "there is the whole thing about the medical...piece for her, her knees really hurting and doctors being just like 'okay!' Front and center 'You need to lose weight.'" Similarly, Mary has a client who is "concerned about her obesity for medical reasons – she was getting high blood pressure and other things."

Greg shared an experience with a client who had been ordered by her doctor to lose weight because she was becoming borderline for diabetes. The client was upset by this directive from the doctor and argued to Greg that her health concerns were not directly related to her weight but rather to her poor food choices and her lack of physical exercise. His client explained to him how many of the studies that indicate fat is the *cause* of certain cancers and diabetes are done poorly. She argued that these studies actually only point to the fact that poor eating habits and lack of exercise lead to higher

incidences of these health concerns – not the fat. Greg's response to his client's argument was, “my exact words were, 'I am not going to join you on this one.' [laughter].” In the intervening week between sessions, Greg sought out these research studies, read them and concluded that:

I had to admit after reading them that her idea that it was not being fat that created these things that there was no more evidence for that...than poor eating habits and poor exercising habits are what led to that...that the fat itself gets the blame because we are able to be as judgmental as we want to about fat people but the lifestyle and food and exercise are really the things that should be targeted and that people's bodies would end up at various levels.

Greg went on to apologize to his client for his empathic failure and for creating the reenactment that she had experienced with her doctor and also with her parents. He saw this experience as a corrective experience for his client.

Margot expresses her frustration with the medical establishment around this kind of treatment.

It is unbelievable to me...even around obesity experts...[they are] an unbelievably limited in their knowledge of the experience of being overweight. Unbelievably limited. Shocking!...Most clinicians assume that obesity is an eating disorder or indicates an eating disorder...so that is one of the prevalent assumptions...then they believe that part of their work is to help their patients lose weight...I mean I have one client who, whose psychopharmacologist, thank God she left him but he said 'you know...you are never going to be un-depressed until you lose weight.'

She goes on to say,

The amount that obesity is talked about in medical circles is enormous! I mean you know everyone says 'obesity causes everything.' Um, you know, and 'we've got to do something about it!' 'There is an epidemic!' 'It's an emergency!' and yet there is not some curiosity about the assumption that I [the clinician] am thin and I know much more about weight than you do because you are obviously unable to manage it'...without any kind of sympathy.

These findings show that fatness as a health problem comes up oftentimes in the midst of therapeutic work with fat clients. As Margot states above, the discussion of health

concerns can come from outside medical professionals, the concerns can be raised by clients and in some cases such as with Greg, Patricia and Connie, health concerns may be brought up by the clinician.

Physical Pain that Fat Clients Experience.

Margot, Jill and Karen all spoke about specific fat clients who suffered physically from their fatness. They discussed the fact that living in a larger body is uncomfortable and difficult. Jill described how impaired her client was physically and she correlated this directly to the client's fatness. Introducing me to one of her clients, Jill describes her as “one in particular was just, a, the one who was the most obese person, you know, like hard time walking and that kind of stuff.” Margot talked about a client who was unable to visit her niece in Europe due to her inability to walk more than ten minutes at a time because of her fatness. Margot's response to this was “God that is just so unfair!” Karen also talked a great deal in our interview about the physical pain that her clients suffer. She notes that people tend to come to see her less concerned about their low self-esteem or appearance and more for help managing the physical pain. Karen similar to Margot expressed strong feelings about the physical suffering of her fat clients, especially her younger female fat clients:

What's really heart wrenching for me is um, a...young female twenty-two, twenty-three, twenty-five, twenty-seven, everything hurts, a nine [out of one to ten scale], physical pain, everything hurts – you are twenty seven years old – I don't, I shouldn't say 'I don't understand.' That is the wrong thing to say. Um, I, I, I — not that I don't understand.— I can't imagine what that is like, and that, that is where my heart goes out to them and that is why I do the work because I just want to help them. I want to take all of that off of them, so they don't hurt because they are only twenty seven – they shouldn't hurt, their knees shouldn't hurt they should be out there running. Um and so my heart goes out to them for that because you know it has got to be crummy.

Margot and Karen, describe their client's physical pain with strong emotional responses of care, concern and even some protective quality.

Weight-Loss Surgery – Physical Changes to the Body and Impact on Therapeutic Work

Every participant had at least one client who was planning to or had undergone some form of weight-loss surgery. Clinicians such as Margot and Karen expressed the opinion that surgeries like bariatric weight-loss surgery can really benefit their clients.

Margot talks here about her changing beliefs around the benefits and drawbacks of bariatric surgery.

Initially, I was like 'oh my God, it is so dramatic and it's so drastic and it so anti-fat and it's and my feeling now is, it's really hard to lose weight and if you are 350 pounds you are really uncomfortable.

Margot refers again to her client who was unable to visit her niece in Europe

I used to look at her and think 'she'll be in a wheelchair by the time she is sixty'...she's just in pain and the strain on her body is just awful....and she's actually decided to have surgery...which is great actually...I just signed the papers last session.

Margot goes on to talk about how clients need to have a realistic sense of what they want out of the surgery. A number of participants noted that not all clients have a grounded understanding of what this surgery means in terms of maintaining results after the initial weight loss. Margot's client who she just signed surgery papers for had asked her about surgery in the past and Margot did not think she was ready to undergo treatment until more recently.

Patricia describes a client who came to see her determined to have the surgery even though Patricia did not recommend it. Her client went ahead with the surgery anyways and lost upwards of 200 pounds. In the end Patricia's client was deeply

depressed and according to Patricia “she felt like a stranger in her own body.” Much of their work together was around processing the devastation her client felt when she learned that her weight loss didn't produce the results she had hoped for. The man she loved still did not love her and she was overwhelmed by the strange men who were now making passes at her.

This theme of surgery changing client's bodies but not their problematic life issues was echoed by Connie, Jana and Laura as well. They all saw clients who underwent surgery, lost a significant amount of weight but continued to have serious problems and still suffer with issues around food, eating and her body. Jana's client lost about 100 pounds but still feels awful about her body. Her client said “I know it is something inside of me, because I am losing weight and I still feel awful about myself.”

Echoing the theme of difficulty in transition to a 'new' body, both Greg and Laura spoke about the ways this issue surfaced in their therapeutic work with clients. One of Greg's clients is planning to have bariatric surgery later this year. He is concerned about the bodily transition for her. He anxiously anticipates the changes that will come with this surgery. He explains that for many years this client has resisted the idea of losing weight. “[Fat] had very powerful dynamic meaning for her...she felt much safer in a fat body.” His client is queer identified and he notes that she has used her fat as a means of protection and also to help hide her womanliness. Greg expressed concern about how she will handle the changes that will occur to her body as a result of the surgery.

Laura's client, who has had the surgery and lost significant weight, spent a good deal of time with Laura mourning the body that she lost. This client is an avid athlete and

she no longer could play certain sports as well as she used to be able to due to her diminished size.

Physical versus Emotional Pain

As participants talked about the physical pain of their clients, they also brought up the emotional pain that their fat clients endure. In response to the question about what sorts of feelings come up when fat clients talk about their fatness, there was often great conflation between emotional feeling and physical feeling. Here Margot speaks to this quite clearly.

In terms of actual feelings about their body, most of it is this sort of cut off sense of, um, or a disbelief. [silence] Sometimes people will talk about 'ugh, I just look disgusting.' 'I can't stand my body.' But it is much more a feeling of 'I can't stand the way it feels.'

Margot talks about feelings both in a physical way but also with terms related to emotions such as 'cut-off.' As Jill talks of one of her clients, she shows a similar conflation of emotion and physicality when referring to feelings of pain.

She's just, just had such a painful, painful time because of the way the medical establishment treats her. So, we talk a lot about that....we talk a lot about...um, you know, a non-diet, philosophy...Um, she talks a lot about digestive problems, and what she can eat, what she can't eat, what she does eat, what she doesn't eat... So she talks about it almost every session...[from] a personal point of view in terms of being hurt.

There is a physical piece here as she talks about the medical establishment and even the very body-centered, physical concern of digestive problems. But somehow it does not seem to be simply physical pain that Jill's client expresses when she talks every session about being 'hurt.' It is hard to distinguish between what is emotional pain and what is physical pain if, as Margot put it “oftentimes there is a feeling of really being removed from their body, like just not even paying attention.”

Fatness as a Problem

As a Problem with the Client's Fatness

A theme that emerged from these interviews was the idea of fat as troubling or of concern. Participants talked about fat as an eating disorder; fat as an addiction and also fat as the outward manifestation or symptom of compulsive or emotional eating. To the participants, these conceptualizations of fatness express problematic behaviors. Every participant addressed the idea of fatness as a problem during the interviews. Sometimes fatness was seen as a problem by the client, sometimes by the clinician and sometimes by the outside world.

Some participants such as Patricia, Greg, Connie, and Karen describe their fat clients as eating disordered.² To the participants, the visible signs of fatness on their clients suggest a disordered relationship to food. These participants take the perspective that their clients eat too much, exercise too little and as a result their clients' bodies are fat. Greg speaks to this specifically as he talks about building relationships with his fat clients.

Something about the way I feel about fat people, where I don't around muscular people or who are average weight, now folks who are on one end of the spec...weight spectrum or the other, so either very big or very small, I personally have a hard time with that...And there is a pretty high level of judgment around well, if you want to be thinner, then eat correctly...That this is under your control...I never buy into the idea that they shouldn't lose weight.

Patricia talked a good deal in our conversation about 'out of control' eating, both for herself and for her clients. In reference to one of her clients, Patricia said,

² Obesity, emotional eating, compulsive eating or 'out of control eating' are not technically considered eating disorders as defined by the DSM V-TR1.

Her weight is out of control – her eating is out of...it is under control now but when she came to me her weight was bad and her eating was out of control.

Using the word 'bad' to refer to her client's weight coupled with the theme of being 'out of control' parallels the kinds of issues that can come up around eating disorders like anorexia and bulimia. In my interview with Karen she consistently referred to the fat clients she works with as “people with eating disorders.” She notes that when she gets referrals from nutritionists and weight management physicians it is for people “with eating disorders in general – whether it be obesity, anorexia, bulimia or binge eating.”

Along with the idea that fatness is a problem, comes the idea that there should be a solution to fix the problem. To varying degrees, every participant conceptualized fatness as a concern for which there are a variety of solutions. For Patricia and Karen, who tend to frame fatness as an eating disorder, their approach in their work with fat clients is to help them come up with a plan to lose weight. In the clinic where Karen works, obesity is treated with a prescription of a weight loss plan; more specifically, either nutritional counseling, specialized diet plans, psychiatric counseling or surgery. In a similar way Patricia sees her work with her clients, as a coach, who helps them to manage their health. She brings her clients into her kitchen and

I show them what I cook with and what I eat and only – no refined carbohydrates, no refined sugars – uh, I teach them how to cook...and how to measure their portions.

Patricia goes on to acknowledge that though some of her clients respond to this 'structure,' or plan it is also 'difficult' for her clients and because of this she will often refer people to Overeaters Anonymous (OA), a twelve step program for recovery from

compulsive eating. Fundamental to the OA program of recovery is an admission that food is an addiction and that people are powerless over food.

OA came up in the interviews with Margot, Jill, Connie and Mary as well. In Jill's words "people show up...at OA...because they want to lose weight." Connie has referred a number of her fat clients to OA. She sees OA as a useful tool for her in working with her fat clients.

I would say that in my experience the people who have worked with me who have had transformative experiences relative to weight and body have all, um, ultimately seeked [sic] out a connection with 12-steps programs, uh, OA.

One client that came up a good deal in the interview with Connie was a woman who came in with a presenting problem of managing the trauma around the unexpected death of her brother.

She was obese and it was not an issue for her in any way whatsoever and at some point into that process I brought it up as a health issue.

She went on to explain what the session looked like when she brought it up with her client

I think I said, you know, I, I, I know this is not something that is troubling or whatever, bothering you but I feel that I would be remiss as a clinician not to at least acknowledge or address it and, you know, specifically as a health issue....Um, you know, since I am in the health care provider realm and I, you know, blah, blah, blah.

As a result of this therapeutic intervention, Connie

Suggested that [OA] might be something that she would want to check out, which she wasn't really interested in at all...but she decided she would go and um, I think, by the second meeting for her it was a fish taking to water and that is now at least maybe two or three years since that and it has completely changed her life so...um, in very complicated ways [laughter] but that's how...[inaudible].

Mary also has experience with clients who participate in OA in conjunction with their therapy with her. Mary didn't talk in detail about whether she referred her clients to

OA or whether her clients chose to attend on their own. Mary talked about clients who participated in a long-term residential weight-loss program called Structure House affiliated with Duke University. As Mary describes the program

Structure House is this um...it's affiliated with Duke University...and it's sort of, it's an eating disorder program down there. But they really focus, I think it focuses, mostly on obesity, diabetes and people trying to manage their weight.

Here again Mary did not clarify if she specifically recommended this treatment for her clients or whether her clients chose to attend the Structure House program on their own.

As a Problem With the Clinician's Fatness

Concerns about fatness as a problem arose not only in discussing clients, but also as the clinicians referred to themselves. As discussed previously, Greg, Jana, Patricia and Jill struggle with their weight and their bodies. They view their own extra weight as a concern or a problem. In the interview with Patricia, it was sometimes hard to distinguish when she was talking about herself and when she was talking about her clients. Patricia referenced her own disordered relationship to food many times throughout the interview.

When I feel, uh, lonely, depressed, sad, bored, I want to eat and want to eat chips...and cookies...or ice cream but I definitely have carbohydrate cravings, always have. Salt cravings...um, and I am lucky that my metabolism is such that I haven't paid, had to pay the price.

Patricia goes on to talk about the fact that she cannot keep any chocolate, ice cream or cookies in the house,

Because if it is in the house I am going to eat it...It is a craving, it is like alcohol. Food works for the same purpose as alcohol does and that is to numb

As a Problem with the Outside World

In contrast to other participants, Margot, Mary and Jill saw much of the concern or problem with fatness as located within our culture. Margot spoke of her belief that,

The vast majority of people who are coming to see me *don't* have eating disorders, they may have what *looks* like eating disordered behavior due to what I consider PTSD from a history of dieting...where the whole relationship with food gets all f^@#\$\$% up

Margot speaks about widely-held cultural beliefs that we are taught about food including the idea that there is 'good' food and there is 'bad' food; Margot also talks about the idea that if we cheat by eating a treat then we must get back on track and return to our perfectly-moderated, restricted-calorie diet. She draws a clear distinction between this culturally-constructed, confused relationship to food and the psychologically-disordered eating that implicates a DSM IV-TR1 diagnosis of an eating disorder.

It's more sort of um, its more sort of cognitively instilled this meaning about 'good' food and 'bad' food. What does it mean that I cheated, you know? All that sort of stuff....And restricting and binging, so it looked like eating disordered behavior but it wasn't really and it didn't serve the same function psychologically.

Jill spoke about cultural construction from more of an oppression standpoint. Here she talks about her approach.

I would say, I am really conscious of oppression and I try to bring it into the therapy a lot so that people, you know, that's like a central approach for me that just is...similar to race...I would say something like 'you know there is fat oppression out there?' and then they would say – They would be totally relieved.

Participants compared their client's fatness to other forms of oppression such as race, gender, sexual orientation or disability. In talking about building relationships with her fat clients Mary noted,

I guess an analogy is the way, um, a white person might not truly appreciate some of the things that are in the air around racism...Similar to if you are on the street and you see an African American person and that might be the first thing you see but if you are friends with that person that's not what you think about, that's not what you really see...as opposed to what you see, you know, just as a flash.

Whether fatness as a problem is identified by the client, the clinician or the outside world, this conceptualization of fatness comes in to play within the therapeutic space regularly.

Terminology and References to Fatness

Client References to Fatness

When I asked the participants about terminology that clients use to refer to themselves, their bodies, their size or their fatness, I got a wide array of responses. Participants gave many examples of terminology that their clients used to refer to their bodies. Consistently, however, the specific term 'fat' came up as a source of discussion with the participants. Connie, Laura, Margot, Jill, Mary and Greg all talked about the fact that many of their fat clients use the word 'fat' to describe themselves. Other terms that were referred to by at least two participants include 'large,' 'big,' 'overweight,' 'disgusting' or 'gross.' Most participants agreed that clients do not typically refer to themselves as obese in sessions. Karen elaborated on this noting that her clients do not use medical terms when defining their bodies. “So the medical...diagnosis might be 'morbidly obese'...the patient may say 'I am overweight.' The patient may say, 'I am fat...I feel gross.’”

Participants also gave varied answers about the attitude that their clients had towards their fatness, whether it be negative, positive or neutral. All the participants described individual clients as feeling variable ways about their bodies and their fatness. Jill, Patricia, Greg, Connie, Laura, Mary and Karen all have clients who identified in a neutral or positively way with their fatness. For clients, positive associations with fat bodies included, mothering qualities, strength and athletic ability. All participants had clients who have negative association with their fat body. Common themes that emerged related to fat client's negative feelings around their body include shame, frustration,

feeling out of control, being unattractive and unlovable. As Greg described one of his clients

She does not talk about it in any way as being helpful or good. It is wholly bad and yet she is wholly incapable of doing anything proactive to change it...and she would like to – consciously, at least.

In the interviews there was also an emerging theme of the changeable nature of how tone adds connotation to terminology related to fat. A range of meaning can be inferred from the tone of a voice or even ability to articulate words without hesitating or fumbling. Mary pointed out that the same word may come across differently depending on the tone of voice clients used to convey a word. Depending on circumstances or the session, some clients as may have a harsh, self-punitive or self-hating tone, whereas other times, clients talk about it with a more matter of fact or accepting stance.

References to Fatness Used by Clinicians

Participants struggled a great deal with what terminology to use with their fat clients. They expressed significant concern about certain words 'being hurtful' or 'being a bad word.' When Connie talked about the terms she uses to address client's body or their size, she chooses not to use the term 'fat' even though her clients do. She doesn't like the word fat and she feels that it implies some sort of “social...or cultural designation...I am conscious of not wanting to speak in a way that would be pejorative.” Connie's preferred to refer to her clients' size with the term 'obese' or 'obesity', which she feels is more medical and less of a loaded term. Similar to Connie, Karen was very clear that she never uses the word 'fat.' She expressed discomfort with the word. With clients Karen sometimes uses the word 'obese,' though she never uses the phrase 'morbid obesity' directly with the patients. She most prefers to use the phrase “struggling with weight

management.” Jana avoids using the word 'obese' with her clients. In fact she expressed great distain for the term.

I hate that word, it has such an awful connotation...I know that is the clinical word...I don't know why it just sounds so, like, hopeless or something.

After inquiring to hear more about her dislike for the word 'obese,' Jana went on to say,

yeah, what *do* I mean by that?...I don't know, maybe just the way it is used, or it is an ugly sounding word, I don't know it's something about how it is not how people normally talk or if they do it's, it's just, it's just to like, it's culturally bound...It's because being obese is not valued as a good thing...it's like have hit danger territory. Sort of has all that red flag threat...bad, bad, bad.

Other participants, including Jill and Margot prefer to use the word 'fat' and avoid medicalized terms like 'obese' and 'overweight.' Jill notes that “you know the only term I really accept is 'fat.’” Jill sees the word fat as

taking a liberty, it's like me saying 'queer'...I believe in calling a spade a spade...because I think it [the word 'fat'] should be taken back.

Margot also uses the word 'fat' because she feels that it is the term that her clients use the most while in sessions with her. Mary and Patricia did not identify a specific terms they use to refer to their fat clients. They seemed to use a number of terms including, 'fat,' 'overweight,' 'heavy,' and 'obese.' Most of the participants had given a great deal of thought to what words they 'should' use in sessions.

Boldness Around use of 'Fat' – Offensiveness of the Word

In my discussion with several of the participants around terminology in reference to their fat clients, they noted that they were surprised that the letter of informed consent for this project used the word 'fat' throughout. Karen acknowledged this as we spoke about the terminology she uses with her clients. She noted,

I would never use the word 'fat.' [*pauses and smiles*], I smile when I say that because I thought of you because I read your consent and I thought [*pauses*] she

uses the word 'fat' and you know, that, and that's a bit bold. I appreciate that terminology...but um, I think for me, I think, I would feel uncomfortable using that, so, so, I wondered about you know, is it my uncomfortableness of that wording or what, what, but it's interesting that some folks will use 'fat' and others will use 'struggling with weight management.'...It probably by in large has to do with the setting in which you are in. I guess I might feel more comfortable to use that phrase otherwise if I wasn't in a professional setting. Maybe? I don't know.

Karen brings up the idea of context here. A number of participants alluded to this as well, noting that depending on who someone is talking to, whether they are in therapy or out in the world and how fatness will be received, will affect the way both clients and clinicians refer to fatness.

Sanitizing or Detoxifying Terminology

Near the end of the interview, Mary returned to the idea of how her clients refer to fatness or size. She explained that some people can be evasive about the terminology they use to refer to their bodies. Often there will be a sanitization of the language used by her clients such as 'being big' or 'taking up a lot of room' or in some cases clients do prefer to use medical terms like 'obese.' She goes on to say that with this sanitization of the language she feels that “you are not allowed to say 'fat'...that immediately it means something...like it is a bad word.” Mary expressed an interest in looking at the ways in which the language we choose, such as words like 'chubby' or 'big', to talk fatness can reflect “a kind of avoidance...of what people think it means.” She sees our focus on medical terminology around fatness as denying all the other cultural meanings inherent in the word 'fat.' Margot also talked in the interview about the fact that she uses the term 'fat' in part to detoxify the word.

That word ['fat'] can feel so humiliating and shaming and yet it is going through their mind and my feeling is it is not so shameful...It certainly is the language I used...when I was overweight...I never would have talked to anyone about being

fat. *Never!* [italics added]...If I didn't mention it maybe they would never know. So it's to sort of neutralize the toxicity in that word.

Margot clarified that both she and her client's use the word 'fat' but almost exclusively in the therapeutic space, not outside.

Fatness as Protection

A reoccurring motif in interviews with participants was the idea of fatness as a protector. Consistently terms such 'shield,' 'armor,' 'barrier' and 'wall' surfaced in conversations with the clinicians. Other ways in which themes of protection emerged include client defenses such as disconnection, avoidance and laughter around the subject of fat, bodies and weight. Finally, another pattern revealed in the data is the effect that this protective behavior had on therapeutic alliance and relationship. Participants reported feeling bored and tired with some of their fat clients. They also noted that in many cases, clients were reticent to talk about fatness in the therapy and if they did it was usually after waiting a long time, a period of safety testing. Ultimately, opening-up required a solid foundation of alliance between the client and clinician.

Shields and Armor

Jill, Greg, Mary, Karen and Jana all spoke directly to the idea that their clients' fatness operated in their sessions and out in the world as a protective barrier. Participants spoke about armor in two different ways. Most often these descriptions came up in conversation as a response to questions about building a relationship with fat clients. Participants spoke of their difficulty in connecting with clients. Here Jana speaks about one of her clients.

There is one woman...she is such an interesting character, cause it's like her body is like part of her [pauses] she's like, I find her so shut down. She is so shut down emotionally. It's almost like her body is in armor...like I can't get past it. Like a wall of a person. Like 'where are your feelings?' She is just numb.

The other way that shields came up in conversations with participants is the way in which fat protected their clients from world. Greg and Jill talk most specifically about this idea.

She was really abused as a kid and by her stepfather...she ran away from home and never went back...I was struck because she was lean up until a certain point and so I asked her about that...and she said...'I know that I feel much more comfortable in the world being fat'...and she thinks of it as some kind of armor or some kind of shield.

Another patient...really did not want to lose weight for a long time...being in a big body provided insulation against dangerous things...when you are really, really big, you can't do much...this was sort of her lot in life – victim-victimizer. Uh, sort of fat shielded her from a lot of that.

In both cases, these clinicians reported that their clients' fat offered a form of safety from a dangerous world.

Client Disconnection from Body and Effect on Therapeutic Relationship

Along similar lines as the armor or shielding, participants also noted that their client's often used defenses such as disconnection, avoidance or laughter in sessions. Margot, Patricia, Karen, Mary, Laura and Jana all experienced difficulty connecting with some of their fat clients. Margot, Mary, Patricia and Karen specifically talk about client's emotional disconnection from their body. Mary talks specifically here about having a hard time staying engaged with a client who seems disconnected.

There's something about her that is a little hard to connect to because everything is a joke and she is laughing all the time and I feel like we don't always get to like, I feel a little sleepy and bored with her because I feel like a lot of feelings are kept at bay.

Jana expresses something similar about one of her clients.

She sits down and it's like I can't get through it [the armor]...She is also hard to sit with...for that reason she is just so mind-numbing...she is hard to connect with. She is so emotionally absent...I almost fall asleep.

This echoing theme of disconnection is described by the participants as a means to avoid feelings and connectedness. Patricia refers to it as a 'cover up.'

This idea relates to another consistent theme of isolation, self-rejection and loneliness. Not only are clients disconnected from their clinicians but in many cases they also disconnect from relationships in the outside world. Jana, Patricia, Karen, Laura and Margot addressed this most specifically in conversations about their clients. In response to a question about what brings clients into therapy, Patricia shares that most of her clients come in to see her “unhappy, lonely, uh, feeling rejected...they just assume that they are not loved and wanted because they are fat.” Jana also referred to a couple of her clients who were lonely and isolated. In the words of one of her clients, “who would want someone like me?” He talked to Jana about the fact that he chose not to bathe very often as an attempt to keep people away from him.

Takes a long time to opening up. Many of the fat clients that the participants talked about in the interviews struggled to open up to their therapists, especially around issues of weight or fatness. Earlier on, Greg discussed his work with one woman who had weight loss surgery forty years ago. The client's surgery was the precursor to modern-day bariatric surgery and was quite crude.

It was a disaster for most people who had them...Many people died, many people had problems with nutrition afterward and she is one of the very few who have never had it reversed....she was not willing to talk about those [weight issues] for a couple of years and dismissed any attempt I had of even asking her experience of having that kind of surgery...now, six years later, is something, very much something she talks about...

Similarly, here Laura talks in reply to a question about how fatness or weight comes up in therapeutic sessions with fat clients.

They [issues of body image] come up sporadically while I think my client is testing out...what my response is going to be...testing for a sense of safety, for a feeling, testing the boundaries...they will sort of drop a factual piece of information, rather than their experience...and then I am aware that they they are looking at me to see how I am going to respond.

Mary and Jana talked about the role of fatness is developing a therapeutic relationship as well, but they both acknowledged that the delayed expression of feelings around fatness in sessions may be less about the client's hesitation and possibly more about the participants' avoidance, hesitation or even 'under appreciation' of how much their fatness affects them. Mary and Jana remark on this issue tangentially alluding to the idea of 'thin privilege.' Though the concept of thin privilege is not specifically stated, Mary intimates it here.

I guess an analogy is the way, um, a white person might not truly appreciate some of the things that are in the air around racism...you know, that I might not appreciate some of the pain that people are talking about especially if they are feeling like a bad person and I think they are terrific...that there are particular things that are specific to their body that maybe they are feeling like I really don't get.

Jana's hesitation to address issues of fatness in the therapy session stems more from her fear that her prejudice will somehow be conveyed to her clients.

I think the hesitation to talk too much about it is probably because I don't want to let on that there might be any disgust or like relief. ' thank God I am not like you' in the conversation...I don't want them to know that I carry that cultural part...I don't want them to think that I think ill of them.

Protection was a prominent discussion point in all the interviews with participants. In some cases it was experienced as armor, disconnection or even avoidance all together.

Stigma and Oppression

A number of participants shared their client's experiences of being stigmatized or oppressed. These clinicians noted that the stories of prejudice really opened their eyes and in many cases really surprised them. Karen relayed a story about her client and the stigmatization related to his size.

I had a male client that came in and he said 'I was supposed to take a trip to go see my family...and I was about to get on the plane. I had my plane ticket. I paid my \$250.00 for the plane ticket and I was stopped by the security guard because I was told I had to purchase another ticket.'...So he could sit on the plane because he was large...and I was even shocked by that because initially I thought I can't even see why you can't fit in a seat....you know he wasn't – he, he made his way into my office...He sits in my seats which are average size.

Mary shared a story—not about her clients, but about her nanny. She felt the story was applicable to her work with fat clients because it opened her eyes to the prejudice that fat people suffer and she recognized how this may affect her process of building relationships with fat clients.

I have an anecdote that is sort of outside work but it really struck me...I had a nanny...and um, she is obese...what struck me is that out in the community um, I would get two reactions. People would...often come up and say, 'I just want you to know...your nanny is incredible with the kids...but I couldn't believe how many times people needed to comment to me on her weight...and ask me if she tends to get junk food for the kids...it was a real education in how people's prejudices were really out there...it was really striking to me.

Jill, Jana and Patricia all talked about clients going to the gym or going to the beach and having stressful, embarrassing or hurtful experiences. Jill's client stopped going to the gym because she received too much attention. She got lots of comments encouraging her to keep exercising as well as many ignorant, hurtful comments about her size. Similarly, Patricia and Jana talked about their clients, choosing not to go to the gym because being in the locker room was scary and they felt judged by the other gym goers.

Clearly oppression takes place outside the therapeutic relationship in the outside world. Beyond these findings of oppression and bias, more nuanced and subjective findings were made around potential bias within the therapeutic relationship and difficulty talking about fatness with the interviewer. Some of these findings are discussed in chapter V – Subjectivity: A Fat Interviewer's Presence.

CHAPTER V

SUBJECTIVITY: A FAT-IDENTIFIED RESEARCHER'S PRESENCE

In an effort to acknowledge my own process throughout this research project, I am dedicating a chapter of my thesis to my subjective experience as the researcher. As a self-identified fat person, I have participated in a number of therapeutic relationships, sometimes as a clinician and sometimes as a client. I come to this research with the bias of my lived experience as a fat person. Undoubtedly, my identification around body size has informed the process of designing the research project, interviewing participants and choices made in data analysis. This chapter evolved in parallel to the findings and discussion chapters. I see writing about my subjective experience as a way to highlight possible parallels between participants' experience of creating a relationship with me and the participants' experience building relationships with their fat clients.

I was most aware of my feelings around subjectivity as I entered into my interviews with participants. With each meeting, I noticed significant anxiety and concerns that I might be judged by my appearance when I met with my participants. In reviewing process notes from my meetings with my participants I found that with seven of the nine participants I experienced a perceptible gaze or awareness of my body. Similarly, I was cognizant of *my* assessment of the participants' bodies and how their ways of self-identifying around their body matched or didn't match my perception of their bodies. My interactions with and reactions to the participants offered me a rich and

complex understanding of what it may be like to sit as a client with some of these participants in a therapeutic session.

Reactions to Interviewer's Body Size

Throughout the interviewing process, I became aware of how much my relationship while interviewing the participants paralleled the fat client-clinician dyad. I wondered at several points throughout the interviewing process how these participants viewed me; did they see me as fat in the way they see their clients as fat? When I met with Margot, Jill, Greg and Karen, I clarified at the beginning of our interview that I self-identified as fat and that I not only felt confident in talking about this subject matter but I also felt confident in my fat body. With Margot, Jill and Greg, this information came up in casual conversation before the taping of the interview. Margot, Jill and Greg inquired before starting the official interview about what drew me to this research and what has motivated me to write this particular thesis. I responded honestly and talked to them about my fat identity and my desire to learn more about clinicians' perspectives on their experience working with fat clients.

With Karen, my last interview, I prefaced the interview by letting her know about my fat identity. I explicitly stated that I hoped she would still feel comfortable speaking honestly to me about her opinions and beliefs. The reason I took this approach with Karen, is because I noticed in my earlier interviews that participants who did not know how I identified appeared uncomfortable during the interviews. Sometimes they would stammer, or avoid questions entirely.

While in the midst of my fourth interview, I noticed a pattern evolving in my interview experiences. I experienced difficulty maintaining eye contact with some

participants, or perhaps they were struggling to maintain eye contact with me. I also noticed that in many cases I felt bored or confused when participants talked about their feelings about fatness or the participant's beliefs about fatness. Some of my boredom or confusion came from participants struggling over their words.

In response to a question about how clients talk about their fatness in therapy- whether their own relationship to their fat, fatness in their interpersonal relationships and/or their relationship to their fatness in our culture, Connie labored to answer the question directly and even seemed to lose track of the original question.

I think I mean it's a combination, cause it is different things for different people...people who I am thinking about specifically, um, I mean, for each of them it was a very different thing [*inaudible*]... I got, I mean, to the extent that I try to like move in that direction....I, I've always addressed it as a health issue...[*inaudible*].

In addition to difficulty answering specific questions, sometimes participants would answer with very terse or one word answers. In response to a question about the effect of a client's regard for her body and if this changed the therapeutic work they did together, Connie responded with “Um, [*pauses*] yes. [*silence*]” When I asked her to elaborate she responded with another relatively evasive answer:

Mh hm, well, okay, I guess I would say I don't [*pauses*] I don't, I don't, um, [*pauses*] I don't approach it as with, I mean I feel like I, I just pay attention to following um where a person I am working with wants to go....and um, so I don't have an agenda on where people should be going with their life.

In the end it appears that Connie's evasive answer ends up contradicting her original answer of 'yes' in reference to whether a client's regard for her body affects the therapeutic relationship.

In a similar way, Laura was very measured with her words. She was thoughtful but also clearly carefully considering and seemingly restricting her answers. A few times she also lost track of her thought or forgot the question I had asked. In reply to a question about what it is like for her to work with her fat clients she responded,

Um, I don't know how to answer that, my client, C, was in treatment a while ago and then left treatment...and has only come back in the last month...ah, uh, I lost track of the question [pauses] isn't that interesting? [pauses] That tells us something...What was the question?

As the conversation continued and the questions became more specific around awareness of bodies in the room and the role bodies in the room play in the process of building the relationship, Laura became increasingly unsure about her answers. In response to this question she explained

[silence] good question. Um, yes, I was aware [pauses] um, how did it affect my building the relationship? [pauses] I think I would have to say that I have a great deal of respect for my clients regardless of how they walk in the door and I don't think that shifts for me with people who enter through the door who are fat...[sigh]...I think that it is right...I mean, I think that is, again, [silence] I have a history of an eating disorder.

Here, Laura makes it clear that she has an awareness of both her body and her clients' fat bodies in the room. In the above quotes she answers hesitantly and in the end acknowledges that what is coming up for her in this conversation is the intersection of her history with an eating disorder as well as what her clients walk in the door with. Her subjectivity became apparent in the room as she reveals the extent to which her history with an eating disorder is with her while she sits with her clients.

At the end of my interviews with Connie, Laura, Mary and Jana I asked them about their experience in talking to me—a fat interviewer—about their therapeutic work with their fat clients. Here are some responses:

Well it makes me feel a little uncomfortable...I mean, I mean sensitively uncomfortable...I guess I would say, you know, stupidly, that it didn't even occur to me that any aspect of that would come into the room with you...that would be – that any aspect – would come into the room with you, that didn't even cross my mind...um, and uh, so given that I don't and won't establish a relationship with you, it's not easy to talk about something that is as loaded as this, with someone with whom I don't have any way of establishing safety nets...so that's not easy.

Yeah, that's a good question. I, I think what is has been is, um, an awareness of that, but not knowing how you feel about it. And so, um, if I knew you were comfortable with it, I think um [*pauses*] the only way I can think of being aware of it is wondering whether there is anything I am saying that would stir things up or be painful of make you feel bad.

Yes, um, it's felt a little awkward. Yeah...That the feelings around not wanting to hurt – I was talking about not wanting to hurt my client's feelings, feeling that here too...but then also knowing that obviously you must be comfortable with your body to even want to do this thesis or like sit with people and talk about it.

In response to my question Connie, Mary, Laura and Jana all talked about being aware of my presence in the room as a fat person. All four of them expressed concern that perhaps they were hurting my feelings. Connie, Mary and Laura all noted that part of the discomfort with the conversation was due in part to our lack of relationship. They drew a distinction between the interview dyad and the therapeutic dyad, the primary difference being that we had not cultivated a relationship built upon trust.

Using myself as the research instrument clearly links my experience to the data outcomes. The data that emerged from this research bears my bias in how I wrote my interview guide, what questions I focused on, my role as the interviewer and my presence in the room as a fat person. Beyond that, all interpretations of the data are branded with my perceptions and also my experience of the interviews. For all the potential issues with bias that this subjectivity brings to bear on the data, there is also a richness and complexity that can be accessed in the relationships between me as the interviewer and the clinicians. Had I chosen to use a survey and take my physical presence out of the

subjective mix, many nuances about language and relationship building may have been lost. The visibility of my size within the interview dyad was a strong presence in this research.

CHAPTER VI

DISCUSSION

Review of the Findings

This qualitative study examined the experience of social work clinicians forging and maintaining therapeutic relationships with fat clients. Multiple frames for understanding fatness were explored through a review of the literature. Semi-structured interviews were conducted with nine licensed clinical social workers and data was analyzed with a grounded approach. The following overarching patterns arose from the data: bodies – both client's and clinician's factor strongly into the therapeutic setting; fatness is often perceived of as a problematic whether by the client, clinician or the outside world; terminology and references to fatness in therapy reflect a complicated relationship to fatness both in culture and in the participant's therapeutic work with their fat clients; and, fatness is often used as a protective 'tool' for clients in the outside world as well as in therapeutic sessions.

Findings revealed that participants were forthcoming about both transference and counter-transference feelings that arose specifically around bodies in their session with fat clients. Social work clinicians have a wide range of awareness or understanding about their relationship to their own bodies. When we bring ourselves to a therapeutic relationship, whether as a client or as a clinician, we bring our histories, our ideas, our biases and we bring our bodies into the room. Bodies may be considered 'appealing,' 'desirable,' 'attractive,' or on the other end of the spectrum, they may be considered

'ugly' or 'grotesque' or somewhere between the two. As clinicians we can not know what kinds of feelings our bodies may evoke in a client until we sit with them, get to know them and see the patterns of relationship that evolve through the building and maintaining of therapeutic alliance. On the flip side of this equation, we as clinicians are likely to have counter-transferential reactions to our clients and these inevitably crop up within the context of the work we do “in the room.” This was clearly evidenced in the conversations with the research participants. Clinicians spoke of their awareness about bodies in the room – both their own body and their clients’ bodies.

Findings revealed that fatness could be assessed as problematic but also as a means of protection. Ways in which fatness was perceived to be problematic include: fatness as indicative of an eating disorder; a propensity to binge eat or as symptomatic of an addiction to food. Our bodies represent ourselves to the world. When we are “seen” by others, we are inherently evaluated by them. Central to much of the work we do as social work clinicians is assessment of our clients. These assessments are necessary to determine a baseline presentation of the client and to help us determine how we may be most helpful to them. Because we predicate many of these determinations based on what we observe, identifying fat as a sign of pathology or problem could lead to biased assessments.

Other findings show that clinicians' can experience clients' fatness as a defense, shield or protection. This protection seems to be useful to clients both as a physical protection against attention or threatening relationships and also an emotional protection against difficult feelings. Interestingly clinicians talked about the ways in which this

emotional protection was often so effective that it could become a barrier to work in therapy.

A primary finding emerged around terminology and references to fatness. Part of our preparation for our work as social work clinicians is to gain knowledge and understanding of ourselves – enough that we can do our best to gain awareness of our biases or judgments so that we can be mindful of their potential to influence our perceptions of our clients. One way that we can check in with our biases is to examine the language that we use and what that language might imply. So much is conveyed in the language and the attitudes around fatness. Participants thought a good deal about the language that they chose to use with clients. There were differing opinions about what kind of terminology is 'appropriate.' About one third of the participants were clear about the fact that they consciously chose not to use the word 'fat' with their clients. They expressed concern that the term is hurtful and in the words of Connie, 'pejorative.' Other participants expressed discomfort using the word 'obese,' as it conjured too medicalized or distancing way or referring to their clients' bodies.

Social work generally favors communication through talk. Thus, the terminology and ways of referencing we use as clinicians holds significant meaning and impacts the development and maintenance of the therapeutic alliance. The profession of social work may really benefit from determining a standard approach to language around fatness.

Findings from this study show that clinicians do harbor judgments and biases against fat people. Judgments voiced by the participants about fat people include: laziness; lacking in self-control; self-loathing and pathological natures. Interestingly many participants noted that they don't feel these judgments about their clients but they

find themselves having these judgments about 'other' fat people. As a profession social workers understand that countertransference is an inevitable part of our work with clients. As such, clinicians are encouraged to examine our histories and our beliefs as well as the ways these intersect, collide and are triggered by our clients. We are asked to have awareness and curiosity around what we, as clinicians, bring to the therapeutic relationship. When viewed through the theoretical lens of intersubjectivity, clinical social work with fat clients requires an examination of our own relationship to fat, our understanding of what it means to be fat and how we talk about fatness.

Limitations

This was a small, exploratory study, intended to identify themes from narrative data. While the small sample size (N=9) allowed for rich and plentiful detail about these nine clinicians' experience with their fat clients, validity and application to a wider population is not possible. With access to more time and resources, the study would have benefitted from more participants. Other limitations of this particular sample include the preponderance of white, heterosexual, partnered, able-bodied, thin participants. Future research should gather information from a more diverse sample.

Another factor to consider in this particular sample is the self-selective quality of the participants. The subject matter was challenging to the participants. Most participants who joined the study expressed a specific interest in bodies and body image. Beyond that, a significant number of the participating clinicians spoke of a history with eating disordered behavior or body dissatisfaction.

My self-identification as a fat person also presented limitations in the interviewing process. A number of clinicians noted difficulty in speaking openly to me

for fear of causing hurt feelings. Participants also expressed fear that there was not enough safety created in the interview relationship to feel confident in talking about their client's fatness. Awkwardness around this subject area was expressed both non-verbally and directly in response to my questions about what it was like to talk about his subject with a fat interviewer. There was a benefit to this as well because my subjectivity lent a possible view into what it might be like to be a client with these particular participants.

Another limitation based on my self-identification, is the bias I hold in this particular subject area. As someone who has been both a fat client and a fat clinician as well as an active participant, advocate and activist in the fat acceptance movement, I am aware that this bias was a consistent and conscious presence throughout the process of the research project. That said, I worked to keep personal bias separate from the research at all stages, in the conceptualization, design, implementation and analysis of the research.

Given the opportunity to do this research again or with access to more resources, I would interview more clients. I would also like to add a qualitative component to the data collection, in the form of an anonymous survey. It would be easier to measure reliability and validity using quantitative data. Using mixed methods using qualitative interviewing and a quantitative survey, would allow for the gathering of rich, narrative data but also for maximum objectivity and a wider range of participants.

Implications for Professional Practice

This research is applicable to social work practice, research and training. The majority of participants noted in interviews that they were thankful to have the opportunity to talk about their work with fat clients. All clinicians expressed that there is

a lack of discussion, knowledge or understanding about work with fat clients. This is clearly reflected by a lack of literature surrounding the subject.

As social workers we are not immune to cultural perceptions and ways of thinking. As discussed in the literature review, fatness is viewed in our culture in myriad ways. Various lenses used to view fatness may include: fat as a health concern; fat as an eating disorder; fat as a political issue; fat as a source of bias and oppression; fat as an impediment to therapy; fat as a source of protection and fat as a means of identification. A challenge that faces us as social workers is understanding our relationship to fatness; what does it mean to us?; what does it mean to our clients?; and what do we make of these multiple meanings within our therapeutic work together?

Social Work Practice Implications Related to Fatness as a Health Concern

As fatness and obesity continue to be perpetuated as an epidemic-level health concern, the incidences of weight loss surgery continue to grow. The number of gastric bypass surgeries climbed more than 600% from 1993 to 2003 (Szabo, 2008; Bariatric Surgery.info, 2008). Recommendations by the National Heart, Lung and Blood Institute call for clients who are clinically considered 'severely obese' and are unable to lose weight through diet and exercise to have weight loss surgery (National Heart, Lung, and Blood Institute in cooperation with The National Institute of Diabetes and Digestive and Kidney Diseases, 1998). As doctor's recommendations for weight-loss surgery become more prevalent for fat clients, social work clinicians will also see a rise in clients who are considering the surgery.

One of few books about the psychological effects of weight-loss surgery entitled, *Obesity surgery: Stories of altered lives* outlines many of the ways in which clients who

are contemplating or plan to have obesity surgery may present to clinicians. The authors talk about the many ways in which surgery candidates may require psychological guidance and support around the process. Therapist may act as a 'gatekeeper,' conducting evaluations and declaring readiness for surgery. Clinicians may also provide support to clients around ambivalent feeling about the outcome of their surgery and subsequent effects. While often the weight loss is invited, some of the unexpected negative consequences are not. A client's relationship to the world may change rapidly and dramatically with the loss of significant amounts of weight (Meana & Ricciardi, 2008).

Social Work Practice Implications Around Fatness as an Eating Disorder

The findings show that fatness is often perceived by clinicians, clients and members of the outside world as a 'problem.' One of the ways in which this manifested in the data analysis was the conceptualization of obesity as an eating disorder. Members of the DSM V task force, who are determining what will be included in the next version of the DSM, would like to add obesity as an eating disorder which would additionally classify it as a mental disorder. In an editorial for the American Journal of Psychiatry, one of the members of the task force to determine what changes will be made to the newest edition of the DSM posits that:

Obesity is characterized by compulsive consumption of food and the inability to restrain from eating despite the desire to do so. These symptoms are remarkably parallel to those described in DSM-IV for substance abuse and drug dependence, which has led some to suggest that obesity may be considered a “food addiction” (Volkow & O'Brien, 2007, p.708).

The opinion that obesity is an eating disorder or even an addiction, though not currently accurate, is popular among influential members of the psychiatric community. Clearly if fatness is determined to be a mental disorder, addiction or eating disorder, it will be

incumbent upon social workers to acknowledge this population as a distinct entity requiring specific attention and care.

Social Work Practice Implications Around Fatness as a Form of Oppression

Findings from this study suggest that fatness as a form of oppression factors into work with fat clients. Clients may bring their experiences of bias or oppression to the therapeutic work. As social workers our professional code of ethics mandates that we maintain cultural competence, including an understanding and sensitivity to clients' cultures and the differences among people (NASW, 1996).

Because a majority of participants were thin, there was a good deal of conversation around 'working across difference.' As a profession we strive to be cognizant of how difference may play out in our work with clients and, as indicated in this research, fatness is clearly perceived as a kind of difference both by clinicians and by clients. Harkening back to the intersubjective theoretical framework, we must be cognizant in our social work practice of the role that bodies play in the therapeutic setting.

Implications for Social Work Research

The implications of this research on further social work research are many. The majority of participants noted that were interested and excited to learn about the results of this research. They believed that this kind of research would be useful for them in their practice with fat clients. It is clear that a wider range of participants would yield more thorough results. Also this subject area would benefit from a more complete understanding of fatness in therapy across sociocultural lines. Obviously lacking from this research is the point of view of the client and their experience. This would be an

important subject area to research, hopefully illuminating best practices for work with fat clients.

Implications for Social Work Training

Lastly, the research reveals just how vital it is to have a discussion about bodies, eating disorders, fatness and its implications on therapy within the context of social work training. Raising awareness around diversity of body size, potentially-held biases and judgments and misconceptions about fatness is critical for successful work with fat clients. Understanding our own relationship to fatness, as clinicians, is also an integral part of what we need to encourage in the training of our social work clinicians.

The Council on social work education is the current accrediting institution for social work training programs. They have comprehensive standards for education policy. Clearly missing from these standards is an acknowledgment of size discrimination. The existing social work education standards address the need for social workers to engage diversity and difference in practice. The following statement comes directly from the Council on Social Work Education standards.

Dimensions of diversity are understood as...factors including age, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation. Social workers appreciate that, as a consequence of difference, a person's life experiences may include oppression, poverty, marginalization, and alienation as well as privilege, power, and acclaim (Council on Social Work Education, 2008 pp. 4-5).

As is evidenced in this research we have seen the ways in which fat or size oppression is at play in many fat people's lives. The lack of attention or dialogue about fat prejudice is problematic and concerning. In many ways fat oppression remains invisible to the profession. Using this research as a foundation to more research on the pernicious nature

of size oppression, the hope is that consciousness-raising will grow and fat people's concerns can be addressed and made visible in an open, engaged way. As long as the concerns of fat people remain invisible to social workers, we will continue as a profession to perpetuate size oppression.

References

- Agell, G., & Rothblum, E. D. (1991). Effects of clients' obesity and gender on the therapy judgments of psychologists. *Professional Psychology - Research and Practice*, 22(3), 223-229.
- Ancis, J.R. & Szymanski, D.M. (2001). Awareness of white privilege among white counseling trainees. *The Counseling Psychologist*, 29(4), 548-569.
- Bariatric Surgery.Info. (2008). *Bariatric Surgery Statistics*. Retrieved June 15, 2009 from <http://www.bariatric-surgery.info/statistics.htm>.
- Becker, H. S. (1963). *Outsiders: Studies in the sociology of deviance*. New York: Free Press.
- Berzoff, J., Flanagan, L.M., & Hertz, P. (2002). *Inside out and outside in: Psychodynamic clinical theory and practice in contemporary multicultural contexts*. Lanham, MD: Jason Aronson.
- Boero, N. (2007). All the news that's fat to print: The American "obesity epidemic" and the media. *Qualitative Sociology*, 30, 41-60.
- Brown, L. S. (1989). Fat-oppressive attitudes and the feminist therapist: Directions for change. *Women & Therapy*, 8(3), 19-30.
- Chernin, K. (1981). *The obsession: Reflections on the tyranny of slenderness*. New York: Harper & Row.
- Chernin, K. (1986). *The hungry self: Women, eating and identity*. New York: HarperCollins.
- Counsel on Social Work Education. (2008). *2008 Educational policy and accreditation standards*. Retrieved June 16, 2009 from <http://www.cswe.org/NR/rdonlyres/2A81732E-1776-4175-AC42-65974E96BE66/0/2008EducationalPolicyandAccreditationStandards.pdf>. pp.4-5.
- Crandall, C. S. (1994). Prejudice against fat people: Ideology and self-interest. *Journal of Personality and Social Psychology*, 66(5), 882-894.
- Davis-Coelho, K., Waltz, J., & Davis-Coelho, B. (2000). Awareness and prevention of bias against fat clients in psychotherapy. *Professional Psychology-Research and Practice*, 31(6), 682-684.
- Dennis, P. K. (2004). *Fat in the countertransference: clinical social workers' reactions to fat patients*. (Doctoral dissertation, The Institute for Clinical Social Work, 2004). Dissertation Abstracts International, 66, 2721.

- Ernsberger, P. & Haskew, P. (1986). News about obesity. *New England Journal of Medicine*, 315, 130–131.
- Fishman, S. G. B. (1998). Life in the Fat Underground. *Radiance: The Magazine for Large Women Online*, Winter 1998, retrieved October 20, 2008 from http://www.radiancemagazine.com/issues/1998/winter_98/fat_underground.html.
- Flegal, K. M., Williamson, D.F., Pamuk, E.R. & Rosenberg, H.M. (2004). Estimating deaths attributable to obesity in the United States. *American Journal of Public Health*, 94(9), 1486-1489.
- Garland-Thomson, R. (2005). Feminist disability studies [Critical Essay]. *Signs*, 30(2), 1557-1587.
- Gaesser, G. A. (2002). *Big fat lies: The truth about your weight and your health*. New York: Fawcett Columbine.
- GovTrack.us. H.R. 554--109th Congress. (2005). *Personal Responsibility in Food Consumption Act of 2005*. GovTrack.us (database of federal legislation) retrieved May 20, 2009 from <http://www.govtrack.us/congress/bill.xpd?bill=h109-554&tab=summary>.
- Hamilton-Mason, J. (2004). Psychodynamic perspectives: Responding to the assessment needs of people of color. *Smith College Studies in Social Work*, 74(2), 315-332.
- Healthy Arkansas: For a Better State of Health (n.d.). Worksite Wellness. Retrieved May 20, 2009 from http://www.arkansas.gov/ha/worksite_wellness/index.html.
- Henig, R.M. (2008, October 5). Losing the Weight Stigma. *New York Times Magazine*, p. 24.
- Jutel, A. (2006). The emergence of overweight as a disease entity: Measuring up normality. *Social Science & Medicine*, 63, 2268-2276.
- Kahn, M. (1997). *Between therapist and client: The new relationship*. New York: Henry Holt.
- Kirkland, A. (2008). *Fat rights: Dilemmas of difference and personhood*. New York and London: New York University Press.
- Kurland, R. (2002). Racial difference and human commonality: The worker client relationship. *Social Work with Groups*. 25(1/2), 113-118.
- Lasalandra, M. (1998, January 1). Doctors say losing weight is emphasized too heavily [Electronic Version]. *The Boston Herald*, p.20.

- LeBesco, K. (2004). *Revolting bodies: The struggle to redefine fat identity*. Amherst: University of Massachusetts Press.
- Leibovich, M. (2006, January 17). Fire in the belly: Arkansas Gov. Mike Huckabee, dedicated to fighting obesity, could have a meaty opportunity ahead [Electronic Version]. *The Washington Post*. Retrieved May 20, 2009, from http://www.washingtonpost.com/wp-dyn/content/article/2006/01/16/AR2006011601380_3.html.
- Lester, R. (1999). Let go and let god: Religion and the politics of surrender in overeaters anonymous. In Sobal, J., Maurer, D. (Eds.). *Interpreting weight: The social management of fatness and thinness*. Hawthorne, NY: Aldine de Gruyter.
- Miller, J., Donner, S. & Fraser, E. (2004). Talking when talking is tough: Taking on conversations about race, sexual orientation, gender, class and other aspects of social identity. *Smith College Studies in Social Work*, 72(2), 377-392.
- Miller, J. & Garran, A.M. (2008). *Racism in the United States: Implications for the helping professions*. Belmont, CA: Thomson Brooks.
- Mitchell, S. & Aron, L. (1999). *Preface to relational psychoanalysis: The emergence of a tradition*. Hillsdale, NJ : The Analytic Press.
- Mokdad A. H., Ford, E. S., Bowman, B. A., Dietz, W. H., Vinicor, F., Bales, V. S., Marks J. S. (2001). Prevalence of obesity, diabetes, and obesity-related health risk factors. *Journal of the American Medical Association*, 289(1), 76–79.
- Mokdad, A. H., Marks, J. S., Stroup, D. F. & Gerberding, J. L. (2004). Actual causes of death in the United States, *Journal of the American Medical Association*, 291(10), 1238-1245.
- Moral. (2008). In *Merriam-Webster Online Dictionary*. Retrieved October 26, 2008, from <http://www.merriam-webster.com/dictionary/moral>.
- Muennig, P., Jia, H., Lee, R. & Lubetkin, E. (2008). I think therefore I am: Perceived ideal weight as a determinant of health. *American Journal of Public Health*, 98 (3), 501-506.
- Myers, A. & Rosen, J.C. (1999). Obesity stigmatization and coping: Relation to mental health symptoms, body image, and self-esteem. *International Journal of Obesity*, 23, 221-230.
- National Association to Advance Fat Acceptance. (n.d). *We come in all sizes: Understand it, accept it, support it*. Retrieved October 20, 2008 from <http://www.naafaonline.com/dev2/education/index.html>.
- NASW. (1996). *Code of ethics*. Washington, DC: Author.

- National Heart, Lung, and Blood Institute in cooperation with The National Institute of Diabetes and Digestive and Kidney Diseases. (1998, September). *Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults*. NIH Publication No. 98-4083 retrieved June 9, 2009 from http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.htm.
- Oliver, J.E. (2006). *Fat politics: The real story behind America's obesity epidemic*. New York: Oxford University Press.
- Olshansky, S. J., Passaro, D. J., Hershow, R. C., Layden, J., Carnes, B. A., Brody, J., Hayflick, L., Butler, R. N., Allison, D.B. & Ludwig, D. S. (2005). A potential decline in life expectancy in the United States in the 21st century. *New England Journal of Medicine*, 352, 1138–1145.
- Orbach, S. (1990). *Fat is a feminist issue: The anti-diet guide to permanent weight loss*. New York: Berkley Books.
- Puhl, R. & Brownell, K. D. (2001). Bias, discrimination, and obesity. *Obesity Research*, 9(12), 788-805.
- Pulera, D. J. (2002). *Visible differences: Why race will matter to Americans in the 21st century*. New York: Continuum.
- Rabin, R.C. (2008). *In the fatosphere fat is in, or at least accepted*. *New York Times*. January 22.
- Ridley, C.R. (2005). *Overcoming unintentional racism in counseling and therapy*. (2nd ed.). Thousand Oaks, CA: Sage.
- Smith, D. (2004). Demonizing fat in the war on weight. *New York Times*. May 1.
- Stunkard, A.J., LaFleur, W.R. & Wadden, T.A. (1998). Stigmatization of obesity in medieval times: Asia and Europe. *International Journal of Obesity & Related Metabolic Disorders*, 22(12), 1141-1145.
- Sue, D. W. (2004). Whiteness and ethnocentric monoculturalism: Making the “invisible” visible. *American Psychologist*, 59, 759–769.
- Sue, D.W., Capodilupo, C.M. Torino, G.C., Bucceri, J.M., Holder, A.M.B., Nadal, K.L. & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, 62(4). 271-286.
- Szabo, J. (2008). Who sets the standards for Bariatric Care? *Hospitals & Health Networks*, 82(7), 60-62.

- U.S. Department of Health and Human Services. (2000). *Healthy People 2010: Understanding and Improving Health*. Washington, DC: U.S. Government Printing Office.
- Volkow, N.D. & O'Brien, C.P. (2007). Issues for DSM-V: Should obesity be included as a brain disorder? *American Journal of Psychiatry*, *164*, 708-710.
- Wallis, C. (2004). Lessons learned from the summit. *Time Magazine Online*. June 5. Retrieved October 26, 2008 from <http://www.time.com/time/health/article/0,8599,646304,00.html>.
- Winnicott, D. W. (1956). On transference. *International Journal of Psychoanalysis*, *37*, 386-388.
- Wolf, N. (1990). *The beauty myth: How images of beauty are used against women*. New York: William Morrow.

APPENDIX A - INFORMED CONSENT FORM

Dear Participant:

My name is Polly Hanson and I am a Master's level graduate student at Smith College School for Social Work. I am conducting research for my thesis designed to explore clinical social workers' experiences of working with fat clients. You have been asked to participate in this study because you have experience working with fat clients. This study is being conducted as part of the requirements for my degree and may also be used in possible future presentations or publications on the topic.

If you choose to participate, you will sit for a taped interview with me that will last approximately 60 minutes. As part of the interview I will ask you to answer a few demographic questions. The interview itself will consist of questions focusing on your experience working with fat clients, such as "What specific themes have surfaced in your work with fat client(s)?" "What issues did your fat client(s) bring to their therapeutic work?;" and "How if at all, does your work with fat clients differ from your work with other clients?" As a participant it is understood that you are a licensed clinical social worker with at least 2 years of experience working with clients. You should also have experience working with at least two fat clients.

There are no major risks to participating in this study. However, it is possible that participating in this study may trigger feelings related to your own body or your experience working with clients who are fat. You may refuse to answer any question, may withdraw from the interview at any time and may withdraw from the study up until April 15, 2009. Should you withdraw, all materials related to you will be immediately destroyed.

While there will be no financial benefit for your participation in this study, it will allow you to share your experience in working with fat clients. Your contributions will provide information that may be helpful in furthering the knowledge of clinical practice with fat people. You may also gain new perspective in developing therapeutic relationships and alliances with fat clients.

Strict confidentiality will be maintained, as consistent with federal regulations and mandates of the social work profession. The audiotape of the interview will be assigned a number for identification. You will not be asked to identify your name while the tape is running. Participants will be asked not to identify themselves or any clients they discuss. Any identifying information that is inadvertently recorded will not appear in the transcriptions. Some illustrative quotes may be used in this thesis but will be reported without identifying information and disguised if necessary. I will be the primary handler of all the data including tapes and any transcripts created. My research advisor will have access to the data collected during the interview including transcripts of summaries created only after it is coded and will assist in the analysis of the data. I will be the only

person doing the transcribing. I will keep the tapes, 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 will be destroyed.

Your participation in this study is completely voluntary. You are free to refuse to answer specific questions and you can withdraw from this study at any time, before or during the interview. Should you withdraw, all materials pertaining to you will be immediately destroyed. However, the final date of withdrawal is April 15, 2009 when the report will be written.

If you have any additional questions about the study or wish to withdraw, please feel free to contact me at the address below. If you have any concerns about your rights or about any aspect of the study, I encourage you to call me or the chair of the Smith College School for Social Work Human Subjects Review at (413) 585-7974.

L. Polly Hanson
300 The Fenway
Boston, MA 02115
617.521.3073
lhanson@smith.edu

Your signature indicates that you have read and understand the above information; that you have had an 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: _____

If you have any questions or wish to withdraw your consent, please contact Polly

THANK YOU for taking the time to participate in this research project. Your help is greatly appreciated.



ARE YOU A SOCIAL WORK CLINICIAN INTERESTED IN BODY IMAGE?



I am a masters-level graduate student who is conducting research on clinical social workers and their experience working with clients who are fat, overweight or obese.



If you are a licensed clinical social worker who has been practicing for at least 2 years, have worked with fat, overweight or obese clients and you are interested in participating in a 60-minute interview for my masters thesis project, please contact Polly at 617.521.3073 or you can email her at lhanson@smith.edu.



Please pass this on to other clinical social workers who you feel might be interested.

APPENDIX C - INTERVIEW GUIDE

How many years have you practiced in clinical social work?

How do you choose to identify...

How do you choose to identify your body and/or size?

What is your theoretical frame for the clinical work you do?

What issues do you feel your fat clients brought to the therapy?

- What kinds of presenting problems did your fat clients bring?
- Did your clients come to therapy specifically around their weight and their body?
- If clients talk about their fatness, do they talk about:
 - Their own relationship to fat?
 - Their relationships with others and how fatness affects these relationship?
 - Their relationship to cultural expectations?

Can you tell about how fatness factors into therapy with these clients?

- Do issues around body image come up often?
- What about weight or size?
- Who tends to bring up body or weight concerns and in what context do they arise?
- How do you feel your clients define their bodies and/or their fatness
 - Is this in a positive way or in a negative way?
 - Are there specific words that fat clients use to refer to their fatness?
- What kinds of feelings are expressed when talking about fatness/weight or body

Can you tell me about your work with fat clients?

- What was it like building a relationship with your fat clients?
- What were your reactions to those fat clients?
- What kinds of counter-transferential feelings have you experienced
- Do you feel you ever judge your fat clients?
 - If so, in what way and why?
- Do you feel countertransference ever informed your responses to your fat clients?
- Do you see any parallel in your work with fat clients as you do with clients who are from oppressed populations?

How, if at all, does your work with fat clients differ from your work with other clients?

- What kinds of goals have you had with your fat clients.
- Does this differ from the goals you have set for your non-fat clients?

How does your relationship to your body impact your relationship to fat client(s)?

- Do you/have you ever struggled with your body image?
- Does this make it easier or harder to sit with fat clients?

APPENDIX D- HUMAN SUBJECTS REVIEW APPROVAL LETTER

February 10, 2009

Lauren Hanson

Dear Polly,

Your revised materials have been reviewed and they are now complete. We are happy to give final approval to your project. I hope that the fact that you have limited your recruitment efforts won't mean that you don't get enough participants. Of course, if you decide to email or post a flier more widely, you can always come back to us with that change.

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 study.

Sincerely,

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

CC: Luba Feigenberg, Research Advisor