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M. Elizabeth Kanard
Weighing In: An Analysis of the
NASW's Web-Based Content
Regarding Theoretical Issues and
Practice Recommendations for
Social Workers Working with
Overweight and Obese Individuals

ABSTRACT

This exploratory study was undertaken to determine the model(s) by which the National Association of Social Workers (NASW) understands issues related to overweight and obesity as represented by their published web content. Since two-thirds of the American population is categorized as overweight or obese, it is important that the NASW address social workers' roles in working with these individuals. As one of the public faces of the organization, the NASW website is an ideal forum for communicating an overarching model that represents the NASW's understanding of issues related to working with overweight or obese individuals as well as propose recommendations for best practices in both clinical and social justice work.

Nineteen published web articles that discussed issues of overweight and obesity were retrieved from the NASW's website and analyzed. In total, 278 article segments were identified for analysis and were then coded by themes and sub-themes.

Based on this analysis of their web content, it appears that the NASW has chosen to frame issues of overweight and obesity primarily as medical issues. The NASW web content also recommends a broad range of roles for social workers in working with overweight individuals. Unfortunately, the NASW's web content does not substantively address issues of prejudice and discrimination against those who are overweight or obese

and does not recommend methods for social workers to address these important social justice issues. Since articles on the NASW website represent the organization's public face, it is important that the NASW "weigh in" regarding social justice work for this population.

WEIGHING IN: AN ANALYSIS OF THE NASW'S WEB-BASED CONTENT
REGARDING THEORETICAL ISSUES AND PRACTICE RECOMMENDATIONS
FOR SOCIAL WORKERS WORKING WITH OVERWEIGHT AND OBESE
INDIVIDUALS

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

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2008

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CHAPTER I

INTRODUCTION

The purpose of this qualitative study was to identify the model(s) that the NASW's website content proposes for understanding issues of overweight and obesity. This study also sought to identify any clinical and social justice implications and underlying assumptions and values of this model(s).

Even a casual review of television, radio and print journalism in the United States makes it very clear that we are in the midst of a dangerous epidemic: the obesity epidemic. Recommendations for curtailing this epidemic range from common diet advice to more extreme recommendations of surgery and legislating healthy food. When entering the search term "diet" was entered into the internet search engine Google, 148,000,000 entries were retrieved! Similarly, when the term "obesity" was entered into search functions at the USA Today (www.usatoday.com) and the New York Times (www.nytimes.com) websites, 664 and 2,203 articles were returned respectively.

Studies on rates of obesity and overweight conclude that they are steadily increasing and The National Center for Health Statistics reports that an estimated 66% of U.S. adults are overweight or obese. That is, two-thirds of the population have a Body Mass Index (BMI), expressed as weight/height^2 , greater than or equal to 30 (where a BMI between 25.0 – 29.9 is considered overweight and a BMI equal to or greater than 30 is obese) (The National Center for Health Statistics, 2004). And despite the increase in these rates over the last 25 years, the limits as to what is considered a healthy or desirable weight continue to decrease (Gaesser, 2002; Maine, 2000; Oliver, 2006).

This discrepancy between “ideal” weights and actual weights in the population has led to a host of diet plans, exercise regimens, weight-loss medications and surgeries all aimed at helping individuals achieve the ideal. While higher weights historically were considered to be an indication of one’s success (Sobal, 1995), these same weights are now pathologized in the medical profession and have become the basis for considerable societal prejudice and discrimination.

Cultural understandings of overweight and obesity were first framed within a religious or moral lens so that “fat” was characterized as a moral failing and those who were overweight were considered “sinful”, guilty of sloth, and morally suspect (Boero, 2007; Evans, 2006; Rogge et. al., 2004; Sobal, 1995). As desirable weights decreased, increasing blame was directed at those who were overweight and therefore, spiritually imperfect (Rogge et. al., 2004). Despite the increasing characterization as overweight and obesity to be a medical problem rather than a moral problem, the morality argument continues in some weight-loss programs (Sobal, 1995).

In the 1960’s and 1970’s, obesity began to be increasingly viewed as a medical problem where those who were overweight moved from being “bad” to “sick” (Sobal, 1995). In addition, third party payers who play a large role in setting the standards for who is “healthy” and who is not (Conrad, 2005; Gaesser, 2002) and an increase in medical interventions for obesity have further contributed to the view of overweight and obesity being medical problems (Conrad, 2005).

In more recent years, the public discourse has also included discussions of individual’s lifestyles, the risks of certain behaviors, and a general increase in the consideration of behavioral and emotional contributors to health. This process has

become termed "biomedicalization" (Clarke et. al., 2003). One of the current controversies about biomedicalization is that those who are overweight or obese have moved from the moral to the medical and back to the moral model again. That is, discussions about making healthy lifestyle choices and avoiding "risky" behaviors end up blaming those who are overweight for making "bad" choices. As Galvin (2002) describes it, an "individual's moral obligation is to preserve one's health" (p. 110). In short, some consider that biomedicalization has simply become a thin veneer for one's moral failings of gluttony and sloth (Evans, 2006), and that the new cultural virtue is good health (Jutel, 2006). This of course, implies that those who are not in good health (e.g., obese) are not virtuous.

Not surprisingly, given the moral overlay by which this culture views issues of weight, considerable prejudice (Crossrow et. al., 2001; Longhurst, 2005; Solovay, 2000) and discrimination (Carr & Friedman, 2005; Puhl & Brownell, 2001; Solovay, 2000) have been documented towards those who are overweight. The poor treatment of those who are overweight and obese can be found in education, employment, housing, law, healthcare, public accommodations, and insurance ratings.

It is with an understanding of the current models of overweight and obesity and the social justice issue of weight-related discrimination, that this study was conducted. Since two-thirds of the population is overweight, the question of social workers' role with this population must be raised. What is an appropriate assessment and recommended course of treatment for these individuals? And how does the profession as a whole address issues of social justice as they relate to weight-based prejudice and discrimination?

One source of information is the professional organization of the social work profession, the National Association of Social Workers (NASW). While not all social workers belong to this organization, it is likely that the NASW has some authority within the profession regarding best practices with respect to assessment and interventions with those who are overweight. In addition, weight-related discrimination is surely a social work issue based on the clear wording of the Code of Ethics for social workers.

It is with this lens that the following study was conducted. Specifically, the NASW's web content was analyzed with respect to the model of understanding overweight and obesity promoted by the NASW, the clinical implications of this model, and the social justice recommendations made by the NASW to address prejudice and discrimination towards those who are overweight.

The following review of the literature addresses frameworks for understanding overweight and obesity, the implications of using these models, the degree and type of prejudice that currently exists towards those who are overweight, and social workers' efforts to this point to address these issues.

CHAPTER II

LITERATURE REVIEW

This chapter provides a review of the literature on weight-based prejudice and discrimination as well as the dominant frames that have historically been applied in attempting to understand and respond to those who are overweight or obese. The changing lens through which overweight and obesity have been understood in western history is discussed in detail elsewhere (Gaesser, 2002; Maine, 2000; Oliver, 2006; Schwartz, 1986; Stearns, 1997). This review focuses on the primary models or frameworks as specified by the sociology, psychology, medical, and social work literature which has guided past and current understandings of weight. The underlying values of these models have led to considerable prejudice and discrimination experienced by those who are overweight or obese. This literature review is particularly relevant to social workers involved in both clinical and social justice efforts. That is, frameworks for understanding overweight and obesity may well have direct effects on how clinical social workers view their overweight clients, therapeutic goals, and the interventions they expect to be effective. From a social justice perspective, the significant prejudice and discrimination experienced by those who are overweight provides numerous social issues and problems for social workers to address and attempt to ameliorate.

In reviewing the literature, three models are identified as the primary lens through which overweight and obesity are framed: the moral, the medical, and the biomedical models. In framing excessive weight and obesity as moral problems the individual who is overweight is viewed as a moral failure. Religion and morality are deeply entrenched in

cultural views of the body and body weight. For example, the prominence of the Protestant work ethic in the U.S. culture has the effect of emphasizing the values of self-denial, discipline, (Bovey, 1994), self-determination, and the belief that people get what they deserve (Puhl & Brownell, 2001). Further, being overweight is associated with two of the seven deadly sins; gluttony and sloth and implies a lack of moral rectitude in the overweight or obese person (Rogge, Greenwald & Golden, 2004). Some religions still emphasize fasting as a means of spiritual growth and excessive weight is viewed as the manifestation of spiritual imperfection (Bovey, 1994).

Medical claims that obesity is unhealthy have been made for many centuries (Bray, 1990), but the medicalization of overweight and obesity has increased considerably in recent years as medical interventions to treat excessive weight-related conditions has risen (Sobal, 1995). Obesity has been further medicalized as insurance companies called on the medical profession to provide weight standards for insurability (Gaesser, 2002).

One of the effects of medicalization as it was originally conceptualized was that it allowed the person to move from being a “bad” person to a “sick” person. Therefore, it was expected that the stigma associated with a condition would decrease once the condition was understood within a medical framework (Conrad & Schneider, 1980). That is, the person was no longer held responsible for their sickness because the medical process separated the person from the body (Lock & Gordon, 1988). Medicalization has evolved into what is now termed “biomedicalization” where the illness is viewed both through a medical and a sociocultural lens (Clarke et al, 2003).

In order to provide a context for a review of the NASW web site content as it applies to overweight and obesity, the literature regarding the primary cultural frameworks for understanding overweight and obesity as well as the literature on weight-based prejudice and discrimination is summarized below.

Models for Understanding Overweight and Obesity

The Moral Model

At one time, high levels of body fat were viewed as a sign of economic success and indicated that one had enough financial resources to have access to more than adequate food (Sobal & Stunkard, 1989). When the agricultural and industrial revolutions insured that adequate food supplies would be available to all people, fat became less of an indicator of high socioeconomic status. Instead thinness became valued and indicative of high economic status and fatness became increasingly more stigmatized (Sobal, 1995). Despite the involvement of the medical profession in addressing overweight and obesity, current weight loss organizations continue to apply a moral model. For example, the twelve-step program, Overeaters Anonymous, relies on meetings as forums for individuals to publicly confess their “relapses” with food (Sobal, 1995).

Historically, overweight and obesity have been closely tied to two of the seven deadly sins: gluttony and sloth (Rogge et. al., 2004). While obesity may be viewed by some as a disease, it is also viewed as both a social and a moral sin. In fact, obesity is a public sin (presumably because of its visibility) and indicative of a lack of self-control (Williams, 2006). Some treatments for overweight and obesity assume a moral stance. Though there are weight loss drugs on the market, their directions for use also require the overweight or obese individual to combine the drug with exercising. In other words, the

drugs still require that individuals “reform their evil ways” (Saguy & Riley, 2005, p. 885). It is this moral stance that equates overweight with sin that leads to a victim blaming stance that is now common in discussions about obesity (Evans, 2006).

Similar to the more Christian view of obesity as a sin, western values of self-control, self-determination, self-reliance, and discipline gleaned from the Protestant worth ethic result in viewing those who are overweight or obese as in direct contradiction of these values (Crandall, 1994; Puhl & Brownell, 2001). That is, individuals who are overweight are viewed as lacking in self-control, lazy, lacking in willpower, and translate into a judgment that these individuals get what they deserve (Crandall, 1994). Even physicians enact moral judgments on their overweight and obese patients by characterizing them as hostile, dishonest, lazy, and lacking in self-control (Klein, Najam, Kohrman, & Munro, 1982; Price, Desmond, Krol, Snyder, & O’Connell, 1987). This stance that emphasizes the will of individuals to overcome adversity places the onus squarely on the individual for maintaining his or her physical and mental health and results in yet another manifestation of victim blaming (Galvin, 2002).

While the moral and medical models have blended over time into what is now called “biomedicalization”, the medical model is reviewed in the next section and the nature and effects of biomedicalization reviewed separately.

The Medical Model

“Medicalization describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders (Conrad, 1992 p. 209). While medicalization can be a partial process, in recent years, the process of medicalization has expanded (Conrad, 2005). Multiple influences have led to

the medicalization of obesity or overweight including the establishment of weight tables by insurance companies, the creation of new drugs by pharmaceutical companies to treat a variety of overweight conditions, third party payer systems to pay for medical services for which insurance companies had not previously paid, managed care's attempts to control medical costs and the increasing tendency of physicians to view patients as consumers (Conrad, 2005; Gaesser, 2002). Recent efforts to medicalize what had previously been considered moral issues have expanded to include alcoholism, AIDS, as well as obesity (Appleton, 1995). It has been suggested in the literature that medicalization has replaced dominant moral views of particular conditions (Turner, 1987; Zola, 1972).

Defining a condition as a disease rather than a moral failing has a number of both positive and negative effects. One of the positive effects of medicalizing a condition is that an individual who may have been cast as a "bad person", is instead considered "sick" (Sobal, 1995) and thereby, in theory, the stigma of weight is reduced (Conrad & Schneider, 1992). In addition, designating a condition as a disease can lead to the development of curative and preventive strategies (Jutel, 2006). The view that obesity is a disease has led to the development of a large body of research and knowledge base regarding the causes of heart-disease, diabetes, and other illnesses in which obesity is thought to play a part.

The disease concept of obesity and overweight has been further extended in both the popular media and academic research by designating obesity as an "epidemic". However, unlike the traditional meaning of the word "epidemic", Boero (2007) called the conditions of overweight and obesity a "post-modern epidemic, one in which unevenly

medicalized phenomena lacking a clear pathological basis gets cast in the language and moral panic of more 'traditional' epidemics" (p. 42). Since we all have to eat, we are all therefore at risk and must be vigilant so as not to succumb to the "obesity epidemic". Boero (2007) further states that this post-modern epidemic represents a shift in public health from a focus on the public to a focus on the individual and can result in a victim blaming stance.

Using the epidemic metaphor can lead to a climate of fear and the need for all individuals to be constantly vigilant and exercise maximal control over their bodies (Boero, 2007). With respect to the emotional health of an individual who is overweight or obese addressing issues of blame, guilt, shame, hopelessness, and detachment that may occur in the midst of this epidemic tend to be marginalized and not a part of the overall medical discourse (Rich & Evans, 2005).

The medicalization of obesity has been partial (Sobal, 1995) where medicalization has not broken from earlier moral and religious views of obesity and overweight, but rather has incorporated them (Boero, 2007). This merging of the medical model and sociocultural values leads the third model: biomedicalization.

The Biomedical Model: Merging the Moral and Medical Models

Biomedicalization acknowledges the social aspects of medicine and also refers to the "increasingly complex, multisided, multidirectional processes of medicalization that today are being both extended and reconstituted through the emergent social forms and practices of a highly and increasingly technoscientific biomedicine (Clarke et. al., 2003 p. 162). That is, biomedicalization includes both social and cultural factors in the medical conceptualization of conditions.

Biomedicalization has introduced the terms “lifestyle” and “lifestyle choices” into the public lexicon. The pursuit of health is now an individual quest where individuals monitor their lifestyle choices in order to maintain maximal health. The “lifestyle correctness movement” (Galvin, 2002 p. 127) leads to an atmosphere of self-righteous social monitoring of individuals’ health status. (Galvin, 2002). In fact, a state of tension that may affect choices around a healthy lifestyle has led to the conceptualization that all individuals are “at risk” which can create a climate of fear and panic. All individuals, regardless of health status, can now be characterized as the “worried well” (Barsky, 1988) or the “potentially ill” (Conrad, 2005 p. 8). Therefore, those who become ill are viewed as failing in their bid for health. In fact, one now has a *duty* to be well rather than one having a *right* to be well. For those who have “failed” in this duty, internalized feelings of guilt and self-recrimination only add to their suffering (Galvin, 2002). Once again, the overlay of a medical framework onto conditions viewed as unhealthy leads to further moral judgments that are applied across the board to all individuals regardless of individual differences (Galvin, 2002).

The word “risk” within the biomedical model plays a prominent role. Our new “risk society” (Galvin, 2002 p. 119) and the “language of risk (Lupton, 2000; Rich & Evans, 2005 p. 351) suggests notions of what is right and wrong, good and bad, and normal and abnormal (Rich & Evans, 2005). Discussions about health risk goes further through the use of medical screenings. A negative result in a screening may result in an individual being considered “potentially ill”. Both Galvin (2002) and Puhl and Brownell (2001) document circumstances where overweight or obese individuals are not hired or promoted in the workplace or are denied healthcare insurance based on their weight

status. In the use of risk screenings, is it possible that an individual determined to be “potentially obese” may be the target of this kind of treatment?

Brandt (1997) summarizes the current language of biomedicalization and its implied moral stance by stating that “illness has become defined as a failure to take appropriate precautions against publicly specified risks, a failure of individual control, a lack of self-discipline, an intrinsic moral failing” (p. 64). Given this strong moral tone of current public discourses of overweight and obesity (Honeycutt, 1999), it is therefore not surprising that one’s weight status has led to considerable prejudice and discrimination in all walks of life.

Weight-Based Prejudice and Discrimination

Weight-Based Prejudice

Stunkard and Sorensen (1993) stated that prejudice towards individuals who are overweight or obese is the last socially acceptable prejudice. Prejudice can be defined as “a negative evaluation of a social group, or a negative evaluation of an individual that is significantly based on the individual’s group membership” (Crandall & Eshleman, 2003, p. 414). A plethora of negative characteristics abound with regard to those who are overweight or obese.

In general, these individuals are consistently the targets of public verbal abuse and ridicule (Longhurst, 2005; Solovay, 2000). They have been characterized as generally less likable (Hiller, 1981), less sexual, self-indulgent, lazy (Cossrow, Jeffery, & McGuire, 2001; Tiggemann & Rothblum, 1988), incompetent (Cossrow, Jeffery, & McGuire, 2001), untrustworthy, unattractive (Forestell, Humphrey, & Stewart, 2004; Tiggemann & Rothblum, 1988), lacking in self-control and self-discipline (Cossrow, Jeffery, &

McGuire, 2001), less intelligent (Crandall, 1994), and unhappy (Harvey & Hill, 2001; Goodman, Richardson, Dornbusch & Hastorf, 1963; Oliver, 2006; Regan, 1996).

Individuals who are overweight or obese suffer social consequences of their weight such as being viewed as a less desirable playmate for a child, less desirable as a romantic partner, and people are less likely to want to associate with them (Bell & Morgan, 2000; Cossrow, Jeffery, & McGuire, 2001; Smith, Schmoll, Konik, & Oberlander, 2007).

When the cause for being in a stigmatized group is perceived by others to be controllable, anger rather than pity is directed towards the stigmatized person and that individual is then punished or rejected (Weiner, Perry, & Magnusson, 1988). Unlike prejudice based on race, prejudice against those who are overweight or obese is particularly difficult to ameliorate (Teachman et. al., 2003). These individuals “are subjected to a unique and more intense form of stigmatization than other deviant groups because of the highly visible obese condition and the societal tendency to attribute personal responsibility to fat people for their condition” (Honeycutt, 1999, p.168). The more people are held responsible for their weight, the more negative are the judgments against overweight individuals (Crandall & Reser, 2002).

These biases can be activated without conscious awareness and can differ significantly from conscious views (Teachman, et. al., 2003). The tenacity of these biases is reinforced by the commonly held view that people are responsible for their weight (Crandall & Reser, 2002). Attributing one’s weight to the success or failures of one’s own efforts results in a victim blaming stance that views overweight individuals as “getting what they deserve” (Rogge, Greenwald, & Golden, 2004). It is this attitude that results in greater bias towards those who are overweight and obese (Cash & Roy, 1999).

Cahnman (1968) was one of the first to acknowledge the importance of attributions to the durability of bias against those who are overweight:

Contrary to those that are blind, one-legged, paraplegic, or dark-pigmented, the obese are presumed to hold their fat in their own hands; if they were only a little less greedy or lazy or yielding to impulse or obliviousness of advice, they would restrict excessive food intake, resort to strenuous exercise, and as a consequence of such deliberate action, they would reduce. . . . While blindness is considered a misfortunate, *obesity is branded as a defect*. (p. 294, emphasis added).

Interestingly, the stigma of obesity is somewhat unique in that both those who are overweight or obese report similar negative evaluations of overweight persons as a group in the same manner that non-overweight/obese individuals do (Teachman et. al., 2003). Negative attitudes towards overweight individuals have been expressed both by those who are overweight or obese as well as those who were once overweight (Honeycutt). Unlike other stigmatized groups, there does not appear to be a protective in-group bias (Crandall, 1994).

Weight-Based Discrimination

In a large-scale study (N = 3,437), Carr and Friedman (2005) distinguished between obese (Type I, BMI from 30 – 34.9) individuals and very obese individuals (Types II/III, BMI \geq 35). Based on interviews and a self-administered questionnaire, very obese individuals reported the most egregious instances of discrimination in the areas of work and health-care and the lowest reports of self-acceptance. But both obese and very obese individuals reported significantly greater instances of discrimination than their normal weight counterparts. Finally, they reported that obese individuals perceived that they were the targets of multiple forms of discrimination and that this had significant effects on their psychological well-being.

In sum, Allon (1982) stated that negative characteristics were associated with overweight individuals more than any other stigmatized group. These biases are held both consciously and unconsciously and are even held by health care workers who specialize in obesity as well as therapists in the mental health field (Agell & Rothblum, 1991; Teachman, Gapinski, Brownell, Rawlins, & Jeyaram, 2003).

As with other biases, weight-based biases translate into discrimination that is evidenced across multiple domains of western society. That is, weight-based discrimination occurs in education, employment settings and medicine.

Peer and teacher rejection of overweight individuals occurs in education at all levels. Richardson, Goodman, Hastorf, and Dornbusch (1961) found that primary school children ranked obese children last in desirability as a friend. The obese children were ranked behind children with crutches, a wheelchair, an amputated limb, and a facial disfigurement. These negative biases continue into the high school and college years (Puhl & Brownell, 2001). High school teachers have characterized their obese students as more untidy, more emotional, less likely to succeed at work, and more likely to have family problems (Neumark-Sztainer, Story, & Harris, 1999). Those who are overweight or obese have lower acceptance rates to college (Canning & Mayer, 1966; Crandall, 1991), receive less financial support from their families (Crandall, 1995), and are even expelled from school (Puhl & Brownell, 2001).

Those who are overweight or obese are also discriminated against in the work place. Highly obese professional workers are 2.5 times more likely to report discrimination in the work place than their thinner counterparts (Carr & Friedman, 2005). As managers, those who are overweight or obese are likely to be viewed more negatively

(Decker, 1987) and as less desirable to work with than others (Klassen, Jasper, & Harris, 1993). Obese job applicants are less likely to be recommended for hiring and are viewed as less productive, ambitious and disciplined (Falk, 2001). When those who are overweight or obese are hired, they are less likely to be hired as sales people and more likely to be hired for less visible positions (Puhl & Brownell, 2001). Overweight or obese individuals also make less money and are less likely to be promoted than their non-overweight counterparts (Loh 1993).

Those who are overweight or obese are viewed more negatively by health care professionals (Hebl & Xu, 2001; Puhl & Brownell, 2001; Solovay, 2000). Physicians spend less time with their obese patients (Hebl & Xu, 2001) and often focus on issues of weight at the expense of the presenting problems as reported by the patient (Solovay, 2000). In addition, medical students report significantly more negative views of obese patients than their non-obese patients and their attitudes did not change after working directly with obese patients (Blumberg & Mellis, 1980). Further, prejudicial attitudes extend beyond medicine and into the mental health field (Agell & Rothblum, 1991; Young & Powell, 1985).

The implications of health care professionals' bias towards patients who are overweight or obese can be considerable. Prejudicial beliefs can influence clinical judgments and practice (Maine, 2000; Young & Powell, 1985) as well as discourage overweight individuals from seeking medical care in the first place (Puhl & Brownell, 2001). Solovay (2000) summarizes the results of a survey of 150 fat women who weighed in the low 200-pound range. Every one of these women reported that they disliked having to discuss their weight with their physician because they were insulted

and made to feel embarrassed. Specifically, they reported being yelled at, having been called names, and slapped by doctors with whom they discussed their weight.

Given the prevalence of prejudice and discrimination against people who are overweight or obese, it is not surprising to find social justice efforts aimed at alleviating this situation. When framed as a medical issue and preventable health risk, the issue of overweight and obese garners less public tolerance and requires that individuals be ever more watchful of their weight status. However, framing overweight and obesity as a sign of body diversity and as a political issue implies that diversity training and increased social tolerance will ameliorate the effects of discrimination (Saguy & Riley, 2005). In fact, the National Association for the Advancement of Fat Acceptance (NAAFA) “is a non-profit human rights organization dedicated to improving the quality of life for fat people. NAAFA works to eliminate discrimination based on body size and provide fat people with the tools for self-empowerment through public education, advocacy, and member support (NAAFA, 2007). Though the number of “fat activists” are relatively small in number, increasingly claims are being made in the popular media that advance the rights of those who are overweight or obese (Boero, 2007; Saguy & Riley, 2005).

While the above literature on discrimination and prejudice was drawn primarily from the sociology, psychology and medical disciplines, this study is particularly interested in exploring the NASW’s official stance on overweight and obesity. Interestingly, the social work literature is surprisingly silent on issues relevant to these clients (Melcher & Bostwick, 1998). However, published articles in *Social Work in Health Care*, *Social Work*, and *Health and Social Work* discuss the role of the social worker when working with clients who are overweight or obese. Primarily, these articles

conceptualize the social worker's role as an assistant to physicians to encourage healthy eating habits and weight loss to avoid future health risks (Mjelde-Mossey, 2005).

Specifically, this literature is consistent with views of overweight and obesity as problems of life-style choices. Therefore, social workers should necessarily focus on providing counseling and education to enable patients to make health promoting food choices and to change eating habits. Social workers can also provide supportive counseling and advice to enhance physicians' patient counseling skills (Eliadis, 2006; Gross et. al., 2007).

Recently the NASW published a special section on their web site solely devoted to addressing the social worker's role with regards to overweight or obese clients (<http://www.socialworkers.org/sections/areas/econnection/emEconnection.asp?econ=60>). In this web-published newsletter, the NASW recommends that social workers place an emphasis on healthy eating habits and exercise rather than weight loss when working with both overweight or obese children and adults. Further, social workers should carefully consider the negative effects of using the word "obese" with clients and perhaps explore other ways in which to discuss the issue of obesity.

What is not apparent in the literature published to date or the NASW's recent newsletter about obesity, is the obvious social justice issue that exists with respect to social workers responding to the considerable prejudice and discrimination experienced by overweight and obese individuals. While the NASW code of ethics (NASW, 1999) emphasizes the importance of social workers in pursuing "social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people", there seems to be a paucity of discussion within the social work literature regarding social justice

efforts targeted to ameliorate the prejudice and discrimination experienced by overweight and obese individuals. In addition, there also appears to be a lack of “best practice” recommendations within the literature as to addressing the “whole” person who is overweight or obese rather than just the “healthy” person.

Given the considerable negative evaluations of the overweight and obese in our culture and the strong emphasis in helping them “reform their evil ways”, the social work profession has a critically important role to be in both macro and micro work. That is, social workers have an opportunity to address a significant social justice issue as well as bring the full force of best practices into clinical work with both overweight and obese individuals as well as educating and training other professionals who work with these individuals. Given the prevailing moral and medical frameworks by which issues of overweight and obesity are understood, social workers have a unique opportunity to provide services that address both the larger societal effects of prejudice and discrimination as well as micro services across diverse settings.

As with any discipline, the NASW can and should take the lead in providing professional guidance to social workers with respect to defining best practices in macro and micro social work. Therefore, the NASW’s web site content is reviewed in consideration of the following questions:

1. What models or frameworks does the NASW use to understand individuals who are overweight or obese? That is, does the NASW published web content reflect common societal models that frame issues of overweight and obesity or does their web content use a different framework? What are the inherent assumptions and

values of these models and what are the clinical implications of these models and underlying meanings?

2. From a social justice perspective, what recommendations does the NASW communicate for addressing weight-based prejudice and discrimination?

CHAPTER III

METHODOLOGY

The purpose of this exploratory study was to identify the model(s) that the NASW's website content proposes for understanding issues of overweight and obesity. This study also sought to identify any clinical and social justice implications and underlying assumptions and values of this model(s).

While the NASW website may not reflect the practice of all social workers (and in fact not all social workers are members of NASW), the web publications were chosen for analysis because the NASW is the official professional organization for the field and presumably has a voice in advocating best practices for social workers working with overweight individuals. Since a variety of authors contribute articles to the website and every NASW member has access to these weight – related articles, it was further presumed that the website content would provide for analysis of a diverse set of views that reach a broad audience. Given the potential for moral judgments inherent in the models for understanding overweight, it seems important to identify the model by which the field's professional organization understands weight and their recommendations for clinical and social justice practice.

To answer the research questions, content-theme analysis was applied to articles sampled from the NASW's web site. This analysis allowed for thematic categories to be developed. Details about the themes emerged upon analysis of textual segments that fit into broadly identified themes. This type of analysis allowed for both broad statements to be made as well as detailed conclusions regarding assumptions, values, and practice recommendations to be identified. In addition, this type of analysis yielded information

about both the manifest (i.e., surface content) and latent (i.e., underlying meaning) content of each article (Rubin and Babbie, 2007). Content analysis on web site content has been used by other researchers across multiple domains (Boero, 2007; Salant & Santry, 2006) for the same purposes. Relevant articles were selected by searching the NASW web site. After articles were included for analysis, open coding and extensive memoing were used to extract recurring themes.

Data Collection

Data for this study was selected by searching the NASW web site on the terms “obesity”, “obese”, “overweight”, and “fat”. All articles retrieved in the search process were read once for preliminary inclusion or exclusion in this study. Specifically, if an article’s primary topic directly related to one of the search terms or if there was at least one paragraph that discussed one of the search terms, it was included in the study. If, however, the search term was mention “in passing” and was not the main topic of the article it was excluded. For example, an excluded article may be about HIV/AIDS and was retrieved because of a sentence that reads, “Much like the obesity epidemic, the HIV/AIDS epidemic. . . “ Though the article was retrieved because of the occurrence of the word “obesity”, the article itself is concerned primarily with HIV/AIDS.

Based on the search results 23 articles were retrieved and 4 of those were excluded from analysis based on the above criteria. The remaining 19 articles were printed and numbered 1 through 19 so that each article could be uniquely identified for later analysis and entry into a Microsoft Excel spreadsheet. See Appendix A: NASW web articles and URLs.

Data Analysis

Before analyzing the data, all articles were read through twice as an orientation to the nature of the data as recommended by D. Burton (personal communication, July, 2007).

Open coding and extensive use of memos, as described by Strauss and Corbin (1990), were used to analyze each article. Open coding identified major themes, categories and concepts in the articles and memoing allowed for identification of underlying assumptions, values, and clinical and social justice practices present in the article. During the analysis phase, the 19 articles were read and themes were identified and refined until no further themes emerged. Portions of an article that expressed a particular theme were color-coded for use in later analysis.

After identifying primary themes or categories, memos were attached (in the form of either written comments on the article or the use of “sticky notes”) to articles to identify connections between themes, support or contradiction of particular weight and obesity models, underlying assumptions and/or value statements, clinical implications of the inclusion of specific models, and description and recommendations regarding weight-based prejudice and discrimination.

Subsequent to open coding and memoing, 173 segments were identified from the 19 articles and were entered into a Microsoft Excel worksheet. For each article segment the article number, theme, and memos were entered. In the process of thematic coding, some segments were categorized into multiple themes (up to 3 different themes). Several segments that were coded within multiple themes are presented in the Findings section of this document. Worksheet rows were sorted in ascending order by theme and segments

for each theme were copied into a separate worksheet resulting in a total of 9 separate worksheets (one for each of the 9 identified themes).

Segments were then read from the worksheets and additional memos were added as appropriate. Quotations were selected from the segments that particularly exemplified the theme for use in the Findings chapter of this study. Finally, article titles were analyzed for common themes.

The following section details the results of this analysis. The findings highlight both the models presented by the NASW's website content in understanding issues of overweight and obesity and further focuses on clinical and social justice implications of these models.

CHAPTER IV

FINDINGS

In previous years issues of overweight and obesity were identified as moral issues. That is, those who were overweight were considered an affront to God and guilty of sloth, one of the seven deadly sins. More recently, overweight and obesity have been reconceptualized as medical problems that require surgical, medication, or “lifestyle change” interventions. Regardless of the framework for understanding overweight, considerable prejudice and discrimination have been leveled at those who are overweight or obese.

Therefore, this study explored the ways in which the NASW web content understands issues of overweight and obesity and proposes or recommends social work clinical and social justice interventions. Specifically, the following questions were explored:

1. What models or frameworks does the NASW use to understand individuals who are overweight or obese? That is, does the NASW published web content reflect common societal models that frame issues of overweight and obesity or does their web content use a different framework? What are the inherent assumptions and values of these models and what are the clinical implications of these models and underlying meanings as represented by the NASW's web content?
2. From a social justice perspective, what recommendations does the NASW communicate for addressing weight-based prejudice and discrimination on their website?

Data was selected from the NASW web site and resulted in 19 articles that were analyzed with the above two questions in mind. Surprisingly, when the general content of these articles was analyzed, articles primarily related to overweight or obesity accounted for the least number of articles. Given the considerable attention issues of overweight and obesity receive, only 16% of the articles focused solely on overweight. Those that did not primarily discuss issues of overweight and obesity included at least a subsection of discussion on overweight or obesity. Table 1 displays the number of articles in a content category and that number's percentage of all 19 articles.

Table 1

Content categories of articles and number of articles in categories.

Content Category	Number of articles	% of total
Healthcare in general	8	42
Eating disorders	4	21
Healthy lifestyles	4	21
Overweight or obese specific	3	16

After analysis of all articles, 173 segments were identified for analysis. Some of these segments were categorized in up to 3 different themes resulting in 287 segments across all themes. The resulting broad range of themes is expected since issues of overweight are addressed across multiple domains (e.g., medical, social, emotional, cultural). Likewise, because social workers often play a prominent role in addressing issues of weight in multiple environments and/or as members of multi-disciplinary teams,

a large number of segments discussed the social workers' role with respect to these themes.

It is also interesting to note that the discussion about overweight and obesity is largely atheoretical since only 4 of the 19 articles referenced a particular psycho-emotional, social or cultural theory. The development of a model for understanding overweight couched within a solid theoretical base may allow for clarification of social workers' roles and yield additional assessment and intervention strategies. Table 2 displays the themes, the number of article segments categorized into each theme, and the percent of the total for that theme (total does not add up to 100 because of rounding).

Table 2

Segment themes and number of segments within each theme.

Theme Name	Number	% of total
Non-medical interventions	78	27
Social worker's role with those who are overweight or obese	50	17
Biomedical themes	35	12
Medical risks of overweight and obesity (e.g., stroke, heart disease)	27	9
Issues for people of color who are overweight or obese	26	9
Weight-based Discrimination and Prejudice	21	7
Contributors to overweight and obesity (e.g., genetics, frequent dieting)	20	7
Statistics related to overweight and obesity	18	6
Integration of a particular theory or perspective in understanding issues of weight	12	4
Total number of segments	287	98

In attempting to identify the underlying model for understanding overweight and obesity, further analysis identified no articles or segments that took a moral stance regarding weight. It appears that the primary model for understanding overweight and obesity is the medical/biomedical model where 35% of the segments could be identified as taking either a medical or biomedical stance. Other segments that could not be identified as proposing a particular model were primarily segments that stated statistics regarding overweight and obesity, referenced healthcare in general for persons of color or commented on discrimination in healthcare for specific populations (e.g., race, weight). Implications of this stance are explored in the discussion section below.

Implications for Clinical or Micro Social Work Practice

The theme most represented in the data was non-medical interventions or treatments. These interventions ranged from individual, therapeutic interventions to macro-level and systemic interventions. These segments were further thematically coded into sub-themes which included:

Table 3

Non-medical intervention sub-themes, number of segments, and percent of total.

Sub-themes	No. of articles	Percent of total
Therapy/Counseling	17	22
Education/Information/Resources	15	19
Macro-level interventions	10	13
Advocacy	9	12

Diet/Exercise	7	9
Multidisciplinary interventions	6	8
Policy/Legislation	5	6
Research	4	5
Prevention	4	5
Systemic change	1	1
Total	78	100

Specific examples of non-medical interventions included:

...treating negative emotions and poor eating habits is done with a combination of cognitive-behavioral, behavioral and psychodynamic strategies.

Our participation in this effort extends beyond our adherence to our Code of Ethics and our sense of each having a "personal calling" to help right the social injustices that remain entrenched in our society

Overweight people need to be encouraged to make food choices that are satisfying to them and to exercise as part of a lifestyle

Social workers...play a role in the prevention of heart disease by educating people about the benefits of healthy lifestyle choices.

The presentation of problems...enables us as practitioners to become involved with changing the systems and social structures that deprive our youths of optimal health.

...eating disorders are highly treatable, usually with a combination of approaches by a team of professionals

The implementation of some of these interventions were also thematically coded as part of a social worker's role. Social workers' roles were as diverse as the non – medical interventions discussed. For example:

... to link their practices to important policy issues such as mental health parity and health services for immigrants.

Complete research and obtain knowledge of issues and laws affecting healthcare for adolescents.

A clinical social worker often will provide psychotherapy

...social workers at all levels of practice will have an even greater need to monitor the health and well-being of this unique population

Also, you can consider a support group. A social worker can help to link you with an appropriate group.

Similar to the analysis of identifying sub-themes in non-medical interventions, social workers' roles were further categorized into sub-themes. Table 4 displays the sub-themes of 50 segments, the number of segments in each sub-theme, and the percent of the total for that segment.

Table 4

Sub-themes for segments categorized within the social worker's role theme, the number of segments in each sub-theme, and percent of total.

Sub-theme	No. of segments	Percent of total
Provide education/information/resources	14	28
Perform assessments	7	14
Macro-level interventions	6	12
Create policy/legislation	6	12
Social Justice/Advocacy activities	6	12
Conduct therapy/counseling	5	10
Conduct research	2	4
Develop systemic solutions	2	4

Be part of a multidisciplinary team	1	2
Prevention activities	1	2
Total	50	100

Examples of segments coded as describing a social worker's role included:

If you undergo surgery, a social worker may help you to understand and ultimately adjust to the lifestyle changes afterward.

...to implement policy and regulatory strategies that address fragmentation of health plans along socioeconomic and geographical lines.

There was the nutritionist, the nurse, the social workers and they worked on it as a lot of pieces of a puzzle.

It is very important for social workers to be sensitive to compulsive eating and to screen for eating patterns and body-image issues

A clinical social worker...acting as a bridge to connect you to additional resources

Social workers...play a role in the prevention of heart disease by educating people about the benefits of healthy lifestyle choices.

Implications for Social Justice or Macro Practice

Segments that were coded as specific to persons of color or discussed discrimination for these individuals in healthcare accounted for 16% of the total segments. Only one of the segments addressed rates of overweight or obesity in non-dominant racial groups and that segment (and the article in general) did not discuss the differing cultural norms for weight that may exist in communities of color. Further of the 21 segments that discussed issues of discrimination and/or prejudice, only 3 (14%) specifically referenced weight-based discrimination or prejudice. The remaining segments discussed racial prejudice in the healthcare system in general. Unfortunately, 2

of these 3 segments specifically identified a therapist or social worker as discriminating against overweight or obese clients. The remaining 18 segments referenced discrimination and prejudice in the healthcare system in general. The following are examples of segments coded in the weight-based discrimination and prejudice theme:

If you or a loved one is obese....you may also face job discrimination, ridicule, and a sense of being an outcast.

Saunders said she had detected a bias in therapists and social work students who wanted to treat anorexia and bulimia but not obesity, which is a much greater problem

...communities of color experience compelling commonalities that disproportionately and negatively affect health status, leading to glaring and significant racial and ethnic health disparities.

...43 percent of African Americans and 28 percent of Latinos compared with 5 percent of white people, felt that a health care provider treated them badly because of their race or ethnic background.

Given the considerable prejudice and discrimination directed towards those who are overweight, it was disappointing that the NASW's website content did not include more articles that spoke to this. While racial discrimination in healthcare in general should not be minimized, social workers have an ethical responsibility to serve all oppressed populations. This is an area that deserves further attention in the social work literature.

Other Findings

Of the 19 articles, seven presented statistics regarding overweight or obesity. However, only 3 of these articles provided specific references for their statistics, 2 articles provided a general citing (e.g., "Annals of Internal Medicine), and 2 did not provide any references. One would expect that references would be cited to bolster the legitimacy of statistical claims. In addition, only two of the articles provided criteria for

defining overweight and obesity. Though BMI levels are most often used as criteria, these articles did not specify this so it is difficult to determine the validity of many of the statistics.

Finally, the Theory/Perspective theme included references to several different theories as the basis for interventions with those who are overweight, obese or are characterized as having a binge eating disorder: behavioral, cognitive-behavioral, psychodynamic, skills training, and strengths-based perspective. The social work field would likely benefit from a model for understanding overweight that is grounded in theory. Perhaps the broad range of social workers' roles discussed in these articles is reflective of a lack of a unified, theoretically based model.

In general, given the great deal of attention directed towards the achievement of an ideal weight in this culture, it was surprising to find that the NASW has relatively little to say about this topic (at least as evidenced by their website content). And yet, two-thirds of the American population is classified as overweight or obese and there is no shortage of work for social workers in this area. A comprehensive model to address this issue would provide social workers with numerous avenues for micro, macro, policy, research, social justice, and advocacy interventions.

In the following section, the above findings are interpreted with respect to the clinical and social justice implications. Specifically, adoption of the biomedical model as represented by the NASW's web content carries with it a certain set of underlying assumptions and values. The discussion section explores the affect this model may have on social workers' micro and macro practice.

CHAPTER V

DISCUSSION

This qualitative study examined the ways in which overweight and obesity are understood in social work as represented by the NASW's web content. The frameworks for understanding overweight and obesity have clinical and social justice implications for social workers. It should be stated that the NASW web content does not represent all social workers beliefs regarding weight. However, the web content of a primary professional organization for a discipline, such as the NASW, is likely influential on professional practice in the field.

Given that measures of overweight in this country consistently report that two-thirds of Americans are overweight (The National Center for Health Statistics, 2004), it was surprising to find that only three of the 19 articles focused on issues related to overweight or obesity (as opposed to those articles that focused on healthcare in general and included a section about weight). Given the prevalence of this issue, it would be expected that multiple articles would address medical social work issues, school social work issues, psychotherapeutic issues as they present in children and adults, and macro social work practices as they related to ameliorating weight-related prejudice and discrimination. Despite the diverse number of interventions discussed in the web articles, the social work profession may benefit from recommendations by the NASW regarding best practices that address the person and their environment regarding overweight and obesity. Since the NASW website is one of the organization's public faces, it seems important that practice recommendations be published on the website.

Model of Obesity

It is not surprising that the primary model represented in the NASW's web articles mirrored the model promoted in the society at large and the popular media: the biomedical model. Unlike previous discussions in the biomedical literature regarding the tendency of the biomedical model to incorporate some level of moralizing because of the tendency to blame the overweight or obese person for their weight, none of the articles analyzed communicated a moralistic stance. Consistent with the underlying value of not "blaming the victim" of social work in general, this lack of moralizing is not unexpected. It is further to the NASW's credit that this tone is absent given the large scale of prejudice and discrimination in the culture and that the NASW has resisted this moralistic bandwagon.

It seems appropriate that given the increased risk of developing serious physical problems as one's weight increases, the NASW web content does provide social workers with a range of interventions to encourage individuals to make positive health-related choices regardless of weight. The interventions discussed by the web content included not just recommendations regarding diet and exercise, but were as diverse as the diverse range of contributors to poor health (of which weight is only one contributor). In fact, several articles pointed out that dieting does tend to lead to "yo-yo" weight loss and gain and in the end simply leads to weight gain.

None of the articles analyzed discussed the possibility that one can be overweight and be healthy (Gaesser, 2002; Wann, 1989). And yet, even if one is overweight and healthy, individuals may suffer from low self-worth or self-esteem, because of exposure to weight-related prejudice. While the NASW web content defined a number of

interventions for social workers to encourage individuals to make behavioral choices to improve their physical health, the content was far less clear in discussing the psychological, emotional, and social issues that may be present because of prejudice and/or discrimination. In addition, there are those who are overweight or obese who do not want to lose weight or cannot lose weight (e.g., due to medications, genetics or the like). And yet these individuals may be consistently referred to social workers for “help”. Do such referrals need any intervention? If so, what would be appropriate interventions and/or treatment goals? This is an area that is unaddressed in the data analyzed and likely could benefit from further research.

Clinical Implications of the Biomedical Model

One of the implications of understanding overweight and obesity solely through one particular model (e.g., the biomedical model) is that the social work profession is obviously much broader than this. That is, social work addresses other aspects of the individual as well as focuses attention at the family, community, and population levels. The breadth of diversity of the non-medical interventions discussed in the data accurately reflects the breadth of social work practice. It would be useful for the NASW to develop a broader model for understanding issues of weight that address all significant areas of an individual’s life. In order for such a model to be easily accessible, it would be helpful for the NASW to publish such documents on their website. Practitioners would be well-served by the NASW if it were to develop and propose a framework for understanding overweight and obesity at both the micro and macro levels. From this, best practices for nearly two-thirds of our population could follow.

While this paper focuses on overweight and obesity, it is clear that weight occurs along a continuum. Many social workers in the field of eating disorders certainly witness this continuum as weights can range from severely underweight to severely overweight. A comprehensive model for understanding weight would incorporate this continuum and likely have implications for assessment and intervention. That is, rather than delineating interventions categorized as applicable to one type of eating disorder rather than another, recognition of this continuum may mean that interventions differ in degree rather than kind. This may also mean that some issues (e.g., control, subjugation to cultural ideals, affect regulation) could benefit from similar interventions that may just vary in emphasis. In fact, one of the articles analyzed (O'Neill, article #11) discusses this very issue by stating that social workers have focused on anorexia and bulimia to such a degree, that binge-eating disorder has received "short shrift". And yet strategies for helping individuals "normalize" their eating are similar regardless of the spectrum at which individuals find themselves.

The biomedical model also assumes that the standard measure for determining if one is overweight, Body Mass Index (BMI), is a valid measure. However, there are those that argue that BMI is either an invalid or inadequate measurement for obesity (Evans, 2006; Gaesser, 2002; Gard and Wright, 2005). That is, BMI focuses on weight rather than measuring fat and doesn't measure anything about how healthy an individual is (regardless of their weight). Further, whether or not BMI is a valid measure or not, social workers should be clear that an individual's psycho-emotional challenges may have to do with their own perceptions of their weight or how they believe others' perceive them that may be at issue. So while BMI may provide an interesting data point or reference for a

clinician it does not communicate who an individual is psychologically, emotionally, socially, or culturally; it does not say anything about an individual's ego-strength or defenses; it does not communicate an individual's strengths; nor does it provide any information about various life events that have shaped an individual. Therefore, as social workers, we should be focused on treating the whole person and not be distracted by a model of understanding provided by only one discipline. Again, the NASW website would benefit from a framework developed to treat the whole person at all levels that are important to him or her.

What BMI also does not communicate is varying weight standards across cultures. Much is written about the need for social workers to be "culturally-competent". It should also be mentioned that not all cultures have the same standards as to what is overweight (Boero, 2007) and what is not. And they also certainly don't agree about what body fat may mean to an individual, the family and the culture (Thompson, 1996). And what does it mean for immigrants coming to a western culture where it is quite likely that the meaning of body fat is different in the west than in their own culture? Given the emphasis on multi-cultural understandings in social work, social workers are in a unique position to address these questions and respond from a multi-cultural viewpoint. This may be an area of future research.

Of particular interest to social workers may be development of a strengths-based intervention model for addressing weight – related issues. While there may already exist specific intervention models, the NASW does not acknowledge this possibility on their website or publish such intervention recommendations on their website. A purely medical/biomedical understanding of weight restricts social workers to viewing

individual's issues as problematic and as deficits. In fact, it is worth noting that in the medical field, many metaphors for discussing medical issues, treatments, or patients in general have an aggressive tone that has a tendency to pit some medical professional against patients or overweight individuals against themselves. For example, in the articles analyzed this aggressive tone was present in such metaphors as young adults engaging in "body battling" to fit into a "culture of thinness" or doctors making concerted efforts to "win the war on obesity". Several articles used language that Boero (2007) characterized as the language of panic in describing obesity rates as "epidemic". In some instances, metaphors imply that one should take a more aggressive stance towards one's own body by continuing to "struggle" with weight-related health problems. However, social workers' interventions often focus on helping the client to accept and care for who they are at any weight. In addition, social workers often come from a strengths-based perspective that is appreciative of the whole person which includes their challenges as well as their strengths.

Finally, one of the underlying assumptions of a scientific medical model is that because it's scientific, it must be true. There is a growing body of literature that questions the fundamental medical claims associated with increased weight (Aphramor, 2005; Blair & Church, 2004; Lee et al., 1999; Raphael, 2002). Further, given the 95% failure rate of many diets, some are questioning even the ethics of healthcare workers in recommending weight loss efforts (Aphramor, 2005). And if weight-loss diets are recommended, are patients made aware of the high failure rate of the "treatment" and adequately informed that more than likely the "treatment" will lead to further weight gain not weight reduction?

The health implications of weight are likely to be debated for some time. However, what is not in question is that regardless of the degree to which overweight contributes to lack of health, a careful examination of messages in the media indicates that not only is weight-related prejudice and discrimination wide-spread, it is even condoned in some cases.

It is clear from reading magazines or watching television that public derision and condemnation of fat people is one of the few remaining sanctioned social prejudices in this nation freely allowed against any group based solely on appearance. (Fitzgerald, 1981).

Social Justice Implications

Russell-Mayhew (2007) identifies two aspects of social justice work: the increase of an individual's sense of efficacy in the world, and that sociopolitical changes should be the result of social justice interventions. One aspect of the medical approach is that it does not address the political arena. And yet this is of critical importance when discussing social justice efforts particularly around issues of weight.

For weight in particular, dominant definitions of impairment and disability are entangled in culture debates about medicalization, group and individual autonomy, cultural decisions and consequences of pathologizing certain bodies, demanding corrective action on the part of individual people rather than collective social action (Herndon, 2002, p. 123).

Certainly this is consonant with social workers' mandate as described in the NASW Code of Ethics (1996) Specifically, the code states that a key value of the profession is social justice and the related ethical principle is "Social workers challenge social injustice".

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to

and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people. (NASW, 1996; emphasis mine).

What was curiously absent from the NASW's web site altogether was a social justice discussion of social workers' role in addressing weight-related prejudice and discrimination. In addition, the NASW published a special section about obesity on their website in October 2007. Again, the social justice component inherent in addressing issues of overweight and obesity was absent from the web content. In fact, recommendations for work at the community, societal and global levels focused on social workers' efforts to support "legislation that bans hydrogenated oils in restaurants", "complain to TV networks about the barrage of unhealthy food commercials during children's television programming", and learn about the global effects of obesity (eConnection, 2007). While there are most likely efforts around the country to address weight-related discrimination, it would be useful for all social workers to have these efforts addressed and communicated by the NASW on their website.

One segment of the analyzed articles stated that ". . .you may also face job discrimination, ridicule, and a sense of being an outcast." (Article #3). However, this statement was suggested as a reason for losing weight implying that if one is a "healthy" weight, than one won't experience prejudice or discrimination. Social workers' roles in addressing issues of discrimination and prejudice appears to be lacking in discussions of overweight and obesity on the NASW website.

The NASW web content did address issues of class and lack of access to healthcare in general. While those who are overweight may not literally lack access to

healthcare (if they're white and of a sufficient economic class), the prejudice among healthcare professionals (Solovay, 2000) can have a silencing effect on these individuals. Perhaps healthcare is not overtly denied, but the prospect of harassment and verbal abuse may effectively prevent overweight individuals from making and keeping appointments.

It is also interesting to note a possible inherent class bias in the articles that identified the importance of healthy eating and recommended that individuals modify their eating by including “vegetables, fruits, whole grains, non-fat dairy products, lean meats, poultry and fish. ...including a variety of foods and paying attention to portion size is key to a healthy diet” (Article #3). The possibility of class-bias is an important issue that should have been addressed in the article. The article segment assumes that individuals have both the economic resources to accomplish this and have the time to shop and prepare these meals. A single parent who works two jobs may not have the opportunity to follow this advice. Therefore, what may be considered “unhealthy” from a purely individual perspective, can be seen as quite adaptive when the context of the behavior is considered (Srebnik & Saltzberg, 1994). In fact, Raphael (2002) goes so far as to say that cardiovascular disease is not affected as much by lifestyle choices as it is by low-income, inequality and social exclusion. While one may consider this an extreme statement, it does point out the importance for social workers to remember the context in which people live and base assessment and intervention activities appropriately.

The implied class bias in these articles was also evidenced in the statement that overweight status is also due to “our culture and environment, which tends to be very sedentary and emphasizes high calorie, low-cost foods” (Article #3). The availability of these foods may be particularly attractive to parents who hold multiple jobs and cannot be

at home during meal time or who are simply unable to closely monitor the nutritional value of the meals their children eat. Social workers should be prepared to support the person *in their environment* if they choose to change exercise or eating behavior.

Social workers are accustomed to addressing racial and class-based prejudice and discrimination and admirably implement multiple successful interventions to ameliorate these problems. Certainly, the NASW website accurately represents this emphasis. It is curious that the profession devotes considerable energy in addressing issues of race and poverty, but does not appear to substantively address an area of discrimination that potentially affects a majority of individuals in this culture. It would be useful to understand the reasons for the NASW's silence in this area as represented by their web content. In addition, given the documented biases of social workers themselves towards those who are overweight or obese (Agell & Rothblum, 1991; Young & Powell, 1985), much more work needs to be done among social workers individually and collectively in reflecting on our own biases and how these biases may significantly affect our work. Certainly this is an area where the NASW should “weigh in” on their website.

Study Limitations

The primary limitation of this study is that an analysis of the NASW's website content does not allow for conclusions to be made for the social work profession in general. Though it is likely true that NASW publications significantly affect some social workers' practice, it should be acknowledged that this study did not consider NASW publications in print or conference proceedings. In addition, not all social workers are members of the NASW and may not be significantly influenced by the NASW.

In addition, this study did not address the large number NASW publications in print or social work publications by entities other than the NASW. Such an analysis may have allowed for more generalizable findings. Certainly, there are numerous books and journals that may well address social workers' understanding of overweight and obesity and make recommendations regarding micro and macro practice. Unfortunately, the scope of this study precluded consideration of a wider range of publications. Given the relatively few articles retrieved from the NASW website that were primarily focused on discussing overweight and obesity, it would be worthwhile to expand this study to consider other data sources. However, it is worth noting that the relatively few articles on the NASW website may be an indication of a general lack of discussion in the field in general. Or it may be the case that the NASW's discussion of overweight and obesity appears primarily in printed volumes.

It is not clear how the NASW determines that an article is appropriate for inclusion on the website. Unfortunately, multiple attempts by this investigator to contact the NASW to discuss this issue went unanswered. The lack of these criteria contributes to the lack of generalizability of this study's findings and in fact may represent limitations of which this author is unaware. That is, the website content may or may not be officially sanctioned by the NASW and the reasons for this are unavailable.

Finally, this study does not address that nature of what social workers are actually doing in the field with respect to addressing overweight and obesity. That is, aside from formal publications, it is important to know what social workers are actually doing in these areas that perhaps may never be the basis for a formal publication. In addition, the NASW is not the only professional social work organization and it would be interesting

to conduct a similar study of the web content of these other organizations. Future research should address these limitations.

Summary

Several aspects of this study are not in question. First, the majority of Americans are classified as overweight or obese based on the standard measure of weight. Second, significant discrimination and prejudice exists in this society that results in negative outcomes for some individuals who are overweight. Third, the social work profession has an ethical mandate to address all social inequalities.

Previous moral understandings of weight seemed to justify the negative attitude towards those who are overweight or obese. However, casting the issue as a medical problem has reduced some of this bias. This study found that the NASW website content was not moralistic and instead was primarily concerned with the health-related problems that could occur for those who are overweight. Further the content appropriately recognized the large number of contributors to one's weight status and ranged from individual's genetic inheritance and behaviors to widely held cultural views and weight-related norms. In line with the diverse nature of these contributors, social workers' roles in intervening with overweight individuals were as diverse. Unfortunately, a social justice perspective was clearly lacking with respect to social workers' role in intervening to address weight-related discrimination as represented by the NASW web content.

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Appendix

NASW Web Articles and URLs

The following articles were used in the analysis of this thesis.

#	Article Title	Web URL
1	Eating Disorders - How Social Workers Help	http://www.helpstartshere.org/health_and_wellness/healthy_lifestyles/current_trends/healthy_lifestyles_-_current_trends.html
2	Healthy Lifestyles - Current Trends and Statistics	http://www.helpstartshere.org/health_and_wellness/healthy_lifestyles/current_trends/healthy_lifestyles_-_current_trends.html
3	About Healthy Lifestyles	http://www.helpstartshere.org/health_and_wellness/healthy_lifestyles/about/about_healthy_lifestyles.html
4	Healthy Lifestyles Real Life Stories - Program Helps Families Lose Weight, Change Habits	http://www.helpstartshere.org/health_and_wellness/healthy_lifestyles/real_life_stories/healthy_lifestyles_real_life_stories.html
5	NASW Practice Snapshot: Highlights from Older Americans 2004: Key Indicators of Well-Being	http://www.socialworkers.org/practice/aging/0705Snapshot.asp
6	Health Disparities: Social workers helping communities move from statistics to solution	http://www.socialworkers.org/pressroom/2004/040804b.asp
7	Youth Development Real World Story - It's a Whole New Ball Game: Turning Young Lives Around	http://www.helpstartshere.org/kids_and_family/youth_development/real_world_stories/youth_development_real_world_story_-_a_whole_new_ball_game.html
8	Adolescent Health and Youths of Color	http://www.socialworkers.org/practice/adolescent_health/ah0203.asp
9	Mapping Aids Person-Environment Insight	http://www.socialworkers.org/pubs/news/2006/05/mapping2.asp
10	NHGRI Launches Social And Behavioral Research Branch	http://www.socialworkers.org/research/news/121003.asp
11	Dieting Called Source of Problem	http://www.socialworkers.org/pubs/news/2003/03/dieting.asp
12	About Eating Disorders	http://www.helpstartshere.org/mind_and_spirit/eating_disorders/about/about_eating_disorders.html
13	Adolescent Girls and Body	http://www.socialworkers.org/practice/adolescent

	Image	health/ah0204.asp
14	About Cancer	http://www.helpstartshere.org/health_and_wellness/cancer/about/cancer_introduction.html
15	Living With Illness - How Social Workers Help: Diabetes: Knowledge and Interventions	http://www.helpstartshere.org/Default.aspx?PageID=1233
16	Eating Disorders Real Life Story - Teen Creates 'Real Barbie' to Fight Eating Disorders	http://www.helpstartshere.org/mind_and_spirit/eating_disorders/real_life_stories/eating_disorders_real_life_story.html
17	Healthy Lifestyles - Your Options: Lose Weight and Maintain Health Through Lifestyle Change Counseling	http://www.helpstartshere.org/Default.aspx?PageID=1203
18	Schools and Communities Real Life Story - Malicious Deeds: It Doesn't Take Physical Contact to Leave Scars	http://www.helpstartshere.org/Default.aspx?PageID=810
19	Youth Development Real Life Story - The Good Guys: Athletes Who Care	http://www.helpstartshere.org/kids_and_family/youth_development/real_world_stories/youth_development_real_world_story.html
20	Adolescent Health: The Impact of Poverty on Health	http://www.socialworkers.org/practice/adolescent_health/ah0503.pdf