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FEMINIST FORUM

Anti-fat Prejudice: The Role of Psychology in Explication, Education and Eradication

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Abstract The field of psychology's explication of anti-fat prejudice and its impact on psychological practice in the U.S. is reviewed. The medical perspective that obesity is itself a disease or a psychological disorder and that fat is the cause of various physical or mental health conditions is challenged and viewed as contributing to weight-based prejudice in the U.S. The role of psychology in educating students and future practitioners about anti-fat bias and research on the ineffectiveness of dieting is examined. Research documenting anti-fat bias in the diagnosis and treatment of fat female clients in the U.S. is reviewed, and potential solutions for eradicating anti-fat prejudice in the clinical practice of psychology, including alternatives to dieting for women, are described.

Keywords Fat · Anti-fat prejudice · Weight discrimination · Sizism · Obesity · Size acceptance

Introduction

The research review by Fikkan and Rothblum (2011) presents a comprehensive review of the literature on weight-based discrimination against women in the United States. "In free societies, bias, stigma, prejudice, and discrimination are considered inherently evil, seen as a threat to the health, happiness, and social status of those targeted, but also to a nation's fundamental values of inclusion and equality" (Brownell 2005, p. 1). Research, such as that reviewed by Fikkan and Rothblum, documents that fat people are stigmatized and prejudiced against in our (U.S.) society, yet generally anti-fat bias and discriminatory behavior based on weight are not recognized as legitimate forms of oppression.

In addition to examining the relation of weight to education and employment, Fikkan and Rothblum examine the ways in which weight bias is present in medicine, focusing on how bias in medical practice represents a barrier to fat women getting appropriate medical care. In a small subsection of this part of their review, Fikkan and Rothblum briefly examine weight bias in mental health. Here we expand on their review, examining in more depth the ways that anti-fat bias has been both explicated by psychologists and evident in psychological practice in the United States. The field of psychology has a responsibility to appreciate size acceptance and to strive to eliminate anti-fat bias. We raise the question: To what extent has psychology contributed to our understanding of prejudice against fat people, and explicated the experience of being fat in our society? We examine the role of psychology in the application of an anti-fat and medicalized view of fat/obesity. We focus on the operation of anti-fat bias in clinical practice, and we offer some suggestions for clinical work with fat women that are not fat oppressive. We begin with a definition and description of anti-fat prejudice, and argue that the important issue of fat oppression has not been addressed in the training of professionals or in the undergraduate psychology curriculum in the U.S. We then examine evidence for anti-fat bias in the diagnosis and treatment of fat female clients. Psychological clinical practices that provide an alternative to anti-fat bias and dieting are briefly reviewed.

Anti-fat Prejudice

Watts and Cranney (2009) define anti-fat prejudice as "the tendency to form judgments about people on the basis of

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excessive body weight" (p. 110). Danielsdottir et al. (2010) integrative definition is that anti-fat prejudice is "a negative attitude toward (dislike of), belief about (stereotype), or behavior against (discrimination) people perceived as being fat" (p. 47). Danielsdottir and colleagues report that weight discrimination, the behavioral form of fat prejudice, has increased by 66% over the past decade with prevalence rates now comparable to race-based prejudice. Fat oppression is hatred and discrimination against fat people, especially fat women, solely because of their body size. It is the "stigmatization of being fat, the terror of fat, the rationale for a thousand diets…and exercise programs…It is, like physical and sexual violence against women, sexism in action" (Brown and Rothblum 1989, p. 1).

In their forum, Fikkan and Rothblum present convincing evidence that fat women have lower occupational attainment and lower earnings than other size groups, and they review experimental studies of weight bias in hiring and assigning salaries. Although such weight discrimination has been called an "obesity penalty"(Cawley 2004, p. 451), the economic discrimination actually begins at medium or average weight for young White women. The lower wages and other forms of discrimination experienced by fat women can produce poverty for women at the bottom of the labor market. These data are consistent with the analysis of Ernsberger (2009) that being fat can result in poverty, as opposed to the more frequently endorsed idea that poor people overeat and/or do not exercise. Fikkan and Rothblum also provide a thorough review of the relationship between weight and educational attainment for women. They review alarming empirical data that elite colleges are less likely to admit fat young women, and that weight is related to parental decisions to finance their daughters' education.

In addition to examining the relation of weight to education and employment, the authors examine ways in which weight bias is present in U.S. medicine, focusing on how bias in medical practice represents a barrier to women receiving good medical care. A physician may not thoroughly examine the patient or reflect on her health condition given stereotypic views and the medical model that being fat is a disease. Shaming and blaming attitudes often dissuade a patient from a return visit. Also, there are physical risks associated with dieting, especially yo-yo or cycling dieting, where the patient loses and then regains large amounts of weight. According to research, the brain maintains a set point to control weight; each person has an established weight set point and the body attempts to return to it after weight loss or gain. Diets do not lower one's set point. In fact, extreme diets could raise one's set point and make it harder to lose weight and easier to regain weight after the diet (Coon and Mitterer 2010). There are also psychological consequences to dieting. Research on dieting and weight loss demonstrates a relationship between dieting and increases in depression, anxiety, and social withdrawal (Wooley and Garner 1994).

Burgard (2009) describes how health concerns, including the use of the body mass index (BMI), are used to stigmatize fat people. In the practice of medicine and in research generally, the BMI is used to determine healthy weights in individuals. Medical research has maintained that obesity is a health problem associated with an array of other illnesses and even with mortality, and that the solution or cure is to lose weight. As a result, there is an emphasis on weight loss as the route to good health. Yet, studies show that the correlation between health problems and BMI is only 9%, meaning that 91% of health outcomes are not related to an individual's BMI. Additionally, it is unknown if weight loss results in better health outcomes because very few individuals maintain weight loss beyond two years. There is not strong empirical evidence that weight loss actually does result in improved long-term health. Burgard asserts that health improvements can occur when individuals improve their health practices without any weight loss occurring, which is part of the mission of a Health at Every Size perspective (described in a subsequent section). According to Burgard, a Health at Every Size approach urges medical researchers to examine the health consequences of anti-fat bias, as the medical pathologizing of individuals creates discrimination for fat people across a variety of domains, as described by Fikkan and Rothblum.

Anti-fat stigma is consistent and severe (Solovay 2000). In a fat-hating society, fat is seen as "dangerous, unhealthy, and disfiguring" (Brown 1989, p. 22). Fat prejudice is a pervasive issue; Watts and Cranney (2009) contend that body size is one of the few personal attributes considered an acceptable target of prejudice. Unlike racism, sexism, and homophobia, fat oppressive attitudes are embraced, excused or rationalized. Comparing fat prejudice to other forms of prejudice, Crandall (1994) asserts that "fatism appears to behave much like symbolic racism, but with less of the negative social desirability of racism" (p. 882). It is more acceptable to engage in fat prejudice compared to other forms of prejudice. Dislike of fat people is an acceptable prejudice held by otherwise progressive persons (Scoenfielder and Weiser 1983). The position that fat people ought to work harder at becoming thin persons is an expression of this prejudice.

Making an analogy to racism, we would observe that as a society, we do not endorse attempts to bleach the skins of people of color, even though non-Anglo individuals have been shown to fare worse in terms of physical and mental health outcomes. Research has documented health disparities that exist between ethnic racial minorities and the European American majority (Hartley 2004). There are significant and persistent differences in disease rates and health outcomes found among minority groups such as lower life

expectancy, higher rates of diabetes, hypertension, and infant mortality (Eberhardt and Pamuk 2004; Hartley 2004). The reduced mortality rates of non-White Americans are generally viewed to be, in large part, the result of the stress of living in an environment of racism, discrimination, and poverty (Puhl and Brownell 2003). Psychologists and sociologists have documented how racist and classist biases have resulted in some individuals receiving inadequate medical and mental health diagnosis and treatment. Internalization of racial discrimination impacts an individual's physical health, resulting in higher blood pressure, problems regulating cortisol, and metabolic abnormalities (Lepore et al. 2006; Guyll et al. 2001). A similar analysis of the problems experienced by fat people in a fat oppressive society has been resisted. We continue to believe that fat people should become thin, rather than recognize that anti-fat bias is a factor is the health of fat people. Puhl and Latner (2007) hypothesize that perhaps the negative health implications that accompany the internalization of racial discrimination may also occur among individuals who experience weight discrimination.

Mechanisms and Consequences of Anti-fat Bias

Being fat in an inhospitable, antagonistic environment creates stress and may compromise health (Brownell 2005). It is unlikely that bias, ridicule, or perceptions of being defective have anything other than a negative impact on individuals. Anti-fat prejudice has extremely negative effects on individuals exposed to weight stigma. Obesity in women is associated with higher instances of depressive episodes, as well as increases in suicidal ideation and attempts (Teachman et al. 2003). Puhl and Brownell (2003) contend that individuals discriminated against are more vulnerable to depression, economic hardship, and isolation. Additionally, fat individuals are not protected by an in-group favoritism that is seen with other marginalized groups. Schwartz et al. (2006) describe evidence that fat individuals engage in anti-fat bias to the same extent as average weight individuals. Instead of fat individuals showing preference for members of their in-group, they may actively engage in prejudice against them.

Social psychology, in particular attribution theory, provides a framework for understanding how fat oppression works. People discriminate against fat individuals because they believe their weight is controllable (Puhl and Brownell 2003; Musher-Eizenmann et al. 2004). Crandall (1994) believes that this attribution of controllability results in stigma towards fat individuals who are perceived as responsible for their condition. These attributions are termed "justification ideologies" and they "represent untested beliefs that promote and justify stigma while also remove feelings of guilt for discriminatory behavior and biased attitudes" (Puhl and Brownell 2003, p. 216). Although research indicates that body weight is affected by an interaction of biological and environmental factors, many people believe that fat individuals are responsible for being overweight; obese individuals are viewed as individuals who could control their weight, but do not (Puhl and Brownell 2003). Crandall argues that obesity stigma results from a social ideology based on negative attributions as explanation for discrimination; the traditional American values of self-determination and individualism are the foundation for anti-fat prejudice. Crandall and Martinez (1996) assert that it is a cultural preference for thinness, in addition to the attribution that weight is volitionally controlled, that leads to anti-fat attitudes (p. 1166). Crandall and colleagues (2001) propose an attribution-value model of fat prejudice that posits that the affect component of attitudes and prejudice toward other people is based on attributions of controllability and cultural values. In this model, Crandall and colleagues hypothesize that prejudice occurs because group members are held responsible for negative stereotypical behavior, in this case, being fat due to overeating. Secondly, there is a negative cultural value for an attribute that characterizes the group. In this model, beliefs about controllability of fatness are related to a set of more fundamental beliefs about the nature of the social world, termed social ideology (Crandall et al. 2001) This research demonstrates that anti-fat prejudice is associated with a social ideology, including the following components: belief in a just world, political conservatism, authoritarianism, belief in the Protestant Ethic, and the belief that poverty is controllable. In summary, the psychology of anti-fat prejudice is that people are prejudiced against fat people when fat is seen as a negative attribute that could be controlled.

Gender and Fat Oppression

All fat people are subjected to fat oppression, but fat prejudice is experienced by men and women differently in our (U.S) culture. It appears that fat prejudice may impact women more severely than it does men. "Loathing of fatness is gendered" (Ristovski-Slijepcevic et al. 2010, p. 318). The stigma of obesity may be greater for women as women are more likely to be concerned with their weight and obese women are more likely to experience bias and discrimination as compared to men (Agell and Rothblum 1991; Tiggemann and Rothblum 1988).

Feminist theorists tied fat oppression to sexism starting with Orbach (1978) in her classic *Fat is a Feminist Issue*. Since then, numerous theorists have observed or documented that issues related to body image and (dis)satisfaction are central to women's lives and are the source of distress (Bordo 1993; Chrisler 1989; Wolf 1990). Brown (1989) asserts that

fat oppression is aimed particularly at women, identifying anti-fat prejudice as a form of patriarchal oppression that has severely impacted women's lives. As a clinical psychologist, Brown observes that fat oppression divides women, prevents women from feeding and nurturing themselves, and being fed and nurtured by other women. Other feminist psychologists have commented on the degree to which fat oppression drains energy and resources from women's lives; the millions of dollars spent on weight loss and diet schemes could be spent to improve the quality of their lives (e.g. Smith 2004). Chrisler (2011) argues that the objectification and sexualization of women contribute to fat prejudice, as does the cultural belief that women should be able to control their desires.

Fraser (2009) describes the historical background to the cultural obsession with weight that exists in the United States. A hundred years ago, the beauty ideal that existed for women included a full-sized body and being heavy was equated with being sexy. The ideal body type was transformed from fat to thin, and Fraser says this shift dramatically changed the way "women's bodies were appraised by men and experienced by women" (p. 14). Cultural expectations for women emphasize that women must be beautiful, and being beautiful equates with being thin (Chrisler 1989). Women are objectified by cultural ideals of beauty to which men are not subjected, and these cultural pressures placed on women to be thin have resulted in widespread body dissatisfaction. When men do experience dissatisfaction with their bodies, it is more often focused on strength and muscle mass (Bell and McNaughton 2007). Men focus on building muscle whereas women are focused on losing weight (Bell and McNaughton 2007).

Bergman (2009), a transgendered individual, presents an interesting example of the importance of gender in living life as a "part-time fatso" (p. 139). According to Bergman, "whether I'm fat depends on whether the person or people looking at me believe me to be a man or woman" (p. 139). Bergman says that differential discrimination occurs for fat men and women in our society. For example, fat men can shop in department stores and expect they will carry their size whereas women typically must visit specialty stores to find clothing that will fit them. When Bergman passes as a man, he says he can order and eat in public without anyone making snide comments. When Bergman is viewed as a woman, she places drink orders for coke and receives diet coke in restaurants and is subjected to pig calls when she walks down the street. It appears that women experience anti-fat prejudice to a different degree as compared to men.

Anti-fat Bias and the Field of Psychology

While extensive research in psychology examines the operation of racism and sexism, little research has been completed examining the operation of fat oppression (Danielsdottir et al. 2010). This is the reason for the importance of the review by Fikkan and Rothblum that documents discrimination against fat individuals, especially women, in the areas of employment, healthcare, and education. Although weight stigma is under-researched, the existing research does demonstrate that anti-fat bias is "powerful, pervasive, and difficult to change" (Puhl and Brownell 2003, p. 313). Not only does psychology neglect fat oppression as a research area, but when it mentions fatness at all, it is within the context that being fat is pathological.

Social disapproval of fat is reinforced and justified by an assumption that greater body fat is harmful to health (Ernsberger and Haskew 1987) and reflects maladjusted or pathological behavior (such as binging or stress eating). As previously reviewed, people continue to believe that fat individuals lack self-control and/or discipline despite clear evidence that concludes that body weight is affected by an interaction of biological and environmental factors (Puhl and Brownell 2003). According to Erdman (1999), newer theories existing in the field of psychology include that fat people have eating disorders, have been sexually abused, are depressed, or are fat because they believe they do not deserve to be thinner. However, research indicates that emotional disturbance is not more common among fat individuals than it is among average-weight people (Wadden and Stunkard 1987). After reviewing more than 500 studies conducted in the United States and Europe, Wadden and Stunkard (1987) concluded that there is no evidence of greater psychopathology among fat people than among average-weight people.

Despite previous research discounting weight as a factor in psychopathology, Caplan (2011) noted that obesity is still sometimes viewed as indicative of lack of self-discipline or reflective of self-loathing. No matter what the theory, psychological theories regarding fatness are based on the assumption that being fat is pathological. In fact, Caplan stated that the DSM 5 task force was considering adding obesity as a mental illness. This proposal was withdrawn but reflects the tendency to consider obesity a sign of mental illness in the field of psychology.

Fat in the Undergraduate Psychology Curriculum

Education is viewed as an important factor in changing attitudes towards fat individuals and rejecting dieting as the solution to weight issues. Brownell and Rodin (1994) advocate for education as a force for size acceptance. According to Brownell and Rodin:

> Education is necessary to promote acceptance of different body shapes and sizes, with the aim of alleviating the need to seek a rigidly lean and contoured body.

> Education is needed to communicate that the body cannot be shaped and molded at will, and the pursuit of an unrealistic ideal increases risk for eating disorders, promotes preoccupation with food, and may have untoward physiological consequences. (p. 787)

Others have noted that psychology, despite concerns with diversity and prejudice in other areas, lags behind in size acceptance. Training and education are needed to help psychologists eradicate their own and others anti-fat bias (Connors and Melcher 1993). Touster (2000) joined other psychologists (e.g. Brown 1989; Chrisler 1989; Rothblum 1999) in calling on psychologists to examine their role in blaming individuals for the societal problem of fat oppression, and for perpetrating this oppression by continuing to participate in ineffective treatments.

Earlier research by Touster (2000) indicated that current and accurate information about the ineffectiveness of dieting and the lack of voluntary control over one's weight was not being integrated into our field. Touster examined the role of psychology in fat oppression through the systematic review of the knowledge base of psychology, as represented in introductory textbooks. Content analyses of the top 10 psychology texts from 1999 revealed that the majority of the texts continued to present a medical model paradigm to address obesity. The texts did not present the research indicating that weight is not controllable, that being fat is not equivalent to being unhealthy, and that diets are an ineffective treatment. Rather, several of the texts included special subsections on dieting that included dieting tips. Touster examined the question: Is fat oppression recognized as a form of prejudice in the psychology curriculum? The answer was no; the texts did not apply social psychological theories of prejudice to the experience of fat people, or consider size acceptance. None of the texts used the word fat; three of the texts acknowledged in a brief way that fat people are subject to maltreatment. Fat persons were also dramatically underrepresented in the pictures included in the texts. Touster concluded that psychology is complicit with fat oppression by continuing to perpetuate myths about weight, body image, and fat that have negative consequences on clinicians in training, clients, students, and the general public. The failure of psychology to provide updated information regarding fat oppression and anti-fat prejudice can contribute to disordered eating, dangerous dieting, and discrimination. In a study of abnormal psychology texts, Rothblum (1999) found a similar lack of coverage of research showing that diets do not work. In a related analysis, Goodwin et al. (2003) concluded that fat women were invisible in Psychology of Women textbooks, and that textbook authors were relatively silent concerning anti-fat prejudice.

A decade later we (Poet et al. 2011) repeated Touster's examination of the content of the 10 best-selling Introductory Psychology textbooks. We examined the coverage of weight-related topics using the index and the following terms to direct us: body weight/shape, body image, dieting, eating disorders, eating, fat, fat oppression, obesity, overweight, overeating, weight. We read and summarized the content included for each of these index terms used by Touster. We completed a checklist of important concepts and checked which were covered in each text including: set point theory, diets don't work, critique of the thin ideal, health at every size, obesity as a health condition. All of the texts discussed indexed eating disorders. None of the texts used the word fat, fat oppression or even overweight to index discussions of fat people. Nine of the texts had content organized under the term obesity. All of the texts included information about the set point, but only one half of them drew the conclusion that diets were ineffective. Eight of the texts included some discussion of cultural values and/or the thin ideal. Two of the texts discussed in some way discrimination or maltreatment of fat people, and two encouraged size-acceptance. Yet, most of the texts included the BMI and the medical model claims that obesity is an epidemic; seven of the books had text that supported dieting. One text highlighted the controversy between the medical model and the alternative view that the data does not support the claims that "obesity" claims lives, with no clear conclusion. This preliminary review suggests that the coverage of weight issues in introductory psychology textbooks has improved since Touster's examination in 2000. However, psychologists continue to subscribe to the medical model and to consider the problem to be fat, and not the oppression of fat people.

Given the pervasiveness of anti-fat bias, it is startling that most introductory psychology textbooks do not discuss fat oppression at all. A related, but not researched, question is how much is fat oppression discussed in graduate school curriculum? Graduate training in psychology is an important area to examine for inclusion of accurate information on fat oppression (Touster 2000). Numerous research literature in psychology emphasizes weight loss as a goal for fat clients, including using behavioral and cognitive behavioral techniques as well as family therapy (Nowicka and Flodmark 2011; Sadeghi et al. 2010; Franzini and Grimes 1981; LeBow 1989). The prevalence of weight loss counseling as a behavioral medicine intervention in the literature may influence graduate students in clinical and counseling psychology to engage in weight management with clients instead of emphasizing size acceptance. If psychology textbooks and graduate psychology courses do not discuss fat oppression, it is very possible that psychologists will continue to demonstrate biases against fat clients and prescribe weight loss for fat clients.

As someone who teaches diversity issues in a graduate psychology course, I (first author) am familiar with most of the texts used in graduate diversity courses, and any mention of sizism or anti-fat prejudice is the exception. Two such

exceptions are the inclusion of the essay "It's a Big Fat Revolution" by Lamm (2000) in the diversity anthology *Gender through the Prism of Difference* by Baca Zinn, Hondaagneu-Soteld, and Messner, and a brief essay on fat people's resistance by Goldberg (2003) in Plous's anthology, *Understanding Prejudice and Discrimination*. As a site visitor for the Committee of Accreditation of the American Psychological Association, I (first author) have reviewed more than 20 graduate programs over the past decade. Based on my reviews, I would conclude that fat oppression and sizism are not typically covered in these courses. Rothblum and Solovay (2009) hope to increase the curricular attention given to weight prejudice with the introduction of Fat Studies as a field of study.

Anti-fat Bias and Mental Health

The lack of coverage of fat oppression in psychology courses and the association between fatness and pathology has important implications for how clinicians will react to, diagnose, conceptualize, and treat fat clients. Davis-Coelho et al. (2000) assert that psychologists are part of a culture where bias and discrimination occurs against fat people, and as such, it follows that they probably are not immune to this effect. Moreover, as members of the (mental) health profession involved with weight loss treatments, psychologists profit from the billion dollar industry (Goodman 1995). Fikkan and Rothblum describe the three prominent studies examining the operation of anti-fat prejudice among mental health practitioners (Young and Powell 1985; Agell and Rothblum 1991; Davis-Coelho et al. 2000). Each of these studies indicates that anti-fat prejudice impacts clinical judgment as practitioners tend to assign more significant pathology to fat clients. This effect is even present when clinicians are given medical information from physicians that the fat client's physical health is fine (Davis-Coelho et al. 2000), which adds support to the idea that anti-fat bias exists in the absence of medical concerns regarding fat clients. Additionally, research has shown that anti-fat bias is more likely to operate in younger clinicians as compared to more experienced clinicians. One of Davis-Coelho and colleagues (2000) findings was that younger psychologists (age 40 or younger) expected less effort from fat clients. When a psychologist has low expectations for a client's prognosis and effort, this can impact the clinician's treatment plan (Davis-Coelho et al. 2000). For instance, a therapist may give fat clients fewer tasks to do outside of therapy, or they may have more conservative treatment goals because they do not expect a lot of effort from fat clients. Davis-Coelho and colleagues (2000) comment that the American Psychological Association's ethical code states that therapists must work to eliminate biases that affect their work, and clearly this should apply to working with fat clients. It is also extraordinarily important to reduce anti-fat prejudice in mental health practitioners as it is likely that obese individuals may seek counseling to cope with the social rejection they face because of their weight. Clients will not benefit from therapy if they receive the same anti-fat prejudice from their counselors as they experience in everyday life (Young and Powell 1985; Allon 1979).

Decreasing Anti-fat Bias

Anti-fat bias has been found to be more pervasive among younger psychologists; this suggests that training regarding awareness and prevention of fat bias should occur early (Davis-Coelho et al. 2000). One aspect of this training should pertain to the controllability of fatness, as the controllability of fatness has been a large reason for bias against fat people (Crandall 1994; Crandall and Martinez 1996). There have been mixed results regarding techniques to reduce anti-fat prejudice. According to O'Brien et al. (2010), there is no evidence for effective obesity prejudice reduction techniques designed to reduce weight bias in health professionals. Crandall (1994) focused on attempts to change anti-fat attitudes by offering persuasive information countering the belief that weight is controllable. She concluded that changing attitudes regarding the controllability of weight can reduce anti-fat attitudes. DeJong (1980) also manipulated participants' understanding of the controllability of obesity. When participants read profiles of obese individuals that included a medical reason for obesity, such as a thyroid disorder, the obese targets were given more favorable judgments and were liked more than obese targets whose profiles did not include a medical explanation.

O'Brien and colleagues (2010) attempted to reduce both implicit and explicit anti-fat prejudice in pre-service health students. Students were either given an obesity curriculum that focused on the controllable reasons for obesity, such as diet and exercise, or were given evidence of the uncontrollable reasons for obesity, such as genes and the environment, in a prejudice reduction condition. Measures of implicit and explicit anti-fat prejudice beliefs about obese people were taken at baseline and post-intervention. Results showed that students in the prejudice reduction condition who received information about the uncontrollable aspects of obesity demonstrated a decrease in implicit and explicit anti-fat prejudice, whereas students in the diet/exercise condition showed an increase in implicit anti-fat prejudice.

Teachman and colleagues (2003) also examined the modifiability of anti-fat bias but found that manipulating controllability of obesity did not reduce fat prejudice. Teachman and colleagues (2003) additionally studied whether evoking empathy resulted in diminished bias towards obese individuals.

They found that increased empathy resulted in lower implicit bias toward obese individuals, but only among overweight participants. This finding is important as it indicates a potential strategy for promoting in-group favoritism among fat individuals.

Because manipulating controllability of fatness does not always result in decreased anti-fat prejudice, additional strategies have been researched. Puhl, Schwartz, and Brownell (2005) examined the effect of perceived social consensus on attitudes towards obese individuals. According to this model, stigma and stereotypes are impacted by people's perceptions of others' stereotypical or stigmatizing beliefs. Previous research has shown that consensus information influences endorsement of stereotypes and also impacts people's resistance to changing existing beliefs. Puhl and colleagues (2005) hypothesize that one might use the social consensus model to reduce anti-fat attitudes through emphasizing favorable beliefs about obese individuals among members of valued social groups. Consensus information can modify attitudes; participants decreased negative and increased positive stereotypes about obese individuals after learning that others had more favorable attitudes towards obese individuals (Puhl et al. 2005). Fortunately, research indicates that negative consensus information did not result in more negative attitudes towards obese individuals. Puhl and colleagues suggest that changing negative beliefs toward obese people may involve trying to get people to identify with desirable in-group members who condemn anti-fat attitudes. They also contend that professionals in health care settings can influence attitudes toward fat individuals by communicating positive attributes of obese people. Thus far, research has not shown a dependable mechanism for reducing anti-fat prejudice. Anti-fat prejudice is pervasive and appears to be resistant to change. It is clear that more research is necessary to determine effective ways to eradicate anti-fat prejudice, especially among mental health practitioners.

Anti-fat Bias and Therapy

If fat clients enter therapy and want to discuss weight issues, fat bias can influence treatment choice. What is the typical therapeutic response to working on weight issues with clients? Are clients encouraged to view fat oppression as a cultural problem or are they encouraged to engage in weight loss? According to Burgard (2009), the "pursuit of thinness is an unquestioned prescription for health and happiness" (p. 42). Erdman's (1999) assertion that losing weight is the standard, culturally endorsed answer in therapy echoes this sentiment. It appears that when fat clients enter therapy and bring up weight issues, it is likely that therapists will engage in weight loss management strategies to assist clients in losing weight. This perpetuates fat oppression as it emphasizes the dichotomy that fat is bad and thin is good.

It is important for psychologists to develop approaches to working with fat clients that are not based on misinformation about fatness and weight or on the unexamined anti-fat biases of the therapist (Robinson and Bacon 1996). In 1989, Brown and Rothblum published a volume, *Overcoming Fear of Fat*, in which they addressed the topic of fat oppression in psychotherapy. The approaches they presented on doing therapy from an anti-fat oppression perspective remain unique today over two decades later. The issues raised by fat activists remain unacknowledged for the most part by practitioners. "Therapists, including feminist therapists, have (continued to collude) with their clients in pathologizing fat, celebrating weight loss, and failing to adequately challenge cultural stereotypes of attractiveness for women" (Brown and Rothblum 1989, p. 1).

Brown (1989) addressed the continuing presence of overt and covert fat oppressive attitudes among feminist therapists. She argues that working with women clients to help them lose weight is both ineffective and oppressive. Chrisler (1989) also argued against weight loss counseling in feminist therapy. Working with women clients on weight loss represents an ethical and political dilemma for (feminist) therapists. Recognizing that research has substantiated the extreme difficulty of losing weight and keeping if off, and given set point theory and the limited behavioral control individuals have over their weight, Chrisler argued that "encouraging our clients to do the impossible is neither feminist nor therapeutic" (p. 35). Working with a client on weight loss reinforces cultural constructions for women and implies that the therapist endorses the beauty myth (which equates a woman's worth with her attractiveness). Similar positions have been taken by others (e.g. Wooley and Wooley 1984). In contemporary psychological practice, there is an emphasis placed on empirically validated treatments. Few mental health practitioners would continue to prescribe medication or administer techniques for other conditions that have been shown to be 95% ineffective. Even more problematic is the fact that in the case of weight loss, the failure to lose weight is most often not viewed as the ineffectiveness of the therapeutic technique, but as the personal inadequacy of the client.

In order to engage in effective therapy with fat clients, therapists must first be aware of any anti-fat bias they may have. Their interventions with clients should not be hindered by prejudices or misinformation they hold about fatness or weight. Davis-Coelho and colleagues. (2000) agree that clinicians must conduct an honest self-assessment of their explicit and implicit bias against fatness. For example, some biases and misinformation that clinicians often hold include: the belief that fat people overeat, that dieting is an effective treatment for obesity, and that fat people have more psychological problems than thin people (Robinson and Bacon

1996). A clinician who is not aware of their own biases could assume a fat client has disordered eating or that the client's weight is the source of the problem or an expression of psychological maladjustment. Erdman (1999) stated that therapists must be willing to see fatness as a cultural problem instead of believing fatness is indicative of pathology. When a client comes in to discuss weight issues, the ethical therapist will talk about cultural bias against fatness and the pain it causes versus focusing on weight loss as a goal (Erdman 1999; Chrisler 1989; Robinson and Bacon 1996). It is also important for psychologists to be aware of the physical environment of the therapeutic setting (Davis-Coelho et al. 2000). Oftentimes, therapeutic environments are fat oppressive and are uncomfortable or embarrassing for fat clients. For instance, if the chairs in the office are too small, fat clients may not be able to comfortably sit in them. The setting of the therapeutic environment will send a message to the client about whether the organization is accepting of fat people. Therapists should work to ensure that a fat oppressive message is not being sent to clients.

Alternatives to Dieting: Fat Accepting Therapies

It is important for therapists to be aware that there are alternative treatments to engage in with clients who are concerned with their weight that do not include weight loss. Burgard (2009) believes that it is "hypocritical to prescribe practices for heavier people that we would diagnose as eating disordered in thin ones" (p. 42). An alternative to weight management treatments is the Health at Every Size (HAES) model, which focuses not on losing weight but instead promotes self-acceptance, appreciation of size diversity, and engaging in self-care strategies (Bacon 2008; Burgard 2009). HEAS's holistic approach targets improving individuals' emotional, physical, and spiritual well-being. HAES encourages engaging in physical activities for pleasure, not as regimented exercise routines. HAES also seeks to end weight bias by recognizing that someone's size or weight does not reflect the way a person eats, a person's physical activity level, or psychological issues (Bacon 2008; Burgard 2009).

There is evidence suggesting that the HAES approach is effective at improving individual's mental, as well as physical, health. Bacon (2008) describes a study completed with women with BMIs greater than 30 who were randomly placed in a HAES treatment group or a conventional diet program group. Women in the diet group learned to restrict their fat and caloric intake. Women in the HAES group focused on body acceptance. Results indicate that women in the HEAS group showed declines in LDL cholesterol and blood pressure. In fact, the areas that improved in the HAES group, such as blood pressure, cholesterol, and levels of depression, did not change or even worsened in the dieting group.

Chrisler (1989) also suggests several alternative strategies to employ when engaging in therapy with fat female clients. First, acknowledge fat oppression and inquire about the experience of the client with the expression of anti-fat prejudice. Denial or minimizing the prevalence and power of fat oppressive practices denies the validity of the client's experience. The client and therapist can explore the cultural construct of femininity, and expectations concerning beauty; clients can be disabused regarding the myths about dieting and the idea that dieting and being thin are related to morality or goodness. While emphasizing the importance of feeling healthy and making good choices regarding food and exercise, the therapist can explain the scientific evidence that diets do not work, and make sure that the client does not engage in dangerous weight loss schemes.

An innovative treatment program for fat women designed to increase daily activities and decrease depression and anti-fat attitudes is described by Robinson and Bacon (1996). Their program stresses the recognition of anti-fat prejudice, a reduction in blame toward fat people, redefining beauty, decreasing restrictions on activities, and teaching clients assertiveness techniques to deal with hostility and discrimination. Evaluations of the program indicate that 75% of the participants decreased restrictions on their activities and 50% reported less depression (Robinson and Bacon 1996). Tenzer (1989) also describes groups for fat women that do not encourage weight loss, but self-actualization. Some of the processes she describes as occurring in her Fat Acceptance group include: addressing size discrimination, recounting personal histories of being fat, and expressing anger. Her approach emphasizes that "reclaiming our bodies is paramount to fat acceptance" (p. 45). Lyons (1989) argues for the importance of exercise as a source of enjoyment. Sport and dance, as forms of exercise, are "ways to nourish our bodies, not reduce them" (p. 72). She has worked to empower women to take care of themselves, and to exercise, but not as a weight loss strategy. She encourages women to participate in activity in groups, acknowledging that social isolation increases stress, illness, and mortality.

Downes (2002) conducted a qualitative study of women's journey, in psychotherapy, from shame and self-blame to self-acceptance. Her informants describe the experience of being shamed for their size and being blamed for not controlling their size, and subsequent feelings of inadequacy and self-blame. The women report difficulty rejecting prevailing beliefs about fatness as an indicator of physical or mental health and the origins of fatness. Self-acceptance required challenging these beliefs and adopting alternative understanding of fat and of beauty. According to respondents, therapists need to understand the physiology of fat and the ineffectiveness of dieting. Therapists should also examine their own biases and educate themselves about issues fat women face.

The approaches to therapy with fat clients described here incorporate common elements. Each of them is designed to challenge existing beauty myths and blaming belief systems. Fat is seen as a description of people, not as a condition or a disease. Fat oppressive beliefs and practices are exposed. Dieting is downplayed or actively discouraged as not effective and sometimes dangerous. Self-acceptance and self-actualization, not weight loss, are the therapeutic goals. Movement, exercise, and physical activity are incorporated as a source of enjoyment and social interaction, not as a punitive, grueling route to weight loss. Negative experiences with hostility, humiliation, and discrimination are processed as forms of oppression, and assertive responses to such experiences are learned.

Conclusion

Fat people, especially women, are stigmatized in our society and yet fat oppression has not been recognized as a form of oppression. The field of psychology has a responsibility to appreciate size acceptance and to strive to eliminate anti-fat bias. Here we raised the questions: To what extent has psychology contributed to our understanding of prejudice against fat people and illustrated the experience of being fat in our society? We examined the role of psychology in the application of an anti-fat and medicalized view of fat/obesity. We questioned: What have psychologists learned in their professional training about fat people/women? How might we help professional psychologists to recognize and reduce their bias against fat women, so they can better serve all female clients?

Fat oppression is maintained in the theory and practice of psychology as being fat is often viewed as pathological and treatment for weight issues is typically focused on helping clients lose weight. However, as Davis-Coelho and colleagues (2000) state, the field of psychology can reinforce or combat oppression. Psychologists can perpetuate oppression or they can encourage clients to accept, appreciate, and nurture their bodies. Anti-fat prejudice is pervasive and could have insidious consequences, as it may operate outside of people's awareness. Therefore, it is imperative that clinicians be aware of the existence of anti-fat bias and engage in self-awareness exercises so they understand how fat oppression affects them and their practice. The field of psychology must promote that fat oppression, and not fat, is problematic in order to work towards eradicating anti-fat prejudice.

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