

2001

# Client Weight as a Barrier to Non-Biased Clinical Judgment

Tricia Duncan Hassel

Carol J. Amici

Nancy S. Thurston

George Fox University, [nthursto@georgefox.edu](mailto:nthursto@georgefox.edu)

Richard L. Gorsuch

Follow this and additional works at: [http://digitalcommons.georgefox.edu/gscp\\_fac](http://digitalcommons.georgefox.edu/gscp_fac)



Part of the [Clinical Psychology Commons](#)

---

## Recommended Citation

Hassel, Tricia Duncan; Amici, Carol J.; Thurston, Nancy S.; and Gorsuch, Richard L., "Client Weight as a Barrier to Non-Biased Clinical Judgment" (2001). *Faculty Publications - Grad School of Clinical Psychology*. Paper 121.  
[http://digitalcommons.georgefox.edu/gscp\\_fac/121](http://digitalcommons.georgefox.edu/gscp_fac/121)

This Article is brought to you for free and open access by the Graduate School of Clinical Psychology at Digital Commons @ George Fox University. It has been accepted for inclusion in Faculty Publications - Grad School of Clinical Psychology by an authorized administrator of Digital Commons @ George Fox University. For more information, please contact [arolfe@georgefox.edu](mailto:arolfe@georgefox.edu).

# Client Weight as a Barrier to Non-Biased Clinical Judgment

Tricia Duncan Hassel  
Nancy Stiehler Thurston

Carol J. Amici  
Richard L. Gorsuch

*Graduate School of Psychology  
Fuller Theological Seminary*

A sample of 95 Christian and 68 Non-Christian mental health professionals were given a picture of either an overweight or average-weight male or female client and a generic case vignette. Participants were asked to make clinical judgments of pathology and client attributions for the pictured client. Results indicated that mental health professionals ascribe more pathology and negative attributes to obese clients than to average-weight clients. In addition, Christian mental health professionals are just as likely as non-Christians to ascribe more negative attributes to obese clients. Ways to remove barriers to unbiased psychotherapy and deal with countertransference issues are discussed from a Christian perspective.

According to the National Center for Disease Control and Prevention, the U.S. has become more obese in the last decade. Some states have had as much as a 77.2% increase in their obesity rate, with the sharpest rise in obesity in Hispanic adults aged 18 to 29 (Morain, 1999). According to a Harris phone survey in March of 1998, 76% of adults over 25 years of age were found to be heavier than the recommended weight for their height and body frame (Miller, 1999a). Amazingly, the money being spent on weight loss products, \$29 billion in 1988, has almost matched the \$32 billion that is being spent on education, training, employment, and social services (Garner & Wolley, 1991). What's more, at any given time, as many as half of all Americans are on a diet, while millions of others think they should be (Miller, 1999b). Delvin (2000) states that America's biggest fear is the "fear of being fat." It is worse than the fear of public speaking or nuclear weapons. The fear is so great that people are willing to take such drastic and life threatening measures as liposuction, starvation diets, prescriptions such as Fen-Phen, and unregulated herbal supplements (Jerome, 2000).

For the first time in history, there are more overweight Americans than there are slim Americans. Yet we are bombarded by media images of waif-thin models and midriff-baring pop artists. The results of this double message are frightening: 85 percent of American women are not satisfied with their body size and either have dieted, are dieting, or believe they should be dieting. Data obtained by surveys in schools, college campuses, supermarkets, and door to door questioning have indicated that between 10 to 20 percent of all women will engage in bulimia at some time during their lives, and 1 to 2 percent will experience anorexia (Battegay, 1991).

The media's focus on thinness has largely shaped society's views about the undesirability of being overweight. McCreary and Sadava (1999) found that those who watched a lot of TV tended to see themselves as more overweight than those who watched less. Its influence is significant in the development and maintenance

Please send correspondence to Tricia Duncan Hassel or to Carol J. Amici, Fuller Theological Seminary, 180 North Oakland Ave., Pasadena, CA 91101.

of eating and body-dysmorphic disorders (Thompson & Heinberg, 1999). What effect does the discrepancy between the majority of Americans' larger body sizes versus the media's presentation of unattainably slim sizes have on 1) society; 2) on mental health professionals who treat overweight individuals; and 3) on the Christian community? A common thread among all three categories is discrimination. Each of these three areas of discrimination are examined below.

### ***Discrimination Against the Obese in Society: Men Versus Women***

As the country has grown in girth, the cultural discrimination of overweight people has increased. Obese people have been described as freakish, lazy, unclean, and unattractive (Baron & Byrne, 1994). Garner and Wolley (1991) point to the "myth of overeating" where selective attention is focused on the eating habits of the overweight person. According to their theory, when overweight people eat, society makes an assumption about their motivations, but similar intake of high-calorie foods by thin people occurs with little or no notice. This may be due to the fact that the obese people are stigmatized for not being able to control their weight (Allon, 1982; Millman, 1980).

Further, obese persons have been shown to face discrimination in many areas of life. The National Association to Advance Fat Acceptance (NAAFA), for example, has cited that overweight individuals have difficulty obtaining health insurance even if a person is only five pounds over the ideal weight recommended by the insurance industry's height/weight tables (Wann, 2000). The literature also suggests that people who are obese are more likely to be discriminated against when they try to rent an apartment (Karris, 1977), frequently face harsher evaluations of their job performance (Jasper & Klassen, 1990), and are considered to be less suitable for their jobs (Popovich, Everton, Campbell, Godinho, Kremer, & Mangan, 1997). They have also been judged as less suitable for dating and are viewed to have lower self-esteem (Harris, 1990; Crandall & Biernat, 1990) and to be less likable and less attractive (Galper & Weiss, 1975; Harris, 1990). Women and girls appear to receive especially harsh judgments and discrimination (Dwyer, 1973; Millman, 1980; Orbach, 1978) including being perceived as having less sexual attractiveness, less sexual skill, and less likely to experience sexual desire (Regan, 1996). Crandall (1994) has asserted that although prejudice against overweight people is similar to racism, it is an easier attitude to hold because it does not have the negative social connotations of racism. For example, one can easily make fun of an overweight person, but the same joke about a multi-ethnic person is not politically correct.

Studies also show that fat discrimination starts early. For example, in one study, when presented with figure drawings of black and white children who were either in a wheelchair, on crutches, facially disfigured, amputees, or obese, children disliked the obese child more than any other drawing except the amputee (Goodman, Richardson, Dornbusch, & Hastorf, 1963; Richardson, 1970; Richardson, 1971). It is fascinating to note that while the purpose of the study was to examine racial discrimination, obesity was found to be a "sleeper" variable. Since then, it has alerted the scientific community that "fat discrimination" exists. By kindergarten, children already show an aversion for obese children (Lerner, 1969; Lerner & Gelbert, 1969). The pressure for thinness is so prevalent that some children are even at risk for problems such as short-stature syndrome and delayed puberty on account of severe dieting due to a fear of being fat (Puglilse, Lifshitz, Grad, Fort, & Marks-Katz, 1983).

The intensity of the stigma of being overweight is so strong that many adolescent girls feel fat even when they are of normal weight (Dwyer, Feldman, & Mayer, 1967; Nylander, 1971) and children as young as eight feel fat and have dieted or are dieting (Maloney, McGuire, Daniels, & Specker, 1989). Furthermore, caregivers are not immune to anti-fat biases. Kristeller and Hoerr (1997) found that physicians may be ambivalent about treating obese patients. Also it has been reported that physicians have shown a disinclination to treat obese patients and tend to form derogatory characterizations of obese people (Maddox et al., 1966; Maddox & Leiderman, 1969, as cited by Ingram, 1978).

### ***Discrimination Against the Obese Among Mental Health Professionals***

Considering the impact of stigmatization coupled with the recent rise in obesity in the United States, how cultural views of obesity impact personal attitudes toward obese clients should be of concern to Mental Health Professionals (MPHs). What attitudes do MPHs have toward overweight individuals? Are their attitudes commensurate with society at large? Erdman (1995, pp. 155) states:

People in the helping professions have significantly contributed to the continuing discrimination against fat people. Psychotherapists have made their own unique contributions to this prejudice by trying to provide *psychological* explanations and treatment for what is clearly a *cultural* problem. Therapists have been confronted about their biases concerning every other special interest group, including the disabled, gays and lesbians, the elderly, and culturally diverse clients. But they have not yet faced their prejudice about fat people. This appears to be the *last socially sanctioned stigma*, because unlike being epileptic or gay or old or Hispanic, being fat is still seen as the person's own fault. I believe that therapists have a responsibility to examine their attitudes and stereotypes about fat people, or they will continue to be part of the problem instead of part of the solution.

Interestingly, prior to 1990 there had been little or no research performed directly on therapists' attitudes toward obese clients (Stunkard, 1980; Stunkard & Mahoney, 1976; as cited by Agell & Rothblum, 1991). The few studies that have focused on client obesity and its effects on clinical judgment have shown that mental health workers are more likely to ascribe negative symptoms to obese clients than non-obese or normal weight clients. Agell and Rothblum found that psychologists judged obese clients as more physically unattractive and more embarrassed. In addition, psychotherapy with obese patients has been described as difficult, frustrating, and emotionally taxing (Drell, 1988). It can also involve a great deal of countertransference. For example, Irving Yalom, a well-known psychologist for his writings about group therapy, described his own feelings about overweight women (1989, pp. 87-88):

I have always been repelled by fat women. I find them disgusting: their absurd sidewise waddle, their absence of body contour—breasts, laps, buttocks, shoulders, jaw lines, cheekbones, *everything*, everything I like to see in a woman, obscured by an avalanche of flesh. And I hate their clothes—the shapeless baggy dresses, or worse, the stiff elephantine blue jeans with the barrel thighs. How dare they impose that body on the rest of us?



Ingram (1978) points out the tremendous influence of cultural pressures to be thin, not only on the client's resistance, but also the therapist's awareness of personal reactions to the client. The therapist must be aware of his/her continued acculturation and inner responses toward overweight and obese individuals to avoid negative countertransference.

Brown (1989) sees "fat-oppression" as particularly a women's issue, due to cultural demands for female thinness. She considers fat-oppression to be a factor in therapy with obese women. In turn, Chrisler (1989) questioned the validity of weight-loss counseling with overweight clients by feminist therapists, citing the implications of reinforcing cultural expectations and biases against women through support of weight-loss issues. These factors play into a patient's insecurities and fears about appearance. In contrast, Young and Powell (1989) found that male mental health professionals were less harsh than female mental health professionals in their judgments of obese clients. They also found that clinicians who were obese themselves were less likely to differentiate between normal weight clients than obese clients.

### ***Effects of the Weight of the Therapist***

Vrochopoulos (1999) found that the weight of the therapist does not have an impact on the therapeutic relationship, nor does it affect how *counselors* are perceived or treated by their *clients*. But how does the weight of the *therapist* affect his/her own clinical judgment of the *client*? Young and Powell (1985) found that overweight mental health workers were less likely to differentiate between obese, overweight, and average-weight clients in their assignment of negative psychological symptoms than were their less heavy contemporaries. In addition, Burka (1996) states that the unconscious of both the therapist and patient create dynamics around the body. Thus, the creation of a body that represents the shared unconscious life of the therapist/patient pair emerges. Heavier therapists align more readily with heavier clients. This makes them less likely to discriminate against obese clients in their clinical judgments of them.

In a similar vein, Stockwell and Dolan (1994) found that women therapists are more suited to treat bulimic patients due to the fact that women therapists have extra resources that men do not, specifically, concerns about shape and weight due to cultural stigmas, and food and eating patterns set by the culture. They suggest that similar concerns regarding weight and body image aid the therapist in aligning with the client. This heightened awareness allows them to understand the links between the patients they see and their own eating patterns, between extreme eating problems, and the problems that revolve on most women around food and body image (Dolan & Gitzinger, 1994).

### ***Discrimination Against the Obese among the Christian Community***

According to literature on discrimination in general, be it against women (Goldfarb, 1993), homosexuals (Miller, 1996), or the handicapped (Devries, 1994), it appears that Christians are just as prejudiced as non-Christians. Clark (1999) has noted that religious and church communities are not exempt from weight prejudices. In fact, she stated that such prejudices may take on an even harsher tone. Not only is there the usual social disgust shown toward fat people, but a dimension of moral and spiritual shame is added. For example, in speaking about a Christian weight loss program called "First Place," Lewis (1998, p. 128) quotes a woman named Karen: "When I was overweight, I was not a testimony to God and His

power in my life. Only by committing all of my life to Him and disciplining myself, could I overcome being overweight." This statement reinforces the cultural belief that being overweight is "bad and undesirable," even to God, and is something to "overcome." It even goes so far as to suggest that being overweight is somehow "not a testimony" of having God in one's life.

Christian weight loss programs such as "Free to be Thin" by Chapian and Coyle often shame participants about sinning against God by eating. For example, Coyle stated, "Lust for food will never be satisfied. Unbridled lust is sinful, and lust for food is as sinful as unbridled physical lust for someone's body" (Chapian & Coyle, 1979, p. 14). This suggests that overeating is as bad as the sin of fornication. In addition, Coyle also asked, "How did you get fat in the first place? Fleshly indulgence. How did you lose weight and gain it back again? Fleshly indulgence. How do you stay fat even though you want to be thin? Fleshly indulgence. Why do you gain weight instead of losing? Fleshly indulgence will rear its head again and you'll be fat" (Chapian & Coyle, 1979, p. 41).

### ***Current Study's Hypothesis***

This study attempted to determine if there is a bias by mental health professionals (MHPs) toward obese clients in either (a) assigning a diagnosis, (b) assigning a Global Assessment of Functioning (GAF) score (i.e., level of pathology), or (c) their attitudes (attributions). In assessing this bias, we wanted to determine if the gender of the therapist or client was significant. In addition, we wanted to determine if the weight of the therapist had any effect on assessments of obese clients. Finally, we wanted to determine if Christians were any more or less biased in their assessments of obese clients. Based on the above literature review, the following six hypotheses are made:

H1: MHPs will ascribe more pathology and negative attributes to obese clients than to average-weight clients.

H2: Female MHPs will be more likely than male MHPs to ascribe pathology and negative attributes to obese clients than to average-weight clients.

H3: MHPs will ascribe more pathology and negative attributes to obese female clients than they will to the other three client groups (depression, anxiety, or relational disorder).

H4: Christian MHPs will be just as likely as non-Christian MHPs to ascribe more pathology and negative attributes to obese clients than to average-weight clients.

H5: The more weight an MHP wants to lose, the less likely he/she will ascribe pathology and negative attributes to obese clients than to average-weight clients.

H6: The lower an MHP's personal attitude toward obese persons in general (as measured by the Attitudes Toward Adult Obese Patients scale, or "ATAOP"), the more likely he/she will ascribe pathology and negative attributes to obese clients than to average-weight clients.

## **Method**

### ***Participants***

The participants in the study were MHPs (87 women and 76 men, mean age = 44.7 years, range = 22–79) currently or recently engaged in clinical work. For the purposes of this study, "mental health professional" is defined as any male or female person holding a Bachelors or Masters degree in psychology, marriage and family therapy, or social work, or holding a Ph.D. or Psy.D. in clinical or counseling

psychology. Participants were obtained through meetings and conventions of professional psychological associations, as well as at graduate schools. Participants held the following degrees: Ph.D. (44.2%), M.A./M.S. (27.6%), M.F.C.C. (11.7%), B.A. or B.S. (9.2%), Psy.D. (6.1%), L.C.S.W. (1.2%). Participants' ethnicities were as follows: 79.8% Caucasian, 8.6% African American, 4.9% Hispanic, 4.3% Asian American, and 2.5% other.

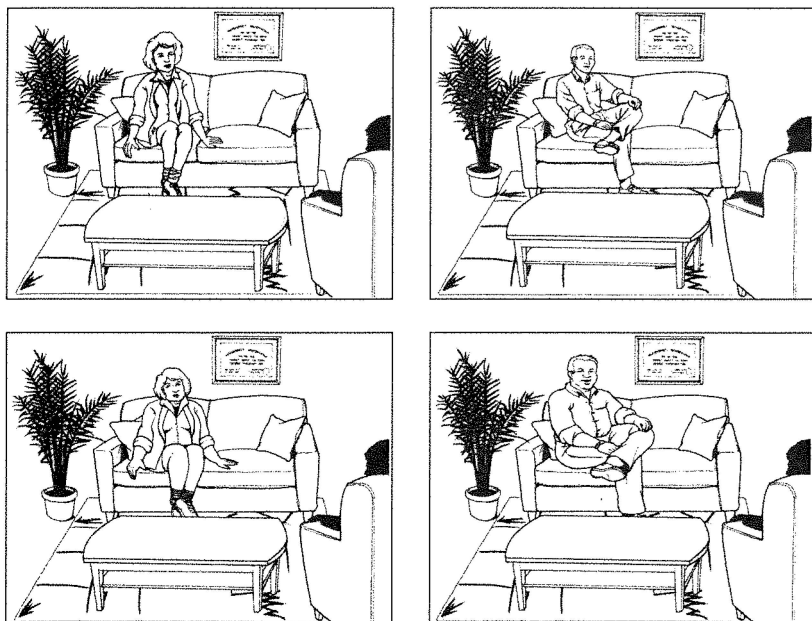
Participants were classified as either Christian or non-Christian for the purposes of our study. To be considered "Christian," three out of four criteria had to be met. First, participants had to report membership in either a Catholic or Protestant Christian denomination. Second, participants also had to report attendance at religious services once or more per month. Lastly, participants answered the following two questions: "How important is religion to you?" and "How important is your spirituality to you?" Religious and spiritual importance ratings ranged from 1 (not at all or have none) to 9 (extremely or center of my life). If the participant indicated a rating of 6 or above, the participant met the criteria for the Christian category. According to these criteria, 58.3% of participants were Christian and 41.7% were non-Christian.

Additional descriptive statistics indicated that only 16.6% of mental health professionals were completely satisfied with their own weight, while 79.1% of the participants desired to lose weight (range = 5 to 120 pounds).

### **Measures**

The first measure consisted of a clinical vignette accompanied by a picture depicting a therapy scene of a client sitting on a couch. The client in the picture was either male or female and either overweight or of average weight (see Figure 1). The therapist's gender was ambiguous in all four conditions. The vignette itself described a person with generic relational problems and remained the same in all four conditions. The participant was then asked to select from 10 *DSM-IV* diagnoses (1994): Major Depression, Mild, Moderate, or Severe; General Anxiety Disorder, Anxiety Disorder NOS; Adjustment Disorder with Depressed Mood, with Anxiety, or with Mixed Anxiety and Depressed Mood; Partner Relational Problem; and Relational Problem, NOS. For the purposes of this study, these 10 diagnoses were grouped into the following four categories listed in descending order of pathology: Major Depression, Anxiety Disorders, Adjustment Disorders, and Relational problems. According to the *DSM IV* (1994), relational problems are listed under conditions that may be a focus of clinical attention and are not considered a form of psychopathology. For the present study, "pathology" was operationalized as assigned diagnosis and GAF score. Finally, the participant was asked to provide a GAF score based on the vignette and accompanying picture utilizing the GAF criteria provided in the *DSM IV* (1994).

The second measure was an Attitude Scale adapted from Harris, Waschull, and Walters (1990, as cited by Yuker, Allison, & Faith, 1995). The participant was asked to rate the client depicted in the accompanying picture according to 22 adjectives on a 7-point Likert-type scale. An overall attitude score was then determined based on their responses. The higher the participant's total score on this scale, the more negative their attributions of the client depicted in the accompanying picture. For the purposes of our study, "attributions" was operationalized as total attitude score. Reliabilities for the original scale ranged from .74 to .76 (Harris, Waschull, and Walters, 1990; as cited by Yuker, Allison, & Faith, 1995).



**Figure 1.** Figure drawings of clients from left to right: Average-weight female client, Average-weight male client, Overweight female client, Overweight male client. The client is depicted in a therapy scene. In each of the four figures, the background remained the same and only the client was changed.

*Note.* The figures are shown at reduced size. The drawings used in the protocol were 8 1/2 x 11 in size and shown at a 90-degree angle. Artwork by Rick Law, Artworx, 818-848-4576; RLAW283030@aol.com.

The third measure was adapted from the Attitudes Toward Adult Obese Patients (ATAOP) scale by Bagely et al. (1989; as cited by Yuker, Allison, & Faith, 1995). The ATAOP was designed to assess the attitudes of nurses in a hospital setting toward obese patients. Although correlations with other obesity scales ranged between .54 and .64, reliability data was not provided. For the purposes of our study, the words "nurse" and "patient" were changed to "mental health professional" and "client" respectively. Additionally, the word "care" was changed to "treatment."

### **Design and Procedures**

Assessment instruments were administered after exposure to one of four conditions in random order stratified by time of administration. In each condition, the participant was given one of the four above-described pictures of a therapy scene. The design consisted of four main groups: Christian male, Christian female, non-Christian male, and non-Christian female MHPs. Each of these groups was exposed to one of the four client pictures of an overweight male client, an overweight female client, an average-weight male client, or an average-weight female client. This yields a total of sixteen cells or possible conditions.

## Results

### *Hypothesis 1*

Mental health professionals (MHPs) ascribed more pathology and negative attributes as predicted, to obese clients than to average-weight clients [ $\chi^2(3, N = 81) = 12.102, p < .01$ ]. Obese clients were 1.77 times more likely to be given an adjustment disorder than average weight clients. Also, average weight clients were 1.49 times more likely to be given relational disorder diagnoses. However, depression and anxiety diagnoses were given at similar rates to obese clients as normal clients.

A one-tailed  $t$  test was used to determine if MHP's judgments of Global Assessment of Functioning (GAF) scores for obese clients were lower than for average weight clients. As expected, average GAF score for obese clients ( $M = 60.4, SD = 7.2$ ) was statistically significantly lower than the GAF score for average weight clients ( $M = 62.7, SD = 7.4$ ),  $t(161) = 1.98, p < .025$ . Also as predicted, MHP's attributions were significantly more negative for obese clients ( $M = 80.2, SD = 9.2$ ), versus average weight clients ( $M = 86.4, SD = 8.8$ ),  $t(161) = 4.34, p < .0005$ . These results support the hypothesis that mental health professions will ascribe more pathology and negative attributes to obese clients than to average weight clients.

### *Hypothesis 2*

Results indicated that both female MHPs [ $\chi^2(3, N = 87) = 3.88, p = \text{n.s.}$ ] and male MHPs [ $\chi^2(3, N = 76) = 3.829, p = \text{n.s.}$ ] did not diagnose obese clients differently than average weight clients.

A one-tailed  $t$  test was used to determine if female MHPs would assign lower GAF scores for obese clients versus average weight clients. As predicted, the average GAF score assigned by female MHP for obese clients ( $M = 60.5, SD = 5.6$ ) was significantly lower than for average weight clients ( $M = 64.2, SD = 7.6$ ),  $t(86) = 2.55, p < .03$ . In contrast, male MHPs showed significant difference in the way they assigned GAF scores to obese clients,  $t(74) = .26$ . Also, female MHP's attributions were significantly more negative for obese clients ( $M = 81.19, SD = 8.7$ ) versus average weight clients ( $M = 88.6, SD = 8.4$ ),  $t(85) = 4.05, p = .00025$ . Though male MHP attributions were also significantly more negative for obese clients ( $M = 79.23, SD = 9.7$ ) than for average weight clients, ( $M = 83.6, SD = 8.6$ ),  $t(74) = 2.04, p < .02$ , the mean difference and the level of significance was higher for female MHPs. The results support the hypothesis that female MHPs will ascribe more pathology as seen in the GAF scores and more negative attributes to obese clients. However, results did not support female MHPs ascribing more pathology in terms of diagnosis.

### *Hypothesis 3*

Results indicate a trend toward diagnosing obese females with adjustment disorder more than depression, anxiety, or relational disorder,  $\chi^2(3, N = 44) = 6.54, p = .088$ . No other diagnosis was attributed differently among female obese clients versus the other client groups. Post hoc analyses determined that when MHPs were presented with an obese female client, they were 1.43 times more likely to give an adjustment disorder diagnosis than when they were presented with an obese male client or an average weight client. In addition, they were 1.73 times less likely to assign a relational problem diagnosis to an obese female client.

MHPs assigned lower GAF scores to obese clients than average weight clients. A one-way ANOVA was then performed to determine if MHPs made more nega-

tive attributions for female obese clients versus the other three client groups (depression, anxiety, or relational disorder). MHP's attributions displayed two main effects but did not show any interaction between gender of client and client weight,  $t(163) = .911$ ,  $p = .162$ . However, they were significantly more negative toward female clients ( $M = 81.14$ ,  $SD = 9.03$ ) versus male clients ( $M = 85.38$ ,  $SD = 9.51$ ),  $t(163) = p < .001$ . Further, male mental health professionals also assigned significantly lower scores to obese clients ( $M = 80.23$ ,  $SD = 9.23$ ) than average weight clients ( $M = 86.36$ ,  $SD = 8.80$ ),  $t(163) = p < .0001$ . These results show a trend toward adjustment disorder as a diagnosis for female obese clients but it does not support the hypothesis for attitudes or GAF, although incidentally they were harsher toward female clients than male clients.

#### ***Hypothesis 4***

To test the hypothesis that Christians will be just as likely as non-Christians to judge obese clients more harshly, a 2 (Christian/Non-Christian MHP)  $\times$  2 (overweight versus average-weight client) between-subjects factorial design was used. Three dependent variables were considered: 1) diagnosis, 2) GAF score ratings, and 3) attitudes.

Results indicated that Christians did not diagnose obese clients differently than they do average-weight clients,  $\chi^2(3, n = 95) = 4.12$ ,  $p = .25$ . Likewise, non-Christians did not diagnose obese clients differently from average-weight clients,  $\chi^2(3, n = .68) = 2.30$ ,  $p = .51$ . Also, Christians ( $M = 61.8$ ,  $SD = 6.98$ ) did not significantly differ from non-Christians ( $M = 61.2$ ,  $SD = 7.99$ ) in their GAF assignment.

Both Christians and non-Christians did, however, assign more negative attributions to obese clients than to average-weight clients. Non-Christians' attributions were more negative for obese clients ( $M = 78.5$ ,  $SD = 9.87$ ) than average-weight clients ( $M = 85.8$ ,  $SD = 8.51$ ),  $F(1, 93) = 10.75$ ,  $p < .005$ . Similarly, Christians' attributions were significantly more negative for obese clients ( $M = 81.3$ ,  $SD = 8.76$ ) than average-weight clients ( $M = 86.8$ ,  $SD = 9.11$ ),  $F(1, 93) = 9.13$ ,  $p < .005$ . Christians were therefore just as harsh in their negative attributions of obese clients as non-Christians.

#### ***Hypothesis 5***

To test the hypothesis that heavier MHPs will be less harsh in their ascribing of pathology and attributes, a hierarchical linear model analysis was conducted. An interaction between the weight of the therapist and the obese client picture was used as the dependent variable, while diagnosis, GAF, and total attitude score were used as the independent variables. No significant correlations were found. Results indicate the amount of weight an MHP wants to lose does not have an effect on diagnosis, GAF score ratings, or attitudes.

#### ***Hypothesis 6***

To test the hypothesis that MHPs will judge obese clients more negatively when they have more negative personal attitudes toward obese people in general, a hierarchical linear model analysis was conducted. An interaction between the total ATAOP score and the obese client picture was used as the dependent variable, while diagnosis, GAF, and total attitude score were used as the independent variables. No significant correlations were found. Results indicate that negative *personal* attitudes toward obese clients in *general* do not affect the way MHPs assign diagnosis, GAF scores, or report client attributions for obese clients.

## Discussion

The results of this study indicate that obese clients are judged more harshly than non-obese clients in several but not in all ways examined by this study. The results of the first hypothesis showed that obese clients were more likely to be given adjustment disorders while average-weight clients were more likely to be given relational problems, which are not actual "disorders" but included in the *DSM-IV* (1994) because they can complicate treatment and management of mental or physical disorders. Although other studies have not targeted specific diagnoses, these results are similar to other studies. Young and Powell (1985) found that mental health workers were more likely to assign negative psychological symptoms to an obese model than an overweight, or best-weight model.

The present study also found that MHPs were more likely to find obese clients to have more pathology in terms of diagnosis, a lower level of functioning (GAF), and more negative attributes than average weight clients have. It should also be noted that although the difference in GAF scores was statistically significant, their small mean difference ( $m = 60.4$  versus  $m = 62.7$ ) may limit its practical effect. However, it does point to the subtle yet pervasive discrimination against obese clients by mental health professionals. These results are consistent with a study using similar attribution items. Harris, Walters, & Waschull (1991) found that college students ascribed obese men and women as lazy, sexless, ugly, self-indulgent, and sloppy while not finding them admirable, attractive, energetic, neat, or sexy. This suggests that some professionals have indeed adopted societal and weight-loss industry biases, and these attitudes have had an impact on MHPs' clinical judgments (Melcher & Bostwick, 1998).

The second hypothesis addressed whether obese clients would be judged differently by female mental health professionals. Results indicate that while female mental health professionals did not diagnose obese versus average weight clients differently, they did assign lower levels of functioning and gave more negative attributions than their male counterparts. These results are consistent with Agell and Rothblum's (1991) findings that showed that female psychologists rated obese clients as more tense, sad, depressed, hard, and cruel. These findings are also similar to Young and Powell's study (1985), which noted that female MHPs were more harsh than male MHPs toward obese clients. Lastly, these results are also consistent with Allison, Basile, and Yucker's (1991) findings that males were somewhat more positive in their attitudes toward obese persons. These results support the view that weight and attractiveness are more critical issues for women (Brown, 1989; Chrisler, 1989) and how societal attitudes toward obesity can impact the attitudes of MHPs, especially female professionals.

Since women have most often been the targets of fat discrimination, the third hypothesis dealt with determining if obese female clients would be assessed differently by MHPs. In terms of diagnosis, the results showed that there may be a trend toward obese female clients being diagnosed with adjustment disorder, versus the other three client groups. MHPs were harsher toward female clients versus male clients, and more negative toward obese clients versus average weight clients, but not significantly more critical of "obese female" clients than "obese male" clients. This indicates there is no interaction between the gender of the client and the weight of the client. These results are not consistent with previous research, which has shown that obese women are more likely than obese men to

be stigmatized (Harris, Walters, & Waschull, 1991; Worsley, 1979, as cited by Agell & Rothblum, 1991).

The fourth hypothesis addressed whether Christians were as likely as non-Christians to ascribe pathology and attributes differently. Results indicate that both Christians and non-Christians describe obese clients more negatively. Christians are, in fact, just as harsh in their attitudes toward obese clients as non-Christians. This suggests there is a discrepancy in what some Christians believe (i.e., Matt. 7:1; "Judge not lest ye be judged") and in what they practice. This is consistent with previous literature on discrimination which states that Christians discriminate against women (Goldfarb, 1993), homosexuals (Miller, 1996), and multiethnic students in Christian colleges (Lee, 1991).

The fifth hypothesis focused on the weight of the therapist, speculating that heavier therapists will not ascribe more pathology and negative attributes to obese versus average-weight clients. Results indicate that the amount of weight an MHP wants to lose does not impact their GAF score rating or attitudes about the client. It appears that a bias against obese clients already exists. Whether or not the therapists themselves are overweight does not impact this bias. The results were similar to Vrochopoulos' research (1999) which states that the weight of the therapist does not have an impact on the therapeutic relationship or on how counselors are perceived or treated. The results were not consistent, however, with Young and Powell's (1985) findings that clinicians who were obese themselves were less likely to differentiate between normal weight clients than obese clients.

The sixth hypothesis assessed an MHP's *personal* attitude toward obese persons *in general* (as opposed to the clinical vignette and accompanying picture), and speculated that the more negative an MHP's personal attitudes about obese people are, the more likely the MHP will be harsher in their clinical judgments of the obese. Results indicate that personal attitudes toward the obese in general did not affect the clinical judgments of MHPs. There was a consistent trend of therapists to assign a lower GAF score and more negative attributes to obese clients, regardless of whether their own personal attitudes toward the obese were more or less favorable. This is not consistent with previous research that states that therapists' personal attitudes toward obesity largely affect their clinical judgments (Erdman, 1995, & Yalom, 1989).

The combined significance of all these results points to the need for Christian mental health professionals to confront their biases toward obese clients and to reflect theologically about the implications of fat discrimination.

### ***How Can We Remove the Barriers of Weight-Discrimination as Therapists?***

Given the fact that 79% of all the therapists in our study indicated they wanted to lose weight, it is extremely important that MHPs be willing to confront their own thoughts and biases concerning fat discrimination. By being willing to confront fat discrimination, MHPs can improve their effectiveness in treating obese clients.

One of the ways to confront fat discrimination is to debunk the myths surrounding obesity. One of these myths is that obesity leads to greater risks of poor health and higher mortality. Andres (1980) found that major studies of population statistics have not produced a higher mortality rate for overweight persons. Indeed, there are associated health risks with obesity, however, these risks occur mainly at the extreme ends of the continuum; that is, the risks are greater for those who are extremely under or overweight. The "average" overweight American is typically



healthy and does not generally encounter the health risks associated with obesity. Also, it appears that repeated efforts at dieting cause more health problems than obesity alone, including an increased likelihood of cardiovascular disease and hypertension (Haynes, 1986; Ham et al., 1989, as cited by Garner & Wolley, 1991).

Further, the myth that weight is solely under the control of the individual is perpetuated by the \$30 billion per year diet industry (Melcher & Bostwick, 1998). While lifestyle factors such as diet and exercise are typically within a person's control, other factors such as heredity, metabolism, body frame, and set-point weight are not. In addition, psychological factors such as depression, anxiety, and obsessive-compulsive tendencies contribute to obesity and are not entirely under a person's control (Garner & Wolley, 1991). The diet industry would like us to believe that diet "x" will work for "anyone" as long as he/she "has the will" to follow the diet. If this were true, the diet industry would be out of business. The fact is that diets do not work because weight is *not* solely under the control of the individual.

Twin studies have shown that the twins' weight was correlated to the twins' biological parents and not their adoptive parents (Stunkard et al., 1986; as cited by Garner & Wolley, 1991). In addition, a person's metabolism is designed to resist weight change. Therefore, those who lose a substantial amount of weight and keep it off, often have to continue to eat substantially less and less, and have a 15% lower metabolic rate than lean controls (Liebel & Hirsch, 1984; as cited by Garner & Wolley, 1991). Hence it is important for mental health professionals to understand that weight problems are often due to a multitude of factors that are not easily attributed to a lack of will.

Erdman (1995, pp. 158-160) has suggested that confronting your own fear of fat or being willing to confront your fat prejudice can play a role in how you feel about your own body and how you interact with other people. She noted that changing your personal and professional perspective involves four steps:

- 1) Become knowledgeable about weight, size, and body-image issues for women and men from a historical, cultural, and size-diversity point of view; 2) engage in an ongoing examination of your attitudes, and reflect on this issue first as it relates to your personal life and second, in regard to your relationship with your own body and honestly examine how you can effectively relate to your larger clients; 3) be aware of the ethics of working with clients who have food and body-image issues while you are in the process of raising your own consciousness; and 4) make the decision to work with larger clients once you have established a non-dieting size acceptance view point in your life.

In making the decision to utilize weight-loss counseling as part of treatment, mental health professionals need to consider whether focusing on weight-loss is conducive to the client's overall mental health or is exacerbating fat discriminating attitudes and self esteem issues (Brown, 1989; Chrisler, 1989). Clark (1999) has designed four criteria for working with obese clients and assisting them to evaluate their body size: (a) Can you do what you want to do? (Is your weight stopping you from pursuing important activities?); (b) Can you go where you want to go?; (c) Do you have the energy to do what you want?; and (d) Do you have a stable bill of health? She also noted that even anorexic clients often cannot meet the above criteria. Clark argued that therapeutic success is reached when clients learn to accept, value, and love them-

selves, regardless of whether the client opts to lose weight. Common thinking is, "When I lose weight, I'll feel better about myself." The psychologically healthier thinking is, "When I feel better about myself, I may choose to lose weight or not."

MHPs can also take a proactive approach to combating fat discrimination when dealing with weight issues with parents. According to Steiner-Adair (2000), director of The Education, Prevention, and Outreach Center at the Harvard Eating Disorders Center, it all starts in the home. As therapists, we can teach parents to teach their children that people come in a variety of shapes, sizes, and colors. Parents can teach their children to be comfortable with their appearance by following some suggestions from Steiner-Adair (2000, pp. 73-74) for raising kids with normal eating habits and a good body image:

- 1) Enforce a no-teasing rule about appearance and eating habits in and out of the home; 2) avoid tossing out platitudes to comfort your child if he/she's worried about his/her weight, i.e., don't just say "Of course you're not fat, honey," explaining that other people's ideas about how much food to eat and appropriate body weight are opinions and not necessarily facts; (3) encourage friendships with children who seem to be open-minded about people's appearances; 4) be aware of your child's television viewing and remind him/her that television does not usually portray a diversity of shapes and sizes; 5) encourage healthy eating, but don't be a food cop; and 6) most importantly, don't ever say anything bad about your own body in front of your child.

In summary, the present study points to the need for MHPs to address the issue of fat discrimination, stigmatization, and countertransference toward obese clients. The good news is that MHPs have made some efforts to address their issues surrounding obesity and the effects of countertransference (Chrisler, 1989; Drell, 1988; Erdman, 1995; Ingram, 1978; Yalom, 1989) One physician at the Center for Obesity Research and Education utilizes a "fat suit" that doctors can wear for a day to begin to understand and empathize with overweight clients (Tauber, 2000). Further, MHPs have begun to recognize that they must confront their feelings and issues surrounding weight. By bringing weight-discrimination into the light, it allows MHPs to formulate more conducive treatment plans and take more objective looks at their judgments of obese clients. MHPs also have the opportunity to take a step forward and apply their awareness of fat discrimination to how they interact with other MHPs who may be overweight.

### ***How Can We Hear the Voice of Overweight Persons as Christians?***

It is interesting to note that Jesus himself was often called a glutton and a drunk because he ate with the multitudes throughout his ministry. He used eating with others as a way to include them and invite them to follow him. Obviously, eating was an important ritual in his day, providing opportunities for fellowship and sharing of the Good News. Christ even used the breaking of bread and drinking of wine to symbolize the very sacrifice he made for us. The promises of God were communicated through an eating table.

The fact that Christ walked this very earth and experienced hunger speaks to the fact that we have a God who has known our struggles himself, for he has experienced them firsthand. Viewing gluttony as leading us away from God and

fasting as leading us to God is a very narrow and limited view of how food can be spiritual, and how God can heal us of our obsession with food and our obsession with our bodies.

1 Samuel 16:7 states, "Do not look at his physical appearance or at his physical stature, because I have refused him. For the Lord does not see as man sees; for man looks at the outward appearance, but God looks at the heart." Similarly, John 7:24 states, "Do not judge according to appearance, but judge with righteous judgment." Many Christian weight-loss programs judge the moral character of overweight persons, using outward appearance as a measuring stick of obedience and/or adherence to God's will for their lives. If one is fat, he/she is certainly not walking in the ways of the Lord. But the Word tells us just the opposite: God looks on the heart.

The prevailing message of the Bible is that *our faith* in God is what is counted unto righteousness. God's love of us is not conditional upon our *performance*, or lack thereof, in maintaining "the discipline" to lose weight. He loves us not *in spite* of our "undisciplined-ness," faults, and sins; He loves us *with* them! He loves us as we are, in the bodies He gave us. We do not have to lose weight in order to prove we are "walking in His ways" or to be a testimony to other people. Those who say that being overweight is a "sin in not maintaining the temple of the Lord" are buying into the cultural belief that being *thin* is somehow *God's idea* of what *God's temple* should look like. If we could only see each other the way our Heavenly Father sees us, as one of God's beloved creation, we might be able to see past the physical body and the "weight" to the vibrant soul beneath.

## References

- Agell, G., & Rothblum, E. (1991). Effects of clients' obesity on the therapy judgements of psychologists. *Professional Psychology: Research & Practice*, 22, 223-229.
- Allison, D. B., Basile, V. C., & Yuker, H. E. (1991). The measurement of the attitudes toward and beliefs about obese persons. *International Journal of Eating Disorders*, 10, 599-607.
- Allon, N. (1982). The stigma of overweight in everyday life. In B. B. Woldman (Ed.), *Psychological aspects of obesity*. New York: Random House. 130-174.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Andres, R. (1980). Effect of obesity on total mortality. *International Journal of Obesity*, 4, 381-386.
- Baron, R. A., & Byrne, D. (1994). *Social psychology: Understanding human interaction*. Needham, MA: Allyn and Bacon.
- Battegay, R. (1991). *Hunger Diseases*. Germany: Hogrefe & Huber Publishers.
- Brown, L. S. (1989). Fat-oppressive attitudes and the feminist therapist: Directions for change. In L. S. Brown, E. R. Rothblum (Eds.), *Fat oppression and psychotherapy HHP: Overcoming fear of fat: A feminist perspective* (pp. 19-30). Binghamton, NY: Haworth Press.
- Burka, J. (1996). The therapist's body in reality and fantasy: A perspective from an overweight therapist. In Gerson, B., Ed., et al. *The therapist as a person: Life crises, life choices, life experiences, and their effects on treatment* (pp. 255-275). Hillsdale, NJ: Analytic Press, Inc.
- Chapian, M., & Coyle, N. (1979). *Free to be Thin*. Minneapolis, MN: Bethany House Publishers.
- Chrisler, J. C. (1989). Should feminist therapists do weight loss counseling? In L. S. Brown, E. R. Rothblum (Eds.), *Fat oppression and psychotherapy HHP: Overcoming fear of fat: A feminist perspective* (pp. 31-37). Binghamton, NY: Haworth Press.

- Clark, M. F. (1999). Christian weight loss programs: An oxymoron? *Update: Newsletter of the Evangelical and Ecumenical Women's Caucus*, 22(4), 1-4.
- Crandall, C. S. (1994). Prejudice against fat people: Ideology and self-interest. *Journal of Personality and Social Psychology*, 66, 882-894.
- Crandall, C., & Biernat, M. (1990). The ideology of anti-fat attitudes. *Journal of Applied Social Psychology* 20, 227-243.
- Delvin, M. (2000). Obesity: What mental health professionals need to know. *American Journal of Psychiatry*, 157, 854-866.
- Devries, D. (1994). Creation, handicappism, and the community of differing abilities. in *Reconstructing Christian Theology* (pp. 124-140). Minneapolis, MN: Augsburg Fortress Publishers.
- Dolan, B., & Gitzinger, I. (1994). *Why women? Gender issues and eating disorders*. London: Athlone Press.
- Drell, W. K. (1988). Countertransference and the obese patient. *American Journal of Psychotherapy*, 42(1), 77-85.
- Dwyer, J. T. (1973). Psychosexual aspects of weight control and dieting behavior in adolescents. *Medical Aspects of Human Sexuality*, 7, 82-108.
- Dwyer, J. T., Feldman, J. J., & Mayer, J. (1967). Adolescent dieters: Who are they? Physical characteristics, attitudes and dieting practices of adolescent girls. *The American Journal of Clinical Nutrition*, 20, 1045-1056.
- Erdman, C. (1995). *Nothing to lose: A guide to sane living in a larger body*. New York: Harper Collins Publishers.
- Galper, R. E., & Weiss, E. (1975). Attribution of behavioral intentions to obese and normal-weight stimulus persons. *European Journal of Social Psychology*, 425-440.
- Garner, D. M., & Wolley, S. C. (1991). Confronting the failure of behavioral and dietary treatments for obesity. *Clinical Psychology Review*, 11, 720-780.
- Goldfarb, S. (1993). Violence against women: Discrimination. *Christian Social Action*, 6, 12-13.
- Goodman, N., Richardson, S. A., Dornbusch, S. M., & Hastorf, A. H. (1963). Variant reactions to physical disabilities. *American Sociological Review*, 28, 429-435.
- Harris, M. B. (1990). Is love seen as different for the obese? *Journal of Applied Social Psychology*, 20, 1209-1224.
- Harris, M. B., Walters, L. C., & Waschull, S. (1991). Gender and ethnic differences in obesity-related behaviors and attitudes in a college sample. *Journal of Applied Social Psychology*, 21, 1545-1566.
- Ingram, D. H. (1978). Cultural counterresistance in the analytic treatment of the obese woman. *The American Journal of Psychoanalysis*, 38, 155-161.
- Jasper, C. R., & Klassen, M. L. (1990). Perceptions of salespersons' appearance and evaluation of job performance. *Perceptual and Motor Skills*, 71, 563-566.
- Jerome, R. (2000, October 30). A body to die for. *People Weekly*, 108-118.
- Karris, L. (1977). Prejudice against obese renters. *Journal of Social Psychology*, 101, 159-160.
- Kristeller, J. L., & Hoerr, R. A. (1997). Physician attitudes toward managing obesity: Differences among six specialty groups. *Preventative Medicine*, 26, 542-549.
- Lee, D. J. (1991). *Ethnic minorities and evangelical Christian colleges: Basic issues and assumptions*. Lanham, MD: University Press of America.
- Lerner, R. M. (1969). The development of stereotyped expectancies of body build-behavior relations. *Child Development*, 40, 137-141.
- Lerner, R. M., & Gelbert, E. (1969). Body build identification, preference and aversion in children. *Developmental Psychology*, 5, 256-262.
- Lewis, C. (1998). First place. Nashville, TN: Broadman & Holman Publishers.
- Maloney, M. J., McGuire, J., Daniels, S. R., & Specker, B. (1989). Dieting behavior and eating attitudes in children. *Pediatrics*, 84, 482-489.
- McCreary, D., & Sadava, S. (1999). Television viewing and perceived health, weight, and physical fitness: Evidence for the cultivation hypothesis. *Journal of Applied Social Psychology*, 29, 2342-2361.

- Melcher, J., & Bostwick, G. (1998). The obese client: Myths, facts, assessment, and intervention. *Health and Social Work, 23*, 195-202.
- Miller, H. (1999a). Why are we fat? [On-line]. Available: <http://www.discoveryhealth.com/DH/ihltH/WSDSC000/14220/20704/224701.html?d=dmtContent>.
- Miller, H. (1999b). Weight Management Answers [On-line]. Available: <http://www.discoveryhealth.com/DH/ihltH/WSDSC000/14220/7099.html>
- Miller, R. (1996, May). Now is the moment to heal our church. *Christian Social Action*, p. 33.
- Millman, M. (1980). *Such a pretty face: Being fat in America*. New York: Norton.
- Morain, C. (1999). *Obesity Epidemic spreads across America*. [On-line]. Available: [http://onhealth.com/conditions/in-depth/item/item,52267\\_1\\_1.asp](http://onhealth.com/conditions/in-depth/item/item,52267_1_1.asp)
- Nylander, I. (1971). The feeling of being fat and dieting in a school population: Epidemiologic interview investigation. *Acta Sociomedica Scandinavia, 3*, 17-26.
- Orbach, S. (1978). *Fat is a feminist issue*. New York: Berkley.
- Popovich, P. M., Everton, W. J., Campbell, K. L., Godinho, R. M., Kramer, K. M., & Mangan, M. R. (1997). Criteria used to judge obese persons in the workplace. *Perceptual and Motor Skills, 85*, 859-866.
- Puglilfe, M. T., Lifshitz, F., Grad, G., Fort, P., & Marks-Katz, M. (1983). Fear of obesity: A cause of short-stature and delayed puberty. *The New England Journal of Medicine, 309*, 513-518.
- Regan, P. M. (1996). Sexual outcasts: The perceived impact of body weight and gender on sexuality. *Journal of Applied Social Psychology, 26*, 1803-1815.
- Richardson, S. A. (1970). Age and sex differences in values toward physical handicaps. *Journal of Health and Social Behavior, 11*, 207-214.
- Richardson, S. A. (1971). Research report: Handicap, appearance and stigmata. *Social Science and Medicine, 5*, 621-628.
- Steiner-Adair, Catherine. (2000, Dec/Jan). Reality Check. *Parenting, 74*-75.
- Stockwell, R., & Dolan, B. (1994). Women therapists for women patients? In B. Dolan, & I. Gitzinger (1994), *Why women? Gender issues and eating disorders*. (pp. 57-64). London: Athlone Press.
- Tauber, M. (2000, October 30). Empathy by the pound. *People Weekly, 75*-76.
- Thompson, J. K., & Heinberg, L. J. (1999). The media's influence on body image disturbance and eating disorders: We've reviled them, now can we rehabilitate them? *Journal of Social Issues, 55*, 339-353.
- Vrochopoulos, S. (1999). Effect of counselor obesity on client perceptions and expectations. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 60*(3-B), 1319.
- Wann, M. (2000). *Height/weight charts and you: How insurers discriminate against fat folk*. [On-line]. Available: <http://www.fatso.com/article.html>
- Yalom, I. (1989). *Love's executioner and other tales of psychotherapy*. New York: Harper Collins, Publishers.
- Young, L. M., & Powell, B. (1985). The effects of obesity on the clinical judgments of mental health professionals. *Journal of Health and Social Behavior, 26*, 233-246.
- Yuker, H. E., Allison, D. B., & Faith, M. S. (1995). Methods for measuring attitudes and beliefs about obese people. *Handbook of Assessment Methods for Eating Behaviors and Weight-Related Problems: Measures, Theory, and Research* (pp. 81-115). New York: Sage Publications.

## Authors

Tricia Duncan Hassel received her M.A. from Fuller Theological Seminary. She is currently an intern at Family Counseling Services in San Gabriel, CA, and expects to receive her Psy.D. and Masters in Christian Leadership in June 2002. Her professional interests include weight discrimination, parenting, and the integration of psychology and Christianity.

*Carol J. Amici received an M.B.A. from Pepperdine University, and an M.A. in psychology from Fuller Theological Seminary. She expects to receive her Psy.D. and Masters in Christian Leadership in June 2002. In addition, she will complete her internship at the Wright Institute in Los Angeles in June 2002. Her professional interests include trauma, PTSD, and the persistently mentally ill.*

*Nancy Stiehler Thurston received her Psy.D. in clinical psychology from Central Michigan University. She is currently an associate professor of psychology at George Fox University. Her professional interests include shame, psychological assessment, and the integration of psychology and Christianity.*

*Richard L. Gorsuch received his Ph.D. in personal and social psychology from the University of Illinois in Champagne Urbana, and his M.Div. from Vanderbilt Seminary. He is currently a professor of psychology at Fuller Theological Seminary. His professional interests include the psychology of religion, research methods, and integration.*