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Michael J. Carter
Male Obesity: A Qualitative
Study of Clinical Attitudes
and Perspectives

ABSTRACT

This study was undertaken to explore the clinical attitudes of mental health professionals towards obese men as well as the effects of these attitudes on mental health treatment. In addition this study contributes to the growing body of literature concerning the shifting role of men's body image in the United States and the ways in which this is understood in the mental health field.

Interviews were conducted with 12 male and female mental health clinicians in an inpatient and outpatient setting. They were interviewed regarding their perspectives on obesity, gender and obesity, male body image, and assessment and evaluation of obesity in the clinical setting.

The findings of the research showed that there are gendered perspectives toward obesity that does affect treatment. Other significant findings were that clinicians were able to conceive of many cultural aspects that generate alternate understandings of obesity. Of further interest was the lack of fluency in discussing male body image.

While participants held varied attitudes, these attitudes were strongly informed by cultural bias about obesity and bias about men. Further research is needed to develop a more thorough understanding of clinician attitudes towards men who veer away from the norm in size and shape, and the impact of shifting configurations of the ideal male on male body image.

MALE OBESITY: A QUALITATIVE STUDY OF CLINICAL ATTITUDES AND
PERSPECTIVES

A project based upon an independent study
submitted in partial fulfillment of the degree of
Master of Social Work.

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CHAPTER I

INTRODUCTION

The male body: the idea conjures virility, strength, and musculature. This idealized body-- think Michelangelo's "David," or Brad Pitt: the idea and the ideal mixed, conjoined so that they are inseparable—is increasingly prevalent in popular culture and is initiating more men into a "struggle with body image similar to what women have long experienced" with some gendered differences (Tager et al, p. 229, 2007). The obese body digresses from the ideal and the ideal digresses from real bodies. For instance, the obese body is medicalized, measured, assessed for symptoms, risks and mortality rates. It is something to cure, a health risk: obesity kills (Devlin, Yanovski and Wilson, 2000). So when an obese man enters a clinical setting as a patient or client what are the assumptions that accompany him? What is the reaction? Is this to be understood as a genetic mutation, an inevitable outgrowth of the good life, an out-growth of a toxic environment?

Since 1960 the rate of obesity in the United States has doubled without regard to race, ethnicity, gender or class. Despite the democracy of this demographic tide perceptions and meanings of obesity differ from one category to another. Perceptions differ between African-Americans and white Americans; for instance, white women (with the lowest obesity rate of any categorized group with the exception of Asian's who have lower overall obesity rates) stigmatize obesity the most and are stigmatized the most

for being obese (Helb and Turchin, 2005). Several writers have noted that there is significant literature exploring the issue of women's relationship to their body, weight, image, psychology and eating habits but there is a concomitant dearth of information about men (Tager, Good & Morrison, 2006) (Helb & Turchin, 2005) (Robb and Dadson, 2002) (Hager, Norman, Zabinski, Sallis, Calfas and Patrick, 2007). This poverty of information is suggestive in and unto itself but there is a rise in the number studies being done in relation to men's bodies. This is a reaction somewhat to a rising number of men developing eating disorders, abusing steroids, obesity rates, expressions of body dissatisfaction and the need for interventions based on constructs that address the psychological needs of men specifically (Hagler et al, 2007) (Helb and Turchin, 2005) (Robb & Dadson, 2002).

The dramatic rise in obesity in the United States has no singular cause. Sedentary lifestyles, junk food, mood disorders, binge-eating disorder, genetics, the diet industry, evolution's slow clock unable to keep up with modern life are all posited as components creating this increase of obesity (Price, 2006). A recent study from the New England Journal of Medicine (Christakis and Fowler, 2007) develops a theory that at least in part the growth of obesity rates has to do with norms in social networks. Though there is no single cause the costs are impressive. In 2002 Finkelstein, Fiebelkorn and Wang estimated that medical spending for obesity was 92.6 billion dollars (NIDDK, 2007). Medical complications associated with obesity are numerous including increased risk and prevalence of diabetes, cardiovascular problems, respiratory conditions, skin breakdown and infections, sleep disturbances, sexual inhibitions, orthopedic degeneration, increased cancer risk among others (Price, 2006). With the seriousness of these problems and the

growth of the population there is no doubt that the social work industry is managing many patients already who are obese and are likely to continue to clinically deal with obese people.

This is an exploratory study. By interviewing twelve mental health professionals this researcher hoped to uncover the attitudinal dynamics of male obesity in two mental health settings: one inpatient and one outpatient. How clinicians perceive obesity and think about obesity may or may not impact treatment. Thus, the central inquiry of this study is: what are the attitudes that mental health clinicians have about obese men? Several related questions that will be raised along the way will have to do with two main dynamics. One of these dynamics is the general attitudes toward obesity. The other is attitudes toward the male body. Many of these questions came out of this researcher's experience working in field placement with a morbidly obese man. There was a poverty of information for treatment directions and options. When searching for materials obesity was frequently paired with eating disorders and, almost exclusively, eating disorders stem from studies on women. This experience left me without full theoretical and practical researched guidance.

Thus, this study is undertaking the dual attitudinal pairings of men and the obese. One population is socially privileged. The other socially targeted.

This study will then be weighed against psychoanalytic theory that explores clinical attitudes and their role in treatment, and especially in the treatment of obesity.

CHAPTER II

LITERATURE REVIEW

This thesis is exploring the attitudes of mental health clinicians toward obese males in order to uncover possible unconscious bias, preconceptions and as to whether there is a gendered perception that colors treatment. The following literature review anticipates the field of inquiry. In broad terms this review will engage the major themes that will be addressed in the interview questions. The questions cover some demographic information including experience and training as well as gender and age. The interview questions include the clinician's thoughts about and experience with obesity; the clinician's belief as to whether gender informs their belief system on obesity or not; the clinician's thoughts on the cause of obesity and where obesity lands in the eating disorder spectrum/continuum. This study also asks about social perceptions of the male body and the male obese body. The interview also asks how, or if, these beliefs affect the clinical setting, and factor in to the overall assessment and treatment plan. Interview questions fall into three basic categories: eating disorders and obesity which includes attitudes toward obesity, the male body and the construction of masculinity, and the psychoanalytic theory/psychodynamic theory of countertransference and theories of how clinical attitudes may or may not impact clinical practice. Examining the literature of each of these categories will provide the framework for this author's investigation of clinical attitudes and perceptions of male obesity and the linkages between the

understanding of the male body, clinical attitudes and perceptions, and obesity and how they impact the treatment of obese males.

Epidemiology

This section will provide a brief discussion of obesity related statistics noting demographics in terms of population groupings across race, gender and age. This discussion will provide the backdrop in which to begin to explore the issue of men and obesity more explicitly. One of the questions for this study is whether or not obesity in men is a discrete category in terms of treatments. If patterns of obesity differ for men and women, and if social norms for men that contain contrasting expectations, then treatment plans, sequelae, root causes, psychological/emotional adjustments, self-concepts, and symptom pictures may also differ for men and women. This section will start by exploring demographic numbers. This thesis seeks to explore then the basic epidemiological numbers to provide the empirical base for further qualitative explorations.

There are several definitions of obesity. According to The Obesity Society (2007) “Obesity is the excessive accumulation of adipose tissue to an extent that health is impaired” (http://naaso.org/information/what_is_obesity.asp). The U.S. Department of Health and Human Services (2007) defines overweight and obesity as:

an excess of body weight compared to set standards. The excess weight may come from muscle, bone, fat, and/or body water. Obesity refers specifically to having an abnormally high proportion of body fat. A person can be overweight without being obese, as in the example of a bodybuilder or other athlete who has a lot of muscle. However, many people who are overweight are also obese (p. 1).

What is important to note in these two definitions is that the former definition includes the issue of health. The latter definition holds a more neutral stance not suggesting any health or psychological associations. The Centers for Disease Control (2007) defines overweight and obesity as “both labels for ranges of weight that are greater than what is generally considered healthy for a given height. The terms also identify ranges of weight that have been shown to increase the likelihood of certain diseases and other health problems”

(<http://www.cdc.gov/print.do?url=http%3A%2F%2Fwww.cdc.gov%>). But these are broad definitions, vague and without specifications. The question remains what is obesity besides excess fat that may or may not affect health? What then are the parameters, measurements and trends?

The world-wide standard of overweight/obesity is based on the Body Mass Index or BMI. The BMI is based on the ratio of height to weight (kg/m^2). BMI measurements of 18.5 to 24.9 are considered healthy, any BMI 25 to 29.9 is considered overweight/obese and any BMI measurements greater than 30 kg/m^2 is obese. These are loose categories or ranges developed by the World Health Organization (WHO) and accepted by the CDC at the National Institute of Health. There are other means to measure obesity among them are skin fold thickness and waist circumference, calculation of waist-to-hip circumference ratios, and techniques such as ultrasound, computed tomography, and, magnetic resonance imaging (MRI). This is important because the BMI is not a diagnostic tool. It is used to estimate trends in weight but it is an inaccurate measurement. It is convenient but can be misleading because for example since muscle weighs more than fat, athletes who are heavily muscled tip the scale; thus, even though

they may have low body fat the BMI might show a heavily muscled person as overweight or obese. BMI is more accurate than weight alone but must also be age adjusted. Elderly or ill people who have lost muscle mass may record too low on the BMI because their mass has diminished but they may still be overweight.

Another measurement for obesity is waist measurement. At 40 inches for men and 35 inches for women obese people are considered more at risk for obesity related health problems. But waist size is not a measurement for obesity per se but rather a diagnostic sub-category where risks from obesity are assessed. This is particularly relevant for this study as fat built up around bellies (known as “apple” shaped) is more common among men. It also connected to specific obesity related health risks (Price, 2006). Another complication using BMI as a measurement is that in self-reported studies, for instance, the trend studies by state by the CDC, the numbers are self-reported. Self-reporting tends to be inaccurate by over-reporting height and underestimated weight which skews the BMI data downward, resulting in lower numbers in the reporting of obesity by state. Therefore the numbers are skewed too low. However, the majority of the US statistics come from the National Health and Nutrition Examination Survey which is a directly applied instrument (The Obesity Society, 2007).

Despite the inaccuracies of the BMI it is widely used as a predictor to estimate broad trends. And the numbers are significant. Please note that though the number of obese people is rising world wide for the purposes of this study only US figures will be explored. But, just to note, according to the International Obesity Task Force (2002) internationally the number of obese people increased 10-40 percent in the last decade: the projection by the WHO is that the number of obese people will double that of the

underweight population by 2025. For the United States the percentage of obesity from the same estimates (obese not overweight) is 45-50 percent.

Currently, based on the NHANES for 2001-2004, about two-thirds of US adults, or 133.6 million people are overweight or obese: 61.6% of women, 70.5% of men. Of this total number 63.6%, or roughly one-third of the population (35 million women and 28.6 men) are obese. A look then at the combined numbers that suggests that one-third of the US population is obese, one-third is overweight, and one-third is healthy or underweight (National Institute of Diabetes and Digestive and Kidney Diseases, 2007). This number illustrates a large increase in the number of obese or overweight. According to the National Institute of Health the numbers have increased between 1960 and 2004 from 44.8 percent to 66 percent of the US population. This is reflected in all population groups—both genders, all ages, all racial and ethnic groups, all educational levels and all smoking levels; but the greatest increase has been among the one third of the population who are obese; this population has more than doubled from 13.3 to 32.1 percent of the population(2006).

Among women there are some disparities in the numbers between racial and ethnic minorities and non-Hispanic White women. Non-Hispanic White women are roughly 20 percent less likely to be overweight or obese at 57.6 percent. Non-Hispanic Black women are the most likely to be overweight or obese at 79.6 percent and Mexican-American women has an overweight or obese prevalence of 73 percent. Asian-Americans have a lower prevalence of overweight and obesity than the whole population (NIDDK, 2007). There is less disparity among men. For men, the numbers between the three measured groups—Non-Hispanic Black, Mexican-American and Non-Hispanic White—a

more closely grouped together at 67 percent, 74.6 percent and 71 percent. This is a compelling statistic as it differs significantly from the racial and ethnic disparities seen among women. It may be telling as to some of the differences that exist—whether physical, cultural, social, or psychological—between obesity in men and obesity in women. Thus far, the numbers that break down obesity as opposed to overweight/obesity between the genders have not yet been unearthed by this investigator in the literature.

The statistical material that has been utilized thus far discusses overweight and obesity in terms of gender and race. That discussion has the most direct influence and consequence for this investigation. But there are costs to the individual as well as social economic costs that also warrant mention because of the immediacy of the problems. Serious health risks associated with obesity include diabetes, coronary heart disease, high blood cholesterol, stroke, hypertension, gallbladder disease, osteoarthritis, sleep apnea and other breathing problems, and some forms of cancer including breast, colorectal, endometrial and kidney. Obesity is also associated with pregnancy complications, menstrual irregularities, hirsutism, stress incontinence, depression and other psychological problems, surgical risk increases and an increased mortality rate of 10 to 50 percent compared with healthy weight individuals (NIDDK, 2007). In addition to these serious health cost are significant economic costs. Estimates from a 2001 study suggest that the total cost of obesity and overweight to the economy is \$117 billion dollars: \$61 billion in direct costs for medical care and \$56 billion in indirect costs in lost productivity (NIDDK, 2007). Thus, while the concrete costs, numbers affected and population demographics have been described in detail there is little information about

the effect of obesity on the individual and the experience of them by others, and how this affects the individuals and the mental health workers that serve them.

Eating Disorders and Obesity

One question that this thesis seeks to explore is whether clinicians view obesity as an eating disorder. Whether clinicians view obesity as an eating disorder or not reflects generally on the attitudes of the larger public toward obese people. When researching obesity this investigator found eating disorders were often placed in the same category as obesity but the connections were unclear. This apparent lack of clarity within the literature raised the question: do clinicians view obesity as an eating disorder despite obesity not being a clear diagnostic category in the DSM IV?

Obesity and Eating Disorders

The links between eating disorders and obesity in the literature reviewed is mostly nascent or framed as parallel issues. Authors Fairburn and Brownell (2002) and Robb and Dadson (2002) write about this most directly. According to the DSM IV (American Psychiatric Association, 2000) “eating disorders are characterized by severe disturbances in eating behavior” (pp. 585) with three diagnostic categories: Anorexia Nervosa, Bulimia Nervosa and Eating Disorder not Otherwise Specified which includes Binge Eating Disorder. Though there is no diagnostic category for obesity Fairburn and Brownell’s (Eds.) *Eating Disorders and Obesity: A Comprehensive Handbook* (2002) addresses the dynamic tension between eating disorders and obesity. The introduction to their volume states “the separation between the fields remains too large” (pp. xiii). Robb and Dodson (2002) in their review of eating disorders in males place obesity along side anorexia nervosa, bulimia, body dysmorphia and binge eating syndrome without

commentary. Another author Clinton (2006) does not mention obesity at all but cautions “diagnostically, even with regard to clinical symptoms, the picture is so varied and perhaps 30-60 percent of all eating disorder patients may fail to meet criteria for the two central syndromes of anorexia nervosa and bulimia nervosa and are thus classified as Eating Disorder not Otherwise Specified (pp. 203). Clinton’s statement suggests then that the Eating Disorders category is plastic, in other words matters for clinical judgment. This understanding is critical for this thesis which is concerned with the application of these categories in clinical/therapeutic venues.

Fairburn and Brownell (2002) offer four areas of commonality between obesity and eating disorders: first, at the concrete physical level, issues of hunger and fullness; second, binge eating as a shared are between obesity and eating disorders (though the authors point out that not all binge eaters are obese or overweight but binge eating may interface between these two areas of study); third, the concern for body image as an interface between eating disorders and obesity; finally, the consideration of cognitive-behavioral therapy as a potential link between obesity and eating disorders. Though Fairburn and Brownell create an argument for a linkage between eating disorders and obesity they do not provide empirical evidence. Robb and Dodson (2002) place obesity within the eating disorders spectrum without addressing the issue, yet inferring that eating disorders and obesity are contained within common boundaries.

Men and Eating Disorders

Carlat, Camargo and Herzog (1997) and Silberstein, Mishkin, Streigel-Moore, Timko and Rodin (1989) hypothesize that a homosexual identity and/or the homosexual subculture were the causes of or risk factors for eating disorders. Carlat et al studied the

charts of men in treatment for anorexia and bulimia. The information was then coded and gleaned for patterns from which the researchers then drew conclusions. The findings were that many of the patterns of females with eating disorders were true for men as well: age of onset, fears of fatness, comorbidity with major depression, substance abuse, anxiety disorders and personality disorders. This study is included because it adds another dimension to previous thinking about the male body—that is sexuality with gay men, according to the study, being particularly susceptible to bulimia and anorexia. Though eating disorders again are defined as only bulimia and anorexia and the readings are informed by a level of homophobia this is a valid area of study--sexuality and sexual identity and targeted populations and oppression as risk or resilience factors in male self-perception. The fact that they decided to focus their discussion on the finding of sexuality overlooked compelling connections between eating disordered men that is not informed by homophobia. Silberstein et al (1989) outright blames the “homosexual subculture” for the higher percentage of homosexual men with disordered eating. This study compared two groups of Yale University men: a gay sample and a heterosexual sample equal at 71 people each, roughly equal for age and weight. The samples were then measured for body dissatisfaction, body esteem, self-esteem, self roles, disordered eating and reasons for exercise. The study assumes a limited a definition of disordered eating among by assuming that disordered eating stems only from a desire for thinness. Their findings indicate that heterosexuals who desired a larger body “had lower self-esteem than men who were heavier than or equal to their desired size” (pp. 337). This suggests a contrasting finding because this body dissatisfaction was found in heterosexual men but this was not considered a valuable finding. Male body image is complex and

may be related to multiple factors. The authors rightly consider that subcultures have different emphasis and relationship with the body, size, muscularity as noted previously but the findings present a more complicated picture: “the gay male’s perceived-ideal body discrepancy may not significantly affect his self-esteem, whereas the heterosexual man’s self-esteem appears to be more readily influenced by a gap between his perceived and ideal body” (pp. 344). There are two important notions to take away from this study. One thing to note is the methodological prejudices. The instruments gathered material that may or may not be accurate: for instance it may be more acceptable for a gay man to admit that he exercises for attractiveness, whereas heterosexual men may be more reluctant to admit to consider an exercise regime as part of a desire to appear attractive (Cafri and Thompson, 2000; Frith and Gleeson, 2004). What is illustrated is that the measurements for men may not be accurate as well as biased towards or away from heterosexual men. There is evidence that that author’s note that gay men may place greater emphasis on appearance but the assumption is that then heterosexual men do not place emphasis on their appearance. This could be clinically misleading by dismissing a possible unexamined stressor for a client or patient. A clinician may carry this bias. But, it may be that there simply is not an instrument that is properly calibrated to measure properly for men’s appearance concerns. Undertaking a qualitative analysis of similar concerns may have provided a more accurate assessment. This thesis is concerned with the ways in which men are perceived. It is therefore important to look at the measurements because they may reflect bias.

Attitudes Toward Obese Individuals

Attitudes toward obesity are culturally and socially shaped. Across racial and ethnic populations perspectives differ: obese people have more or less latitude and stigma depending on the socio-cultural context. Gender injects another dynamic into general attitudes toward obesity. In the United States there is a strong cultural anti-fat bias that has particular manifestations of obesity being a moral failure (Crocker, Cornwell and Major, 1993; Devlin, Yanovski and Wilson, 2000; Helb and Turchin, 2005; and Teachman, Gapinski, Brownell, Rawlins and Jeyaram, 2003) but among individuals in different populations there is less or more bias attached to obesity.

In a 1963 published question and answer period with Albert Stunkard, the Chairman of the Psychiatry Department at the University of Pennsylvania, the question is posed: Is obesity primarily a physical or psychological problem? Professor Stunkard answers, "It is entirely conceivable that obesity in some persons may result from biochemical or enzymatic disturbances whereas the obesity of other persons may have largely psychological origins" (pp. 1375). Stunkard also addresses the stereotype of the "jolly" fat person: "In this day of emphasis on psychosomatic medicine, the usual stereotype of the obese person is that of the frustrated neurotic." (pp. 1376) In addition, Stunkard points out that fat people are considered "fair game for ridicule" and are "scapegoats," are associated with lower socioeconomic segments of society, fat men are considered "jolly" and fat women "motherly, nurturing." Some of these stereotypes still stand 40 years later and anti-fat bias carries a strong cultural charge (Crocker, Cornwell and Major, 1993; Devlin, Yanovski and Wilson, 2000; Helb and Turchin, 2005; and Teachman, Gapinski, Brownell, Rawlins and Jeyaram, 2003). For both sexes "anti-fat

bias is especially strong because being overweight is deemed blameworthy...that weight is thought to be controllable is likely to reduce empathy for obese people” (Teachman et al, pp. 69). Crocker et al (1993) concur that obesity elicits two types of stigmas: one aesthetic and a character “that carries with it the shame and guilt of self-blame for a moral failure” (pp. 60). Devlin et al (2000) posit that “negative attitudes toward obesity are prevalent in society at large and among health care professions” that leads to “tangible disadvantages” (pp. 855). Though both males and females are scapegoats-- in Stunkard’s words-- they have distinct connotations. However, Christakis and Fowler (2007) present data which provides a contrasting point of view, that obesity is becoming more acceptable. Whether attitudes toward obesity are more acceptable or maintain the stigma suggested in most of the literature, these beliefs are strongly affected by cultural contingencies including race, ethnicity and gender.

Utilizing a study of male college students Helb and Turchin (2005) undertook a study of males to clarify the ways in which obese men are stigmatized and how obese men themselves might stigmatize obesity. The researchers posit that obese women do not necessarily have psychological dysfunction associated with obesity but that perceptions of obese women is frequently hostile by characterizing them as lazy, undisciplined and unhappy. Study findings indicated that both white and black men stigmatized obese women, black men do not likewise denigrate average sized women as white men did. When it came to judging males both white and black men had similar reactions: when males increased in size the higher degree of denigration with white men judged more harshly than black men. This points out that social categories defined by race, ethnicity

and class, a guideposts for trends relative to perceptions of and attitudes toward size and that hostile attitudes are nuanced by these social differences.

Contrastingly, Christakis and Fowler (2007) hypothesize that the stigma towards obesity is actually breaking down because of sheer numbers: increasing numbers of obese people is making obesity less stigmatized: “having obese social contacts might change a person’s tolerance for being obese or might influence his or her adoption of specific behaviors (e.g. smoking, eating, and exercising)”(pp. 371). By reviewing a longitudinal study—the Framingham Heart Study—the researchers looked at clusters or social networks for the prevalence of obesity. What they found is very intriguing: friendship and perceived friendship has a significant association on the prevalence of obese. In other words, it is the influence of friends that may create the space for becoming obese. This was particularly true among men: “among friends of the same sex, a man had a 100% (95% CI, 26 to 197) increase in the chance of becoming obese if his male friend became obese, whereas the female-to-female spread of obesity was not significant (38% increased chance; 95% CI, -39 to 161)”(pp. 376). It is important to note that the friendship ties that influence obesity is directional. That is, the friendship can be simply an admiring one for one of the parties and not mutual: “obesity may rely less on behavioral imitation than on a change in an ego’s general perception of the social norms regarding the acceptability of obesity. The point is further reinforced by the relevance of the directionality of friendship”(pp. 378). This study then lifts or complicates the obese individual as an individual, making obesity both a social networking issue as well as an individual problem. There appears then to be two trends accreting in the literature: one is that there is ongoing denigration and stereotyping of obese people. The second trend is that as the

numbers of obese people increases exposure to obesity is increasing, this increase of exposure is leading to more obesity acceptance.

The Male Body

Originally, this section intended to focus on the social construction of body image. As the process unfolded it became clear that male body image is intimately tied to the idea of masculinity. In other words, the literature explains, the way in which many men view/conceive/perceive their body is through the lens of masculinity: whether it is masculine enough, thin enough, muscular enough the experience of the male body overlaps and intersects with a man's experience of masculinity (Cafri and Thompson, 2000; Drummond, 2002; Drummond, 2002). This section explores the literature of masculinity and the impact of this construct on individuals in the four sections that follow: one, the Social Construction of Masculinity/Body Image: two, Issues of Measurement for Male Body Image: three, Cultural and Racial Differences and Male Body Image; and four, Male Body Image and Psychological Well-Being. The discussion looks at current trends unfolding in the area of masculinity studies, in particular the ways in which current representations of men in the media are impacting men's self-definitions. One overarching comment that from the literature is that masculinity is indefinable: it is the perception of it that defines it. There is no clear definition from the literature. In fact the literature suggests that there is a "crisis" of masculinity because shifting gender roles are leaving men without clear definable parameters.

Social Construction of Masculinity/Body Image

Ideas and perceptions of the male body and masculinity are stitched to the fabric of the shifting patterns of cultural and social expectations. Shifts in gender expectations

and roles, according to some investigators, complicates the relationship of men to their body and their masculinity (Cafri and Thompson, 2000; Drummond, 2002; Drummond, 2002). This has led to a “threatened masculinity” (Cafri and Thompson, pp.23, 2000): a “Hegemonic masculinity” (Drummond, 2002) with its emphasis on competition, misogyny, homophobia, and individualism is a “threatened masculinity”(Cafri and Thompson, pp. 23, 2000) and is negotiated by many men through their physical selves through extreme training regiments that endanger them both physically and socially. The increased importance placed on male images in the market place as well as the idealized images of men becoming both more muscular and leaner is bringing men’s body image difficulties more in line with women’s (Cafri and Thompson, 2000). However, the dynamics emerging are slightly different from those of women. Carlat, Camargo and Herzog (1997) and Silberstein, Mishkin, Streigel-Moore, Timko and Rodin (1989) hypothesize that a homosexual identity and/or the homosexual subculture were the causes of or risk factors for eating disorders. According to the authors men measure their bodies differently from women; in particular men are more concerned about the shape of their body as opposed to the weight.

Cultural/Racial Differences and Male Body Image

One of the difficulties for researchers has been finding the proper instruments with which to study men’s perceptions of themselves (Cafri, 2004: Harmataz, Gronendyke, and Thomas, 1985: Holle, 2004: Tager, Good and Morrison, 2006). Though obesity is denigrated by others, these authors suggest that it is the underweight under-muscled male that has the lowest self-esteem. Though often socially denigrated obesity does not necessarily impact the obese individual in expected ways. There are contrasting

relationships to the body and obesity across cultures according to race and ethnicity (Ricciardelli, McCabe, Williams and Thompson, 2000).

Ricciardelli, McCabe, Williams and Thompson's (2007) have studied the extent to which cultural differences exert pressure on the perceptions of body. In a meta-analysis which distills the findings of over 40 studies on male body image, weight loss strategies and binge eating, weight/muscle gain strategies and steroids and mediating/moderating factors. Each of these categories took into consideration different ethnic/cultural sub-populations world-wide: blacks in the US, blacks for other countries, Hispanic Americans, Asians, Native Americans and other first nations, Pacific Islanders, and Middle Eastern cultural groups. Their review is a meta-analysis from other studies and provides benchmark materials providing evidence that perception of self and others is a culturally sensitive dynamic. Significantly these researchers discovered support for the idea that cultural differences exist for men's body size preferences and images. For instance, black men have a greater preference for a larger body size and a more positive self image than whites; but despite having a more positive body image, black men may place more importance on their body. That cultural differences exist and exert pressure on the perceptions of body is central when considering the collection of data, the review of the data collected and its relevance in within the greater cultural framework for this thesis.

Issues in Measurement of Male Body Image

One of the difficulties faced in the study of male body image, as noted by Cafri and Thompson (2004), is lack of clear and accurate measurements of body image among men. As noted above there is significance in terms of culture as to the perceptions of the

body among males. This article states: “Given the potentially wide array of harmful effects that can occur in males as a result of the way they perceive and think about their bodies, it is clear why accurate male body image is necessary” (pp. 26) Cafri critiques previous measurements for not taking into account the concerns that men present about their bodies. Rather than being concerned about being overweight, men have a tendency to be dissatisfied with their body composition, in particular the muscularity of the chest and arms. This is somewhat echoed in *The Adonis Complex* (Pope, Phillips and Olivardia, 2000) that posits “muscularity is masculinity” (pp. 242) and that contemporary masculinity is “threatened”:

threatened masculinity arises from the long-standing desire of men to establish their “maleness” within their societal group. Throughout most cultures in history, men who exhibited traditional ‘male’ pursuits have received approval and respect. But nowadays, what are these male behaviors and pursuits? What can a modern boy or man do to distinguish himself as being ‘masculine’ (pp. 23).

Relying on their own qualitative research and by calling upon the quantitative research of others Pope et al (2000) developed the *Adonis Complex* to describe one of the ways in which men are responding to “threatened masculinity.” The qualitative research, which was then combined with social theory to create the “*Adonis Complex*” took place in gyms where bodybuilders train. The researchers focused mainly on how masculine ideals, particular men’s desire to be more muscular yet never feeling muscular enough, were enacted. The authors were concerned mainly with two social strands: first, the increased muscularity of cultural representations; second, the unclear role of masculinity

in the contemporary American culture. They securely knot their theories into the social fabric, that the Adonis Complex is a social problem brought on by social pressures.

Though this book mentions obesity only fleetingly the ideas are important for this thesis because this book accounts for the shifting expectations of male self-perceptions and the cultural pressures exerted on men.

Two articles by Drummond add complexity to the picture of men's body images and masculinity: *Men, body image and eating disorders* (Drummond, 2002) and *Sport and images of masculinity: the meaning of relationships in the life course of "elite" male athletes* (Drummond, 2002). Drummond investigated the social construction of masculinity in sports using qualitative methods. In the latter article Drummond examines male athletes' relationships with women as both competitors and as romantic partners to provide a "looking glass into the problems associated with the social construction of masculinity for men in contemporary Western society" (pp. 129). The former article examines the same material in order to emphasize some critical issues confronting men and boys in relation to body image concerns and eating disorders while providing links with the social construction of masculinity. Both articles explore notions of what they call "hegemonic masculinity" which are the assumed qualities of masculinity: competition and aggression, the marginalization of peers perceived as not masculine enough or homosexual, endurance of pain, and the dismissal of women and anything perceived of as feminine. Both of these articles are describing extreme examples using 12 elite athletes and 8 eating disordered men in treatment: the small samples limit the application of the findings. The findings portray the internalization of so-called masculine ideals and how these ideals impinge on participants. These shifting masculine ideals are becoming more

concerned with body. That is, masculinity is become less about doing and more about appearing masculine in superficial ways: muscularity, fat phobia, and eating disorders as a form of competition. Other finding among participants includes the dismissal of the importance of relationships and the fear of appearing weak. The researchers rightly look at a microcosm of men and whether there are macro applications for their findings. How do these findings further tie into the question of this study because obese men are on the opposite end of the spectrum? These studies understand that attitudes towards men do not exist in a vacuum but the masculine is a presupposed category for which clinicians may not acknowledge a bias—positive or negative-- not just toward obese men but men generally.

Male Body Image and Psychological Well-Being

Other authors have looked at the relationship between male body image and psychological well-being. Tager, Good and Morrison (2006) carried out a study with college students, voluntary participants, who were assessed for body satisfaction, psychological well-being, masculine norms, and victimization and bullying. The researchers hypothesized five points: body image will be associated with psychological well-being; body image will be associated with environmental mastery; men who report body satisfaction will report greater self-satisfaction than those who report discrepancy between their actual and ideal weight; body image will have a relationship with masculine norms; and body image will be associated with childhood experiences of victimization and bullying. This appears to be a sound study; its limitations are the large majority of white participants, the participants are technically adolescents and that may limit the study's application upon a mature population, and they do not attend to

sexuality. The findings were more or less in line with their hypotheses except for one important finding that “only our perceived overweight group endorsed lower levels of self-acceptance”(pp. 234). The authors believe that this was due to the age of the participants as other studies have shown that underweight or undermuscle men report lower levels of self-acceptance. Holle (2004) declared that little information exists that compares body dissatisfaction measurement levels between overweight and underweight men. Therefore this self-assessment study of college aged men enrolled in psychology classes used questionnaires to gather data to measure not just for the above statement but to combine body-self questions with a social physique anxiety scale, fear of negative evaluation measures, and an exposure scenario. Researchers devised a study to test whether the participants were willing to expose their upper torso or not to a panel of judges. There were two judging panels one male and one female. The participant’s willingness to expose their upper torso was correlated with two dynamics: the fear of negative evaluation with weight self-assessment of over or underweight men. Both self-assessed over and underweight men reported less willingness to expose themselves to the scrutiny of a panel. One of the modifying elements was that men were more willing to show themselves if the panel was made up of women. The research controlled for the desire for muscularity respecting the measurements of body satisfaction endorsed above however it was unable to control for socio-economic identities. The researchers also did not consider sexual orientation as a possible factor in their study. The most interesting finding is that there was a wide margin between those willing to be seen shirtless by a panel of female judges as opposed to a panel of men. There was no discussion by the

authors on this point. Perhaps the participants felt women would be less judgmental. This article adds to this study the idea of avoidance of exposure to male body image concerns.

Harmataz, Gronendyke, and Thomas (1985) studied underweight men. Though this study was done some time ago it does point to a thread of information that is compelling. This study of undergraduate psychology students used several anonymously self-administered questionnaires for scales of eating and relationship patterns. Again, this ties to the question of my investigation by noting another measurement that men have about their bodies. This study found that it is underweight men view themselves most negatively compared to all but overweight females. Underweight men scored lower on self-perception scales than normal and underweight females and normal and overweight males. This study counters, as the authors note, cultural expectations. The author expected self-perception scores for overweight men to score lower but that did not happen. As I am researching clinical attitudes toward obese men, and they score higher than underweight men, it is an important consideration. However, this contradicts Tager, Good and Morrison (2006) who found in their research just the opposite: overweight men reported lower levels of self-acceptance. This may be due to the 20-year interim between studies. It also contrasts with the earlier discussion of Christakis and Fowler (2007) who hypothesize that the stigma towards obesity is actually breaking down. For women generally, as the studies noted, there is a desire to be smaller and thinner although not for all time and not for all women or cultures but this literature review is not primarily focused on women and body image. The evidence that is presented on men suggests that men have a different relationship to their body image than women but it certainly is not uniform. This is supported by Frith and Gleeson (2004) who used mixed methodology to

discover and quantify shifts in men's relationship to clothing and body shape. What they found is that men are fast becoming pressured to fit more of a cultural ideal, a stereotypical fetishized body and are facing more extreme measures to make that happen. Within the scope of this research it is important to note that clinicians are a part of the cultural landscape and may be participating in these expectations when faced with an obese client.

Psychoanalytic/Psychodynamic Theory and Obesity

To properly understand the dynamics of male obesity it is important to understand how psychoanalysis thinks of obesity in order to contextualize this exploration. This section will consider several different ideas subsumed under this topic. First, this review defines countertransference in order to better understand how it fits into the understanding of male obesity. Next this section will look at psychoanalytic writers who have previously written about obesity. Following this, the author will look at previous work on how personal attitudes impact clinical attitudes. The discussion will conclude with a review of the literature addressing the ways in which these attitudes are incorporated into practice.

Clinical Attitudes

This thesis is concerned with the clinician's attitude toward obese men. The technical term for this attitude would be countertransference. Countertransference is a term Freud coined to illustrate the clinician's unconscious reaction to the client (Murphy and Dillon, 2003). This term has undergone some transformation as Horner (1991) writes:

The term counter-transference refers to the therapist's reactions to the patient that have dynamic significance either within the therapist or within the interpersonal

matrix. These reactions may be to the patient as a person (young or old, male or female, attractive or unattractive), to the patient's material, or to the patient's behavior in the session and vis-à-vis the therapist (pp. 69).

Wachtel agrees (1993) "the therapist must continuously monitor her participation in the therapeutic process with the patient and attempt to understand the contribution of her own history and vulnerabilities to what is happening and how she understands it.(pp.13) He continues:

It is crucial that the therapist be alert to her emotional response to the patient's communication and to what has transpired between them. One's attitude is conveyed not only in one's words, but in one's tone, rhythm, posture, and so forth, and it is virtually impossible to disguise over the long run how one feels about the patient or about what he is saying (pp. 12).

Murphy and Dillon (2003) also agree "that the clinical relationship is multilayered, complex, and mutually influencing. The clinician must attempt to understand the relationship as both real and symbolic and as evolving over time (Murphy and Dillon, 2003, pp. 225) Countertransference can then be considered to encompass the attitude, perceptions and bias. Ingram (1978) introduced the term "cultural counterresistance" (pp. 157) to encompass cultural bias into what was considered countertransference. This illustrates one psychoanalyst's attempt to include what he terms counterresistance as "the analysts own resistances and blockages interfering with the analyst's appreciating his inner responses elucidate the patient's neurotic solution" (pp. 160). He wrote this using case material from the treatment of an obese woman.

Therefore, one facet of a clinician's attitude is the cultural piece. Hall (2002) suggests that race and gender exert pressure on the therapeutic relationship. Therefore it stands that obesity among men will have some effect on the therapeutic relationship as well, which this thesis hopes to discover.

Psychoanalytic Theory and Obesity

A review of the psychoanalytic literature in the area of clinical understandings of obesity revealed the following: there is very little writing about obesity and countertransference; and most of the writing is about orality. Psychoanalyst and psychiatrist Bruch and Psychologist Slochower reviewed the psychodynamics of obesity. Bruch (1969) looks at the traditional psychoanalytic supposition that obesity comes from "disturbances during the oral phase" of development. Speaking directly to obesity, Bruch noticed in her experience that hunger is not an innate drive, that there is separation between hunger and the desire to eat: "it became gradually clear that the old charge of obese people having 'no will power' described an important deficit in their functioning related to their not being aware of bodily sensations; one cannot exercise control over a function or need which is not even recognized" (pp. 131). This encapsulates an important stance as it points to a commonly held belief and the more complicated picture a clinician might consider. Slochower suggests that "the causal connection between oral drive frustration and obesity is not quite so straightforward" and that obese people are "unable to accurately label their emotional states...but food related interactions continue to be an important ground for emotional communication throughout childhood" well past the first two-years during the oral phase. The symbolism of food, hunger and eating in Slochower's finding are related to the obese person's inability to label affective states and

their use of food to contain a free-floating anxiety. Bornstein, Galley and Leone (1986) point out that orality is aligned with anaclitic depression symptoms including “helplessness, weakness, depletion and being unloved...Intense wishes to be cared for, helped, fed and protected...and...oral cravings”(pp. 81). Bornstein et al (1986) found a strong link between orality and parental representations tying together orality, the parental influence, and the psychoanalytic belief that obesity and orality are linked, and orality is linked with a certain passive character.

In their study on the relationship between sexual dysfunction and eating behavior in a sample of 30 obese men, Jagstaidt, Golay and Pasini (1995) found a high correlation between body dissatisfaction and sexual disorders (lack of sexual desire, lack of erotic fantasies, lack of adult auto-eroticism, sexual energy or motivation in sexual advances). Their research was limited by a small sample size but it does interject another important factor into the discussion which is that there is a probability of a sexual component for those obese men that have high body dissatisfaction. Bornstein, Wong and Licinio (2006) call for a psychoanalytic approach to the obesity epidemic: “what strikes every dietitian or practitioner dealing with obese individuals is the strength of the ‘repressing ego’ governing illusions, wishful thinking and denial in these individuals” (pp. 1071). Approaches to dealing with obesity on a conscious level, according to these writers, are doomed to failure because of the strong demands of the unconscious mind.

Summary

The literature reviewed creates a background of knowledge, theory and sociocultural dynamics effecting attitudes toward male obesity. Important dynamics discovered in the current body of writing highlights several variables including race and

gender expectations as influencing dynamics in clinical attitudes. One of the central components is how men conceive of themselves as opposed to how men are perceived socially, as well as the larger conversation of obesity which includes preconceived judgments and moral disapproval this despite an evolving obese population that cuts across all sub-populations in the United States. All of these issues are crucial to the development and application of this study.

The following chapter describes the methodology, recruitment process and a break down of participant demographics.

CHAPTER III

METHODOLOGY

The purpose of this study is to explore the clinical treatment issues that arise when working with obese men. My research question focused on attitudes and perspectives of clinicians toward obese men including countertransference material. Questions attended to gender, body image, the clinician's understandings of how beliefs effect treatment, and the importance to treatment of obesity in a mental health setting.

Study Design and Sampling

Since these questions have not been directly investigated previously, an exploratory study using qualitative methods was chosen. In-person, flexibly structured interviews were conducted with 12 clinicians in two different mental health care settings: one in-patient and one outpatient. Findings were then analyzed qualitatively. To qualify, participants had to work or intern as a mental health professional: psychiatrist, psychologist, social worker, resident, mental health worker, psychiatric nurse or intern. Participants also needed to speak English because translation services were not available.

A recruitment process was developed for obtaining and selecting the sample. Flyers were printed and then disseminated and posted in both the inpatient and outpatient clinics (see Appendix D). Interested persons were instructed to contact this researcher by phone or email. However, because I was present in both study recruiting sites, every participant first approached me in person after receiving the recruitment flyer. At that

point this researcher then contacted the participant to schedule a mutually agreed upon meeting time. Potential participants were screened by phone or in person to ensure they met the study's criteria. The small sample size meant that it was not possible to ensure diversity among participants regarding gender, age, race/ethnicity or religious affiliation. However, every effort was made to recruit a diverse group of participants by recruiting from agencies that already have a diverse population.

Because of scheduling conflicts one person who contacted me for an interview was not interviewed. Eight participants came from the Outpatient Clinic, four from the in-patient unit. All of the psychiatrists and psychiatric residents interviewed had worked on the inpatient unit and still did call occasionally which would take them onto the inpatient unit. One participant did not want to give their age, every other question was answered by all participants. No one requested to withdraw from the study.

Data collection

The design of this study was approved by the Human Subjects Review Board of The Smith College School for Social Work (see Appendix A). Informed consent letters were sent or given to all potential participants (see Appendix B) a day in advance of interviews: the letter described the study and the defined criterion for participants. It also outlined the risks and benefits of participating in the study. Informed consent was obtained before the interviews began.

The method for data collection was an open-ended flexible interview that focused on the clinical attitudes toward obese men as noted above. Face-to-face interviews were conducted in a location designated by the participants or in a neutral office in a near-by library. The length of the interview ranged from 10 to 30 minutes depending on the

participant's involvement in the material. A set list of questions guided the interviews (see Appendix C). Despite the set question sets elucidation was elicited when necessary for clarification. Thus, each interview was a unique elaboration on a set theme. Interviews were recorded on a digital recorder and transcribed at a later date with all identifying information deleted or disguised.

Sample Characteristics

The study was comprised of 12 participants, 9 women and 3 men. One was a psychiatrist, 3 were psychiatric residents, 2 were social workers, 2 were mental health workers, and 3 were social work interns. The mean age of the participants (of those answering the question) was 39.5 with a range of 55 (oldest) to 24 (youngest). Average number of years in practice was 15.92 (range 2 to 38 years).

The sample was diverse as observed by this researcher. Seven were Caucasian. Two were African-American. One was African. One was Indian. One was Puerto-Rican. Three were foreign born: one from Romania, one from India and one from Nigeria.

Data Analysis

Transcripts were reviewed to identify relevant content, themes, patterns in the area specific to this research including the gendered response to obesity, countertransference response, attitudes toward obesity (is it considered an eating disorder?), the role of obesity in mental health treatment. Transcripts were also gleaned for the content and themes not laid out by the set question material.

Due to the small sample size, limited geographical reach of participants (Philadelphia proper) universalizing generalizations cannot be made from these findings. Rather, the results of this study highlight some of the experiences with, beliefs about, and

attitudes toward obese men. Hopefully, some of the data here will provide the basis for further discussion and research in this overlooked area of study.

CHAPTER IV

FINDINGS

This study seeks to explore clinical attitudes toward obese males. Twelve interviews were conducted over a five-week period with mental health professionals in two different settings, one inpatient and one outpatient. Interview questions were designed to elicit two main data streams: one, how male bodies are considered in clinical settings; and two, how clinicians think about obesity. How clinicians view male obesity in particular has possible ramifications for treatment. As the literature illustrated male body image is understudied this thesis seeks to add to the literature towards a fuller understanding of the shifting terrain of men's body image. One of the goals of this study is to uncover the salient intersections, or lack of said intersections, between clinicians' understanding of obesity and clinician's understandings of how men think about their bodies.

In an effort to unearth demographic trends participants were asked four demographic questions: gender, age, training and years practicing. The 12 person sample ranged was diverse and broad: male and female, black and white, Latino, young and middle-aged. The study was comprised of 12 participants, 9 women and 3 men. One was a psychiatrist, 3 were psychiatric residents, 2 were social workers, 2 were mental health workers, and 3 were social work interns. The mean age of the participants (of those answering the question) was 39.5 with a range of 55 (oldest) to 24 (youngest).

Average number of years in practice was 15.92 (range 2 to 38 years). The sample was diverse as observed by this researcher. Seven were Caucasian. Two were African-American. One was African. One was Indian. One was Puerto-Rican. Three were foreign born: one from Romania, one from India and one from Nigeria. Eight out of the twelve have an advanced degree. All of them participate in the direct care of patients. Except where noted there were few discernable threads as to perspectives, thoughts and attitudes and any demographic information. In other words, there were no clear trends in regard to the demographic information garnered. Demographic statistics are included with direct quotes from the data collected.

This is an exploratory study is pursuing nodal thematic information. This discussion is split into four main sections with sub-sections providing more detail. The first section, Gendered Views of Obesity deals most directly to the main question of the attitudes of clinicians towards male obesity as determined from questions directly posed to gender and obesity. The second section—Views of Obesity—includes material gleaned from several questions posed to interviewees concerning attitudes toward obese, the ways in which obesity is treated in the two mental health settings, how obesity is assessed and evaluated and if obesity is an eating disorder. The third section is concerned with treatment issues that arose during interviews. The fourth section is smaller but terrifically important. It reports responses to the question: Do men think differently about their bodies than women think about theirs?

Gendered Views on Obesity

One main area this thesis sought explore is whether or not there is a gendered view of obesity. There was general consensus among interviewees that obesity is harder

on women than it is on men but there was some divergence. In the following two sections *Big Dog is in the House* and *Women are sensitive* this dynamic is elaborated. Of note, several participants felt that at some point obesity transcends gender: obesity is obesity. This is noted in the territory of morbid extreme obesity “social perceptions begin to blur” (55 year old, female social worker). One interviewee, a 25 year old female social work intern, suggested mutuality in social judgment for the obese male and the obese female: “all-in-all there’s a feeling that obesity is grotesque.” In terms of treatment three respondents felt that the treatment options were similar between men and women but there was consensus that obesity is socially harder for women. As one clinician, a 45 year old female social worker, articulated it:

So, I’ve worked with obese females and males who were in the same group and the men could be the same height and weight as the woman or women in the group but the men... it didn’t seem to affect their self-esteem as much as it did with women. So, in a way it may have been affected but I tried to go back to what that client wanted to work on. And I think society at times isn’t as hard on men as they may be on women.

A 29 year old male physician says similarly, “I feel it’s much more difficult for women who are obese than for men who are obese, socially...” he continues “even though it is as unhealthy for a man as it is for a woman, but there is more of a comparative body image thing for women than there is for a man.” He goes on to say, but I don’t see a difference when a woman is obese or a man is obese. It doesn’t matter. No matter the sex. I don’t differentiate like that. But there is definitely a

perception that I have when an obese person comes in, that, you know, the first thing that comes to mind is that if they're unable to take care of their weight, how can they take care of other things?

One participant suggested that it is physiologically more difficult for women lose weight: "because of the anatomy of the female it is harder to lose weight as opposed to dropping it like a male" (a 49 year old male mental health technician). Despite this sense of mutuality or commonality of experience all except one felt that obesity has more intra and inner personal difficulty for women. A complicated picture was exposed for both men and women and this is explored in the following discussions.

"Women are sensitive"

When asked if gender affected their thoughts about obesity or whether or not obesity is different for men than it is for women all but one interviewee (a woman) believed that obesity for women is much harder emotionally and socially than it is for men:

In our society women are supposed to be 'feminine' and part of being feminine is keeping up an appearance which is acceptable by society which doesn't include obesity. I think that an obese woman is chastised perhaps in a way that in a patriarchal society a man might be looked at through a different lens (24 year old female social work intern).

Mostly this was due to social-cultural pressures: media pressure, pop culture—"its more sexier for woman to be more and more thin, and that is shown on fashion TV, or... women are stronger if they're thin...It's a cultural thing" (29 year old male physician).

Or as a 24 year old social work intern put it, “with women it [obesity] is more shameful... “ she continued, “it’s more that with the women, it’s more like they feel really bad about themselves... it’s more acceptable to be a big man than a big woman.” According to these clinicians there is a perceived sense of shame attached to the obese woman because of the strong social pressure on women to be slender: “I feel it’s harder for women because they are more emotional and they have the pressure that they have to look good” (a 39 year old female psychiatric resident). Not only that, though women are perceived of as more sensitive, they are also more likely to be evaluated for obesity or body image issues (8 out of twelve interviewees): “I probably, and this isn’t necessarily a good thing, I’m probably early on more attuned to women’s body image issues than I am to men,” said one 55 year old female social worker. One male social work intern (aged 50) agreed: “I might be more inclined to describe a female as obese that actually has the same BMI as a man: I might not use the word obese to describe him.” Though the clinicians felt that obesity was a larger social burden for women one clinician expressed that there is a stronger mental health component for women: a female physician said,

I don’t have any really good scientific foundation for this but I think women tend to eat to comfort and self-soothe more than men do...So I guess is there are more obese women who have mental health problems than there are obese men who have mental health problems.

All three female physicians responded that women had better reasons for being obese: “childbearing really packs on the pounds that are hard to lose—you have estrogen in general which does things that lead to obesity” (33 year old female physician). These

better reasons evoked more sympathy and empathy for obese women from these clinicians. As one of these respondents (a 33 year old female physician) put it “I hesitate to say this, maybe I’m more forgiving of women. Especially if they’ve had children, it’s really difficult. So people become obese because of that...next question.” There is contradiction in these findings. On one hand, there is a nearly uniform belief that because of social perceptions of women obesity is more difficult for women. But then, on the other hand, some of these same interviewees felt that some women had a good reason to be obese and held more empathy for obese women. One clinician sums this position up nicely: “I would say in general there are certain biases around women’s attractiveness and their appearances that make it a different experience for them and for me if I’m working on it in therapy” (55 year old female social worker).

Big dog is in the house

According to these clinicians obese men are perceived differently evoking less empathy and less scrutiny than obese women. This was the general perspective for both female and male participants. The minority opinion of one gave a contrasting opinion: “I think the perception is definitely more negative towards the obese man” (29 year old female mental health worker) she continued, “I think socially they are rejected more, they are looked at more... but this is what I see but not what I believe... among my friends and from conversations they are rejected more, looked upon as lazy, they are looked upon as not wanting to take care of themselves, not caring about themselves.” Measuring this specific assertion is the greater cultural context where men are seen as more active; more athletically inclined and thus have fewer reasons to be obese: “you have this image that men are supposed to be so active, so physical and jump around and hence should have

less of a tendency to be overweight” (33 year old female psychiatric resident). Another female resident, aged 39, replied when asked: how do you believe obese men are perceived of socially:

Lazy. You find excuses for women: you gave birth, it’s post-birth, whatever.

We’re always finding excuses for women but with guys... what excuses do we give you? Usually it’s the man that works and works out so for the guys to be obese it’s: Ok...you have a disease—its endocrine or something—or you’re just lazy.

Obese men are given more leeway, more freedom and can be more lighthearted: a joke, as one clinician put it, when an obese client comes into the treatment center its “Big Dog is in the House.” The obese man has it easier, more latitude, are allowed to eat publicly without the shame or tittering of the others at the picnic, without being scrutinized. One 45 year old female social worker put it:

if you see a heavy man, an overweight man in a social scenario and he’s eating and he’s having a good time he’s not looked upon like he’s doing something wrong but women if they are overweight and they are eating something everything they eat is scrutinized. So I think that men are given a little bit more leeway and it’s ok if they are big and brawny even if they are bordering on the unhealthy.

This was true for all but for the one interviewee mentioned previously who felt that obese men are judged more harshly than obese women. Men are less likely to be assessed in the evaluation phase for obesity, or body image issues: “I think I address it

less with guys than with women” (39 year old female psychiatric resident). Multiple clinicians inferred that socially obese men are seen as lazy and lack the self-consciousness of obese women: “I’m not saying men feel any better or worse about it but I think that there’s probably going to be less social criticism and less self-criticism around it” (55 year old social worker). One male psychiatric resident, aged 29, says:

a man might not perceive his obesity as, um, as essentially being a very bad thing, whereas for women it’s a huge thing. Um, and it, um, is a factor which weighs on self-esteem that I’ve seen more so with women than with men. I don’t find differences in the weight, but a man doesn’t really care about his weight in a negative way, whereas a woman does. And, um, there’s—self-esteem is a lot more associated with weigh in women than in men.

Another mental health worker, a 49 year old man said, the obese men are seen as, “Pigs, fat slobs, lazy and as some points in the conversation, a disgrace. They are because they allowed themselves to get to a certain weight.” And men don’t have the same sensitivity:

I think that, at least the majority are not that self-conscious. I have friends that I kind of tell them “you’ve gained weight” and they take it kind of light. Women get hurt, get worried, get anxious, they actually might do something, or say something or get ashamed but they guys get whatever. Some of the guys are happy to have a belly and they don’t care: they’re like whatever, I’m happy, I’m big, I can put you down. Maybe it’s an expression of their... [makes a gesture

suggesting it's about their penis] I don't know maybe they are insecure and when they are big they feel more secure (39 year old female psychiatric resident).

Four participants felt that bigger for men can also be a positive but that is dependent on the social sphere, for instance for some athletes: "being overweight, unless you are doing something like Sumo wrestling where it's great and you are still as virile and powerful...you have to do something really physically active where it pays to be big. Otherwise, you feel really badly about yourself" (33 year old psychiatric resident). And, said a 50 year old male social work intern, "I don't know if we're talking about morbidly obese at 500 pounds or someone who weighs 80 pounds more than they should. If that's the case, it's kind of a masculine trait to be big and burly." One interviewee, a 24 year old female social work intern, suggested that obese men are not real men, that they become desexualized:

Obese, obese men, are not taken as seriously maybe, as men, and ya know, that the size thing becomes different when you think of obese in terms of weight in muscle and weight in fat, and if you just think of a large obese man. I think it connotes just, ya know, yea, not a real man... yea, desexualized, de---... The power thing changes, I feel like they have less. It's funny, I want to say it makes them less of a man, but what does that mean? The sexual power, the authority...the, I dunno.

Despite this "an overweight, successful, middle-aged man can get a date easier than an overweight, successful, middle-aged women" (55 year old social worker). This finding illustrates a double standard. On one hand, socially men are understood to be held

to a lower standard than women, but they also are afforded less empathy and held to a different clinical standard by receiving less care.

Views on Obesity

Eleven out of twelve participants believe that obesity is a major health concern (“scary” even). As such clinicians diverged on how they framed the issue. Themes fell into several overlapping and interwoven categories: obesity as a health concern; obesity as a medical concern with mental health components; as a mental health issue; obesity as a public health issue; obesity as a social disease; and definitions of obesity. The attendant discussion will describe each of these positions as they arose in interviews.

Obesity as a health concern

Nine out of twelve interviewees expressed concern for the health of their obese patients in response to general questions about their thoughts on obesity. The MD’s included and listed the serious side effects of obesity including diabetes, joint problems, sleep apnea and so forth,

Obesity is associated with a lot of morbidity; it’s generally not good for you. There’s a lot of health problems. It’s hard to find an obese person who isn’t diabetic, hypertensive, have back problems, joint problems...whatever it is it is generally not good for you (33 year old female psychiatric resident).

The MD’s all spoke of seeing obese patients during medical rotations and in medical school treating the sequelae of obesity. One spoke of obesity as “dangerous” (33 year old female MD” she continued, “You put your health in jeopardy.” She went on,

When I did my medicine rotation, I think every other patient was obese. Half of them were obese. They had a lot of horrible problems... Once you pass a certain weight it's really bad. It's really hard to lose. You're done. You're done. You have to take drastic measures like bariatric surgery... I'm a physician and I worry about their health it's like well I hope I stop before that, before it gets to that. That's how I look at that. It's scary.

Obesity is considered an illness: an illness that has mental health ramifications and mental health ramifications and is an illness that impacts the mental, physical and social lives of individuals. But the majority of the MD's concerned that obesity is a medical concern. Five of the non-MD's also expressed that obesity has serious medical consequences: "from a health stand point there is a lot of evidence that being significantly overweight is a health concern" said a 55 year old female social worker; its "harmful for their bodies and for themselves" added a 25 year old female social work intern. And despite their concern that it is a serious health problem all the out patient clinicians (7 out of 12) felt as though that they under-addressed it: reported one 33 year old female psychiatric resident,

to be honest it's something that I mention in passing. What I say in passing I mean it's something that I don't dwell on week to week, it's something that I'll mention in a session or two, I bring up your weight and ask do you want to do something about it and then I ask them to see their primary care doctor (laughing).

Additionally a 45 year old female social worker says:

We need to spotlight a little more because we need to see what's happening that this person's health, they aren't taking care of their health...it's not asked for in the medical assessment. It's just something that can be added. So we're asking about other things specifically: it just says medical issues. You can opt to put it in or not. So maybe we need to look at exactly what's needed in those sections. I think it's probably something that we're not addressing.

There was a sense of unease with talking about the material as well:

I'm very, uh, I have some mixed feelings about it. I mean, from a purely medical point of view, it's a dangerous condition and very widespread. And I say I have mixed thoughts about it, sometimes I look at people who are obese and think, "what is wrong with them that they can't control their weight?" (middle-aged female physician).

In sum, obesity is seen as both having serious health consequences and as a serious health problem. All agree that obesity is a problem that needs treatment.

Obesity as a mental health problem

Most participants articulated several versions of obesity as having mental health components. Within the general rubric thoughts on obesity clinicians volunteered that a mélange of mental health issues are associated with obesity. One (39 year old female physician) felt that obesity stems from a lack of will, an inability to say no to high calorie treats. Simply put "overeating" is the central cause of obesity. Seven see eating to obesity as a response to emotional needs. Four of the five clinicians from the inpatient setting spoke of childhood trauma being a cause of obesity, only one outpatient clinician mention

trauma being a cause of obesity. One 47 year old female social worker from an inpatient unit “the cause of obesity can vary: anywhere from people, from trauma, people growing up guarding themselves through eating...” One participant, a 25 year old social work intern from the inpatient unit, reported that for one severely obese patient “eating is his only vice, his only way of coping with early sexual trauma.” In that vein a middle-aged female outpatient psychiatrist suggests:

You know there is a some reason why—I mean I guess one of the typical things is people who’ve been sexually abused sometimes put on a huge amount of weight just as a way to push people away so that doesn’t happen again. But you know even something not that dramatic in the past. There’s got to be some reas— something driving this, not only the acquisition of body fat, but maintenance.

In particular to obese men six out of twelve posited laziness as a cause of obesity or that it is socially seen as cause of obesity. Of the previous six, four participants then aligned lazy or lacking motivation with depression. One clinician even suggested that obesity was a type of self-mutilation. A majority of participants felt that obese people have low-esteem and they weren’t sure which came first, the chicken or the egg. A clinician who worked with one morbidly obese woman relayed this analysis:

She had depression. I think her main diagnosis was probably Major Depressive Disorder but in a way everything also stems back to weight issues: self-esteem, self-confidence, and ability to socialize, just going to social events and how it interferes with having friends and developing relationships. It affects every aspect

of a person's life. It is important that you are treating everything; you can't just treat the depression. Obesity definitely has an effect on the depression.

It's an eating disorder, sometimes

When asked, all twelve interviewees believed that obesity is an eating disorder with some ambivalence, "I think it is, sometimes, but not every time" (47 year old female social worker). Though the clinicians interviewed felt they could categorize obesity as an eating disorder the findings highlight an uncertainty. Several of the MD's expressed that they wished it were an official eating disorder, that there was a clear diagnosis. Another clinician, a 24 year old female social work intern, said: "people tend to focus more on thinking that it's an issue of laziness than an issue of access—my first reaction is to say it's an eating disorder" (24 year old social work intern). A male psychiatric resident in this vein said: "well I'd say it is [an eating disorder], and it's more than that. The eating component of it cannot be denied. I think obesity is also. It's a phenomenon in which is affecting, especially in America, the country as a whole. The lifestyle, the emphasis on what it does." The ambivalence issued may be an expression of the clinicians straddling between the social judgment and their clinical perspectives.

Addiction

In response to two questions which asked for causes of obesity five participants thought that obesity might be related to addiction. In this vein one participant said:

if people would get scared that they could lose control they would be able to stop before it's too late. It's like a drug addiction. I think food has become like a drug addiction. We have the sugar rush, we have the insulin that kicks and then you

feel even more high. If only they know this vicious cycle: the more you eat the more insulin and it keeps going in the circle unless you put an end to it” (33 year old female psychiatric resident).

Another clinician compared obesity to addiction because of the compulsive and impulse qualities “covering emotional stuff” (24 year old female social work intern).

Another social work intern, a male, aged 50,

There’s, there’s like the idea of using the same steps for, that I use for my recovery from drugs and alcohol for eating is just something that I’ve just not, not made the decision to do. Um, and it’s just, I guess it’s just sitting on the fence not wanting to take the plunge, or sitting by the side of the pool not wanting to take the plunge. Um, and the sad part of it is that I know if I don’t, that every year I don’t, that I go without taking, addressing my eating issues is taking some time off the time that I’m going to live.

It’s a social disease

There was an understanding, particularly among all of the social workers and social work interns (6 out of the 12), that obesity is part of the greater social grids in which patients live: family history around food and eating, economic strata, and the greater cultural setting. One social work intern (female, aged 24) says:

when poorer people don’t have access to healthier foods, because you have so much money in food stamps that will cover certain foods, there’s not the access a lot of times, and how are people going to pay for a gym, or how are people going to buy weights, that people of different economic statuses can afford. So “why

would you choose a bag of chips over this. Well you know, this can feed a whole family when this one can feed...So, the money issues is a big one.

Some of the dynamics that contribute to obesity are lack of access to good healthy nutritious food, lack of affordable resources such as gyms and safe neighborhoods to walk in, a lack of institutional support. One physician called obesity a “lifestyle disorder” that is an extension of a sedentary life that lacks the resources to act upon a desire to change. “I think the main cause of obesity is a changing lifestyle...Um...mainly lack of activity, dependence on fast foods, very little exercise” the 29 year old male psychiatric resident went on to say, “Obesity is a public health issue...obesity is an epidemic, whereas if you take individual eating disorders they’re not. It has been reaching epidemic proportions, and there is a lot more to it than eating right.”

Definition of terms

It cannot go without reporting that few clinicians parsed overweight from obese from morbid obesity. This seemed to reflect a general lack of clarity as to what obesity is exactly: “What’s the difference between an overweight man and an obese man? I’m not quite sure how to categorize them, but you can think of a large football player as an obese man, and that’s different from , you know, one’s you see on shows that are stuck in bed and can’t get out” (24 year old social work intern). One clinician laid out the definitions in officious terms, that obesity is a matter of measurements and ratios. A 50 year old male social work intern says, “obese—I don’t know if we’re talking about morbidly obese at 500 pounds or someone who weighs 80 pounds more than they should.” But since many of the clinicians (10 out of 12) had worked with patients who were over 400 or 500

pounds they may have a skewed sense of the measurements because of the extreme nature of those people. There was a general lack of separating out obese from overweight.

Treatment Considerations

Four overlapping themes emerge in terms of treatment issues: the first, and most important, is the need for a holistic approach; second, is a need for creativity; third, is the need for a patient centered approach; and fourth, frustration. These themes emerged throughout the interviews responding to several different questions including clinician's experiences with obesity and what is important to say about this issue. These themes are not directly gendered, but if they are calling for a patient centered approach this researcher would assume that this would include a holistic (another thread) approach that would include a gendered understanding.

Holism

Holistic approach to treatment includes thinking about the person as a whole:

It's important to learn how to talk about it in ways that aren't shaming or blaming, that are health inducing. I think it's good for most clinicians to have a practical knowledge of nutrition and also to understand the ways that disregulated eating, including the emotional ones but also realizing that those aren't the only reasons. And that it's also a really, it's such not an easy thing for people to change too, that it's not just a simple thing "(55 year old social worker).

Part of the holistic approach that clinicians pondered is having an appreciation of different body types and to look beyond physical appearance. A different female social

worker's point of view concurred: "We have to look at the holistic point of therapy. We have to look at what's healthy for the client not just emotionally but physically and in relationships and everything." A female mental health worker, aged 29, said, "I can honestly say its now about seeing patients holistically instead of just thinking that they don't take care of themselves."

Creativity

"Changing bodies change the way people feel about themselves," asserted a 24 year old social worker. According to four clinicians creativity is needed, "being creative in treatment of what's present for the person so they don't continue a path that they view as negative and harmful" (25 year old female social work intern). A creative approach might include avoiding judgment and empathizing with limitations, but because food is necessary for survival clinicians have to find ways to, as one interviewee put it: "it is better to make small important changes in your lifestyle to make a difference than to make a restricting diet" (33 year old psychiatric resident). Some of these small important changes might be learning new coping skills. Lack of coping skills was a serial reason for overeating: "we deal with the psychological as much as the physical... cutting back the food and calories and the psychological aspects: teaching coping skills, teaching different ways to release frustration." Helping patients develop new coping skills would be a place for creative approaches.

Patient Centered

Working from where the patients are was also a reoccurring theme, as one female social worker (aged 47) put it: "how the client feels and how they are interacting in different scenarios to set goals that are going to be obtainable and what they want to do.

We have to look at weight issues for men and for women and you have to look at each individual.” One social work intern (female, 24) said:

we talk about family histories in a lot of other ways, but not regarding weight or food or...yeah, it's an important part of a person's history. Every person I can think of has their own thoughts about it because of how they've grown up and its really not even a consideration until a person brings it up and says “I wanna lose weight” or something, if it's not a serious health concern at that moment because of diabetes or whatever, it's not usually addressed.

A 55 year old female social worker said that she assesses for the motivation for a patient to lose weight (in a healthy way not to look better) but she also prioritizes according to the risk to their health. She continues,

I'm also aware that people are ashamed to talk about it, so if I'm sitting with someone who's obviously obese to the point—and they're telling me that they have, one of their big complaints is like joint pain in the knees, even if they haven't presented it to me as a problem then I have to find a way to bring it up. And to explore with them kind of their understanding with how their weight impacts on it, if that's something they want to do something about so I think, I do have my own impression about when it's a problem and when it's not depending on what the other treatment issues are so I might look for ways to bring it up.

Obesity “need to be a part of the plan, it does,” a 47 year old female social worker said, “the level and the direction in which you want to start is up to the patient.”

Frustration

There was a sense of frustration too. One physician felt particularly that her empathy was challenged by help seeking and help rejecting behavior exhibited by one patient who refused to make the changes necessary in her diet but would complain about all the chronic effects of obesity on her daily living:

So I sit there and, and look at that, and talk with, you know, still bring up occasionally, but think how, how much are you really invested in doing anything about your weight when you won't even do these simple things. It's not that you've tried Weight Watchers you've really invested in doing something and nothing has worked. That's kind of a different thing. But when I encounter people who are just rejecting, help-rejecting, in terms of even simple things, I think, I don't know it certainly doesn't color my attitude about medications or things like that, but in terms of my empathy for their struggle, I'm sure it does.

Another clinician, an inpatient 47 year old social worker heartily opined:

I've really been analyzing my view in depth and looking at the prejudice that goes along with obesity. And I'm finding that it is such, there's such a culture of disgust and prejudice towards obese people. And it's worse because people have this idea that they can help them self, that they did this to them self. There's no compassion for people that are in situations like this and it's sad, really sad, and it's a prejudice: it really is.

One 39 year old female psychiatric resident expressed this:

When I did my medicine rotation, I think every other patient was obese. Half of them were obese. They had a lot of horrible problems. And here, in the clinic, maybe 80-90 percent of the people right now that I see are at least overweight and obese. I'm scared. It's scary to look at someone who is very big. You realize that it is a very fine line; you could see yourself in every one of these people. It's a very fine line. You could lose control and look what they got, and they are miserable and they don't know how to get back online. Once you pass a certain weight it's really bad. It's really hard to lose. You're done. You're done.

Another psychiatric resident, a male aged 33 adds:

How is it affecting their mental health? I think it does have significance now especially with, um, women. Uh, it's very difficult to doctors. It's very difficult to address right now because it is hard for patients to hear signs of self-esteem problems that they are obese, whether or not you can get me because I am obese.

Resources available to clinicians

Participating clinicians felt that they wished they had more resources, more understanding, and more knowledge. One female social worker aged 47 reflected:

We will research for the clients outpatient private therapy, resources, housing, resources for electric and gas and how to get the client a wheelchair but we don't thoroughly research too much eating disorders unless it's something...unless they binge and purge something that is clearly an eating disorders but if the client is just over weight, the client's obese than it's something we're not researching:

weigh watchers and does insurance pay for it, does their insurance pay for them to go to the YMCA.

Another interviewee, a 49 year old, male, mental health worker, called for more institutions that specialize in obesity: “if there were more places that specialized, that had treatment, therapy for this particular category of people. That would help a lot.” One social work intern suggested that clinicians ought to learn more about obesity: “Any research or studies done about obesity: I think psychologically or physically what obesity does...What causes obesity? Biology, genetics...or environmental stressors or trauma history? Things like that. Just general research.” “I wish there were more resources for people who are less, for people who don’t have many resources because it would be a big project but there are, there are, there is a lot of stuff out there, I just don’t know where it is,” reflected a 33 year old psychiatric resident.

Race, culture, ethnicity, class matters

Without being asked any questions about race, class or ethnicity these three cultural dynamics became salient themes. Three interviewees were from other countries: Nigeria, India and Romania. They all three talked about the difference in culture from America in terms of obesity. In particular the Nigerian and Indian spoke that their perceptions of obesity and the meanings of obesity has changed since moving and studying in the west. Obesity in those countries wouldn’t be seen with such a putative gaze and is accorded different cultural meaning. In Nigeria obesity was seen as a sign of prosperity and of being spoiled. Obesity in India is seen as unhealthy and unusual but

here it is depressing and an outgrowth of lazy. Both of them felt that their views of obesity changed through media and pop culture.

Clinicians also volunteered that socio-cultural differences effected beliefs about obesity that showed up in their offices. One person felt that these differences were more comprehensive than gender. That, for instance, African-American culture is more accepting of obesity and that obesity is more accepted among lower social classes: “It’s kind of seen as, like, grosser, I guess for white women.”

Men’s bodies: they have them?

Almost universally among the participants is an inability to gain purchase on the experience of men in their body. This is important. If a person is being treated in a mental health setting for obesity (or even with obesity) how they conceive of themselves would be an important dynamic. Clinicians by not considering the male body in its greater context might be driven by unconscious bias or by assuming that men and woman conceive of themselves in mirrored ways. Both male and female interviewees articulated that men and women think differently about their bodies but many (7 out of 12, including all three men interviewed) were unable to imagine beyond a relative response. For instance, when asked if men think differently about their bodies several spoke to women’s experience: “Women have more of a—um awareness of their bodies” (middle-aged female physician); “I do think there’s a difference because I think there’s more of an emphasis on appearance for women than for men” (55 year old female social worker); “I have no idea because I’m not a man and I don’t spend a lot of time with a lot of men but my experience as a woman was that I was really affected by what a woman should look like and I personally was obsessive about my body and food... I think that that’s a

product of our society: through myths of told about what feminine is through media” (25 year old female social work intern); “I think women probably pay more attention to the appearance of their bodies than men do” (50 year old male social work intern); “I think that women are more conscious of their bodies as opposed to males. I don’t think men, when it comes to it, care as much about their bodies. Men care less about their bodies” (49 year old male mental health worker). One contrasting opinion, from a 45 year old female social worker, “But I do think that men have an ideal that they want to look like physically. They may not outwardly complain as much as women do.”

Six respondents gave answers that undertook men’s bodies. Three women and one male respondent suggested that there shifting expectations for men’s bodies: a lean muscular build is becoming more of a norm, “the ideal man is becoming bulkier and bulkier every day. In this country at least, you’ve come from um, [indiscernible] to GI Joe to all these WWE star toys who are really, really bulky and big. And the bulkier you are, the more manly you are, is a bias that is growing I think” (33 year old male physician). Another interviewee, a 45 year old social worker said: “having worked with men and knowing men in my personal life maybe in the last 10 or 15 years you’re finding more men who have eating disorders than we realized before. So, I think that men want to have that magazine perfect body also.” When asked about how men think about their bodies respondents some framed their answers in terms of sociologically “men think about their bodies as power, um, vehicles, ya know, and woman kinda think of theirs more like, um, sexual, uh, vessels” (24 year old social work intern). This is one of the only answers that took into account how men think about their bodies. All the respondents thought the men and women could conceive of a different experience for

men and women it did not translate into being able to describe how men think about their bodies.

Two interviewees suggested that there are differences between heterosexual and homosexual populations in terms of body image. A 24 year old social work intern, who had studied male body image, said,

gay men have a different body image issue, often, than heterosexual men, and there's the—also from friends I know that there's, like, there's almost—and it could also change by age, actually—but younger gay men, there's like this skinny this small thing going on that a lot of men want to be really small, I guess? And then there's that heterosexual, macho-type male standard that's, you know, the bigger the better, and muscular, and this and that.

Another clinician, a 29 year old female mental health worker: “I could break this down [meaning into gay/straight]—the majority of men I don't think view their bodies the way a woman would (Do I look nice? Do I look fat in this? How's my waistline? How do these shoes look? I know I look really fat in this?) But I'm stuck...because I'm having difficulties with there are these people who do and then this person who doesn't...so I think that overall it's not the same but there are exceptions.”

Summary

The findings suggest that there are several nodal dynamics that contribute to clinical attitudes toward male obesity. Among these dynamics are clinical perspectives on male body image, ideas about obesity including causes, treatments and obesity's place in clinical setting as well as the influence of gender on clinician's perception of obese

clients. In addition, race and culture were shown to be salient themes affecting the attitudes toward obesity by the study participants. The following chapter will synthesize these findings with previous literature. The implications of these finding for research, education and social work will be discussed as well.

CHAPTER V

DISCUSSION

This thesis explored through a qualitative process clinical attitudes towards obese males. The following discussion synthesizes the data collected with the previous literature in order to more fully comprehend the information gathered using psychoanalytic theory. The previous chapter discussed the findings in terms of their relationship to four major topical areas revealed in the data analysis: Gendered views of obesity; Views of obesity; Treatment issues; and, Responses to the question: “*Do men think differently about their bodies than women think about theirs?*” In the following discussion, these topical groupings are organized into the following four themes having relevance for the profession: Obesity as primarily a health concern; Gendered perspectives; the mystery of the male body; Cultural differences and obesity; and, Discipline-based approaches. The implications of study findings for social work practice, social work education, and research are explored and integrated throughout discussion of each thematic area.

Obesity as primarily a health concern

Universally subjects recognized obesity as a health problem. There was a more variable view that obesity has an emotional/mental health component. The variable view of obesity as an emotional/mental health problem is reflected in the literature (Fairburn and Brownell, 2002; Robb and Dadson, 2002). How patients are conceived of directly

affects patient treatment (Horner, 1991; Murphy and Dillon, 2003; Wachtel, 1993). Since sequelae associated with obesity are implicated in increased mortality and costs to both the health care system and the individual (NIDDK, 2007) the stakes are high for clinical attitudes toward obese people. Clinicians interviewed believed primarily, especially the medical professionals, that the medical consequences of obesity are the primary concern. However since obesity was also viewed as an eating disorder by these clinicians, a perplexing picture is created: treatment of an eating disorder and the treatment of a medical issue take place in different settings with different sets of tools. This suggests that obese patients might be caught in this in-between space in the medical and mental health complex with confused clinicians. This researcher might speculate that some of this ambivalence may stem from prejudice towards obese people. Obese men in particular were characterized as lazy.

The notion that obese people are lazy or lack will fits in nicely to the difficulties that clinicians felt with obesity and obese clients. Clinicians seemed to be overwhelmed by obesity. They had a sense of obesity as a major health problem and a public health problem but did not feel they had the tools or resources to address it more fully. Murphy and Dillon (2003) write that “the clinical relationship is multilayered, complex, and mutually influencing” (pp. 225). If the clinicians feel overwhelmed or frustrated the treatment is being shortchanged. But, the “anti-fat bias is especially strong because being overweight is deemed blameworthy... that weight is thought to be controllable is likely to reduce empathy for obese people” (Teachman et al, pg 69, 2003). Ingram (1978) coined the psychoanalytic term “cultural counterresistance” to describe this phenomenon of the analyst’s own cultural bias that interrupts or interfere with the analyst’s appreciation of

the patient's issues. There are possibly two biases that braid together here: first, there are received notions of gender and then the received notions of obesity. There is a diminishment of the person, not because of a lack of compassion but rather because the dynamics are so complicated, layered and informed by cultural preconceptions. For obese men this seemed to be especially true. Clinicians struggled to define men's body image as well as struggled to think of ways to include this issue in therapy. Part of this might be the failure of the theory to address a gendered notion of obesity. The holes in the theory are cultural holes. Obviously, if obesity has the major mental health component as the findings outline, then why the difficulty? What impedes comprehensive treatment? It is possible that a feeling of helplessness overtakes the treatment, and is combined with cultural counterresistance toward obesity and prejudicial attitudes toward obese men in particular ways limiting the therapeutic space. This calls for multifaceted training accounting for the biases toward obese people and clinician preconceptions, using a flexible model that incorporates physical and mental health needs, while continually examining one's own attitudes in order to counter the cultural counterresistance. In addition, more research is needed on the treatment issues arising out of a system that variably recognizes the medical and mental health needs of obese people seeking help. Social workers' global approach to issues can help to reshape obesity treatment by drawing upon the expertise of multiple disciplines.

Gendered perspectives: the mystery of the male body

There is a double bind for men. Clinicians were able to articulate the dangers of obesity. Clinicians were able to articulate their understandings of the difficulties of obesity. But, the obese man is seen as a "joke" or as less worthy of empathy or as "lazy,

they are looked upon as not wanting to take care of themselves, not caring about themselves” and then if a man is in treatment he is less likely to be evaluated and treated. This blind spot continues despite the heavy medical impact of obesity on mortality. Clinicians were unable to organize the relationship of men to their bodies. Men’s bodies are unknown territory or some mysterious land. This is in contrast to women, whose bodies have been so commodified that they were able to locate women’s bodies at least through the lens of social pressures and pop culture (Cafri and Thompson, 2000). But, the literature points out that the social pressure for an idealized body is increasingly prevalent for men (Frith and Gleeson, 2004; Pope, Phillips and Olivardia, 2000). And there are dangers in not recognizing this. Men are increasingly using steroids, exercising to extremes and dieting toward a super muscular lean body (Drummond, 2002; Pope et al, 2000). A few of the clinicians were aware of the pressures exerted on men, but for the most part there was an inability or unfamiliarity of thinking about men’s bodies. Feminist critiques of female representations have been disseminated and have become part of the conversation. This critique pointed out rightly and usefully the ways in which female representations were distortions intruding warped ideals into the culture. There was an associated critique of the “feminine” as an essential and unchallengeable category. There has not been an equal undertaking of representations of men and masculinity thus masculinity has not been simultaneously examined. The interviews reflected unexamined notions of men that would not be acceptable for their considerations of women. By no means do I suggest that all things are equal, but masculinity as several writers asserted is in “crisis” (Cafri and Thompson, 2000; Pope et al, 2000) and most clinicians interviewed were in collusion with the idea that men are less needing of help and need/deserve less

empathy which reflects standardized conceptualizations of masculinity that men enact, much to their detriment (Drummond, 2002; Drummond, 2002).

Still among the clinicians there was a general view that obesity impacts women more than men agreeing with Helb and Turchin (2005) who wrote that obese women are denigrated more than obese men. There seemed to be a matter of degree as respondents described that the morbidly obese blurred gender and that obesity overshadows some of the social conventions that hold for the non-fat population. This reflects Crocker, Cornwell and Major (1993), Devlin, Yanovski and Wilson(2000), Helb and Turchin (2005), and Teachman, Gapinski, Brownell, Rawlins and Jeyaram (2003) all of whom described anti-fat bias which is based on fat alone without a gender dimension. One participant elegantly attended to this point: “No matter the sex. I don’t differentiate like that. But there is definitely a perception that I have when an obese person comes in, that, you know, the first thing that comes to mind is that if they’re unable to take care of their weight, how can they take care of other things?” Though this particular participant explained that he does not differentiate between women and men, he did describe obesity being more socially difficult for woman than for men. Therefore, there was a perception of differences based on gender that might be usefully mined for nuance in experience of obesity. This is a rich area that needs further research to be fully fleshed out. There were no studies on attitudes or countertransference issues with obese males. But it also needs a superior instrument that takes into account all of the dynamics presented here: gender, culture, medical and mental health, sexuality (though it only came up twice in interviews the literature suggests a more need for more research) because most likely the findings will reflect the multiple perspectives of study participants. For instance a medical doctor

will view the issues from one angle and then view it from another angle reflecting another piece of them like their race or gender. The findings point to the reality that in the mental health field, obesity plays out differently for men and for women but the theory does not contain a gendered understanding. Social workers have done, and continue to do, useful and important work advocating for oppressed people and victims and the vulnerable in this culture. This may be a time to reconfigure this mission to include both obesity and men in more complexity with the understanding of men's body image concerns.

Cultural differences and obesity

Perhaps one of the most salient and interesting findings was that without having the question raised, practically all participants discussed culturally disparate perceptions on obesity. This may point out to an important area for further exploration, key in clinical work going forward, especially given the rise of obesity. It is also instructive as to what clinicians bring to the clinical encounter: including an understanding of cultural differences. It may speak to a “cultural” orientation to obesity—in the larger anthropological sense, in which gender, race, nationality, sexuality, age and class might be seen as elements—and bringing this understanding to clinical practice and education. The clinicians were correct that there are cultural differences in perceptions of obesity and contrasting body image concerns among sub-groups (Christakis and Fowler, 2007; Frith and Gleeson, 2004; Harmataz, Gronendyke, and Thomas, 1985; Tager, Good and Morrison, 2006; Ricciardelli, McCabe, Williams and Thompson, 2000). The limitations of cultural understandings is that they are not truths; they shift and vary among individuals. It is one descriptive dynamic among many that interweave around and within

a person. For instance, African-American does not describe an individual and does not take into consideration the clinician's perception of that, it is not an objective term but rather a subject term that is relative as to whom is employing it. In a similar way, clinicians who were from countries other than the United States spoke of how their attitudes towards obesity changed. For instance, for one clinician from Nigeria explained that in her home country obese people are seen as spoiled because they have enough food to eat. Another clinician put it this way: "My guess is that [perceptions of obese men] changes from culture to culture." She continued by saying that,

in the cultural group that I'm associated with it's looked down upon... there is a group in Polynesia that used to think that obese people, men and women, were healthy and happy and that was something to be admired. And I think in the African-American community there's less of a stigma associated with it.

More education and research is needed in this area. In particular, more research is needed to find culturally appropriate approaches to treatment that utilize diverse perspectives to enhance understandings for obesity in the clinical setting, in particular with men.

Discipline-based approaches

By interviewing a diverse group of clinicians from varied disciplines there were some telling differences and similarities. Across disciplines interviewees understood obesity as a problem that needed treatment. Clinicians across disciplines were dedicated to the well being of their patients. They were also for the most part uncomfortable speaking about obesity and stymied by men's body image. Many of them rushed through

the interviews and as soon as the recorder was turned off they more lucidly spoke about cases and feelings surrounding these dynamics. I will not discuss any content here because the interviewees assumed that the interviews were over. However the fact that there was such a shift in tone suggests that this material has a charge to it and that these clinicians were sensitive to it. They were also cautious. There may be a kind of “gentlemen’s agreement” for obesity. What they would not say on tape to me they were able to say privately. These were not surprising things, more revealing of the conflicted notions of individual obese patients or a more interior less “kind” reaction to a question. One supposition is that the charge to be a good and thoughtful clinician conflicts with the cultural bias that dog these issues.

Yet, some important contrasts can be drawn. Whereas psychiatrists and psychiatric residents focused, for the most part, on behavioral approaches to both cause and treatment of obesity without a greater context for obesity, social workers created a broader picture. Social workers discussed family of origin, food mythology, access to fresh food, grocery stores, poverty, and appreciation for different body types. There was also a stronger desire among social workers to have compassion for obese patients. This does not necessarily mean the doctors did not have compassion but rather they may conceptualize the issue differently.

More empirical studies are needed that examine what diverse professionals’ understandings of obesity are and how these understandings impact treatment.

Study limitations

This study has significant limitations. The relatively small convenience sample limits the application of the research findings in a broader arena. The study was also

presents geographical limitations: all of the interviews took place within Philadelphia using two related –in one inpatient and one outpatient-- clinical staff populations well known, or previously known, to the interviewer. A broader sample with a more comprehensive geographic and clinical range may alter or dispute the findings in a quantitative survey. There are also the limitations of the researcher who brings bias to data interpretations, and who is continually constrained by preconceptions.

Conclusion

This study was undertaken to understand better the clinical attitudes toward obese men. Obesity is a problem that has multiple medical, psychological and emotional facets. While one-third of the United States population is obese, preconceptions, misperceptions and hostilities abound about this targeted group. Every clinician will eventually face an obese patient, and yet, clinicians in this study did not feel that they had the tools to manage obese patients: especially male obese patients. Obese men were seen as lazy, received less empathy from clinicians than female patients, they were desexualized, or considered a “joke.” This was in contrast to the more social or cultural view that obese men have an easier time, are less socially judged than obese women. The clinical attitudes that this study highlighted imply that there are conflicting contradictory perceptions of and attitudes toward obese men that reflect cultural, social and personal prejudices. These attitudes may directly impact the treatment of obese men. Future research may find this study useful while examining the shifting image of the male body, male body image concerns, and empathy and bias in the clinical setting. Social work educators should provide profound training on the role body shape and size takes in

clinical settings. In addition, as a community, social work should undertake a rigorous inspection of the lens through which men and men's needs are seen.

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Appendix A

January 23, 2008

Michael J. Carter

Dear Michael,

Your amended materials have been reviewed and you have done a good job with your revision. We are therefore glad to give final approval to your project. We do have one request. Please delete the sentence in the Informed Consent that suggests people “call their mental health provider”. Please send Laurie Wyman that one corrected page for your permanent file.

Please note the following requirements:

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

Maintaining Data: You must retain signed consent 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: Beth Lewis, Research Advisor

Appendix B

INFORMED CONSENT

Dear Participant,

My name is Michael Carter. I am a candidate for Master in Social Work degree at the Smith College School for Social Work. I am conducting a study that involves research with mental health professionals. This study is focused on the experience of working with obese men to further understand the clinical implications of obesity. The data collected from this research will be used in completing my MSW thesis. The findings of the thesis will be disseminated publicly to the Smith community and may be used in published materials.

You will be interviewed for about one hour and no more than one-hour-and-a-half. We will meet in a private place and the conversation will be recorded. Participants must be at least 21 years old and work (or intern) in the mental health field including psychiatric nursing, psychiatry, social work, and psychology. Once the interview is taped it will be transcribed either by myself or by a professional transcriber. If a professional transcriber is used she/he will sign a confidentiality pledge to protect your privacy.

Though there is little risk for participating in this study you may feel some emotional discomfort or stress in thinking about and answering questions.

By participating in this study you will be contributing to knowledge that may benefit a large and growing segment of the population who may either seek or require mental health services. Your participation may help to deepen the clinical understanding and by extension social understanding of this population. By participating in this study you may

also benefit from gaining new insight into your perceptions regarding obesity and how these perceptions may impact your practice. There is no monetary compensation for participating in this study.

Every precaution will be made to protect the confidentiality of participants. Only research advisors, myself and professional transcribers will have access to data. Within the research names and other identifying information will be stored away from the data. Each participant's interview will be assigned a number code and during transcription any identifying information will be removed. All transcribers will sign confidentiality pledges. Data from this study used in published forms or in presentation will be carefully disguised. All data (notes, tapes, transcripts) will be kept for three years in a secured location as required for Federal guidelines. If data should be needed for further research beyond three years it will still be kept securely, otherwise it will be destroyed.

The study is voluntary. You may withdraw at any time during the data collection period and refuse to answer any question without penalty. To withdraw from this study you may inform me in writing by March 30, 2007. All data collected from you will be destroyed upon withdrawing. After March 30, 2007 it will be impossible to remove material from the study as it will have been incorporated into a final form. If you have any questions or wish to withdraw from the study please contact me in writing: Michael Carter by email or call. If you have any concerns about your rights or about any aspect of the Smith College School for Social Work Human Subjects Review Committee you may contact them at (413) 595-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR

PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

SIGNATURE OF PARTICIPANT/DATE
RESEARCHER/DATE

SIGNATURE OF

Please keep a copy of this signed statement provided to you for your records.

Appendix C

Interview guide

Interviewees Gender?

Professional background?

Age?

Number of years practicing? (Year/level, if in training)

What do you think about obesity?

Where do you think your ideas about obesity come from?

Do you have any experiences with obesity in a clinical setting? Can you speak a little about your experience?

Do you think your feelings about a patient's obesity are informed by the patient's gender at all? In what ways? Do you think that obesity in women is different from obesity in men? In what ways?

What do you believe is the cause of obesity? Is it an eating disorder?

Do you think that men think about their bodies differently than women? In what ways?

How do you believe obese men are perceived of socially?

How do these beliefs affect the clinical or therapeutic setting?

What do you think is important for clinicians to learn/understand about obesity?

How does obesity fit into the overall clinical assessment and treatment plan?

Is there anything else that you would feel is important to say on this topic?

Appendix D

Recruitment Instrument

For a study about obesity, I am looking
for mental health clinicians from any discipline
who would like to volunteer for an hour long interview.

If you are interested please contact:

Michael Carter

Or email: