What do fat women want? : An exploratory investigation of the influences of psychotherapy on the process by which fat women work toward acceptance of their size and weight.

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WHAT DO FAT WOMEN WANT? AN EXPLORATORY INVESTIGATION
OF THE INFLUENCES OF PSYCHOTHERAPY
ON THE PROCESS BY WHICH FAT WOMEN WORK TOWARD
ACCEPTANCE OF THEIR SIZE AND WEIGHT

A Dissertation Presented

by

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DEDICATION

This dissertation is dedicated to my mother, Beatrice Convey Downes, an unwavering source of support and inspiration whose wisdom and love have allowed me to learn patience and perseverance.

At 93, her light her continues to shine.
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Completion of a project of this scope reflects the support and encouragement of many people. I feel blessed to have been surrounded by people whose interest in the topic and belief in me sustained me as a writer, a researcher, a therapist and a feminist.

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ABSTRACT

WHAT DO FAT WOMEN WANT? AN EXPLORATORY INVESTIGATION OF THE INFLUENCES OF PSYCHOTHERAPY ON THE PROCESS BY WHICH FAT WOMEN WORK TOWARD ACCEPTANCE OF THEIR SIZE AND WEIGHT

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This study explores the process by which a selected group of fat women work toward a positive acceptance of their size and weight and on the experiences and perspectives of these women as participants in psychotherapy. Research questions focused on participants' childhood, adolescent and adult experiences as large women prior to choosing to emphasize accepting, rather than changing their bodies; on the factors that influenced their decision to make that choice; and on participants' experiences as clients in psychotherapy. Psychotherapy experiences were examined to determine what role they may play in a woman's process of working toward acceptance of size and weight. Participants were asked to describe therapist characteristics necessary to their being effective with clients who are fat women.
In-depth phenomenological interviewing served as the primary method of data collection. Each participant was interviewed twice individually in sessions lasting from ninety minutes to two hours each. The study employed reflective and interactive components. Participants were given copies of the transcriptions of their individual interviews for review and comment and invited to take part in a focus group interview.

The data are organized into four areas: childhood and family of origin, adulthood and independence, working toward acceptance of size and weight, and experiences in therapy. Findings indicate that the negative sequelae of participants a) being shamed for their size and b) blamed for not controlling their size, continued well into adulthood. Adult experiences of prejudice and discrimination based on size confirmed and recapitulated attributions of unattractiveness and inadequacy.

The journey toward acceptance of size and weight is life-long, non-linear and involves embracing an alternative paradigm of assumptions concerning the origins of fatness, prevailing cultural standards of beauty, and the tendency to regard fatness as an indicator of compromised physical and mental health. In order to conduct effective therapy with fat women, psychotherapists need to understand the biological bases of fatness and the exacerbating effects of dieting; examine their own biases concerning size and weight; educate themselves regarding issues that fat women face; and remain aware of dynamic considerations specific to conducting therapy with fat women as clients.
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CHAPTER I

INTRODUCTION

This chapter presents a description of the study, the statement of the problem, the purpose of the study, and the significance of the study.

Description of the Study

This study focuses on the processes by which a selected group of fat women work toward a positive acceptance of their size and weight and on the experiences and perspectives of these women as participants in psychotherapy. The study is descriptive and exploratory in nature. In-depth phenomenological interviewing (Seidman, 1991 and 1998) served as the primary method of data collection. Each participant was interviewed twice individually in sessions lasting from ninety minutes to two hours each. Participants were invited to attend a focus group interview of all participants that followed the group of individual interviews.

Interview questions focused on participants' experiences as large women prior to choosing to emphasize accepting, rather than changing, their bodies; on the factors that were influential in their decisions to make that choice; and on their experiences as clients in psychotherapy. Psychotherapy experiences are examined to determine what role, if any, they may have had in a woman's process of working toward acceptance of size and weight.
Participants were asked to describe what therapists need to know and do in order to be helpful toward clients who are fat women.

Study participants were ten women between the ages of thirty and fifty-seven living in New England who self-described as working toward acceptance of their size and weight. All participants had sought help from a psychotherapist either prior to, or concurrent with, the study. Each participant had a body mass index (BMI) of at least 34. Body Mass Index equals weight in kilograms divided by the square of height in meters. People with a BMI of 25 or more are considered obese by a 1998 study on health and obesity released by National Institutes of Health (National Health and Nutrition Examination Survey III, 1998).

This study focuses on three main areas of exploration. The first consideration focuses on issues that study participants faced as children, adolescents and adults as a result of their size. The second consideration focuses on the processes by which these women work toward acceptance of their size and weight. The third consideration examines the experiences of these women as clients in psychotherapy.

This third consideration constitutes the primary research question of the study: what role does psychotherapy play in a fat woman's process of working toward acceptance of her size and weight. The inclusion of the first two considerations was necessary to establish the framework from which an individual participant's experience in psychotherapy might be examined and
understood. People turn to therapy for understanding, solace, and insight and for help in making changes.

Moreover, the experiences one brings to therapy form the backdrop against which all interactions with the therapist are illuminated. The dynamic relationship between client and therapist that defines psychotherapy is the avenue by which both parties change and evolve as a result of their interactions. Participants in this study were asked to speak about the issues that brought them to therapy and to reflect upon the process of that therapy. Some participants had entered therapy with size and weight as presenting issues; most had not. All participants offered observations regarding interactions with their therapists in terms of the effects those interactions had on participants' process of working toward acceptance of size and weight.

My research interests and involvement in the topic of psychotherapy and in issues pertaining to fat women are significant and form the foundation for this project. In the mid-1980s, I was a member of a study and support group for fat women. My membership in this group played a key role in coming to an understanding of what it means for fat women to accept rather than change their bodies. As a clinician, I have long maintained an interest in the developmental issues of women. Prior to the current study I had maintained a sound, but anecdotal, research interest in the issues and experiences fat women bring to therapy, as well as in the dynamics of the therapeutic process when either client or therapist, or both, are fat women.
As a result of my clinical training, including coursework and experiences in mental health settings, I was made aware of the potential for psychotherapy to be a source of support, insight and change for individuals, couples, families and even organizations. Despite the generally progressive inclinations of the field of psychology in general, however, it was clear that many in the profession had absorbed the values of the larger culture regarding size and weight. I began to make note of negative remarks and assumptions made by some clinicians on the basis of clients' size. The great majority of these clients were women.

As a researcher, I engaged in preparatory activities prior to undertaking this study. These activities included participating in events sponsored by the National Association to Advance Fat Acceptance over the course of several years. Immediately before beginning the current project, I facilitated a focus group comprised of fat women in Western Massachusetts and conducted directed conversations with fat and thin individuals who, in the context of their jobs, work with large women. These activities, together with my personal interest in the topics involved, formed the impetus to embark on this study which examines issues that affect the lives of fat women and the influences of psychotherapy on the processes by which they work toward acceptance of their size and weight.
Statement of the Problem

Current research on the physiology of fatness indicates that body type and size derive from a number of factors: genetics, nutrition, exercise, amount and type of food consumed, and acquired or inherited conditions such as thyroid disease, that can affect metabolism. Recently researchers have begun to include and emphasize the role of genetics, concluding that some individuals and groups are simply meant to be fat by reason of genetic determination (Ernsberger and Haskew, 1987; Gaesser, 1996 and 1999). Some of the recent research on the causes of fatness expands upon and re-examines studies conducted much earlier (Keyes, 1950; Sims, 1968).

Researchers have brought to light the role of successive dieting in creating or exacerbating a tendency to gain weight (Bennett and Gurin, 1984; Gaesser, 1996 and 1999). More Americans than ever are dieting: nearly 50 percent of adult women and more than 20 percent of men are trying to lose weight at any given time. Yet Americans as a group are fatter than ever: 97 million adults, 55 percent of the population, are considered overweight according to the 1998 National Health and Nutrition Examination Survey III conducted by National Institutes of Health.

The fact that there are more fat Americans than ever has not brought a diminishment in the discrimination and prejudice fat people encounter in several arenas, including education, employment and healthcare. Studies have shown stigma towards and discrimination against fat people by kindergarten children (Richardson, 1971); elementary school children
(Levine, 1987); college students (Rothblum, Miller and Garbutt, 1988 and Crandall, 1994); medical students (Blumberg and Mellis, 1985 and Weise, Wilson, Jones and Neises, 1992); high school teachers, nurses and school psychologists (Quinn, 1987); mental health professionals (Young and Powell, 1985; Abakoui, 1998); and employers (Rothblum, 1990 and 1992, Roehling, 1999). Wertz (in press) found that 16 percent of the general U.S. population would abort a fetus if they knew the child would be untreatably obese.

Results of recent studies indicate that while attitudinal prejudice takes an emotional toll, discrimination in the areas of employment and healthcare most negatively affects fat people as a group. Rothblum maintains that whereas previously it was thought that poverty causes obesity, there is increasing evidence that obesity causes poverty because the stigma of obesity blocks fat people's access to jobs, promotions and benefits including health insurance (Rothblum, 1992).

Packer (1990), Olson, Schumaker and Yawn (1994) and McAfee (1996) each gathered extensive data on the discrimination experienced by fat people in their interactions with healthcare providers. Packer (1990) found that fat women were made to feel insulted and embarrassed by their interactions with doctors and that conditions they sought treatment for were downplayed or overlooked because of disproportionate concern about their weight. In their study of hospital nurses Olson, Schumaker and Yawn (1994) found that overweight women delayed and sometimes avoided seeking medical care. McAfee (1996) concluded that fat women are more likely than thin or
average-weight women to experience serious complications, and in some cases die, from treatment that was postponed because women were told to "come back when they lost weight" or from procedures that were improperly administered because of lack of knowledge about how to administer treatment to large bodies.

Statistics published by the Council on Size and Weight Discrimination indicate that 50 percent of nine-year-old girls and 80 percent of ten-year-old girls in this country have dieted and that young girls are more afraid of becoming fat than they are of nuclear war, cancer or losing their parents. Ninety percent of junior and senior high school girls diet regularly, even though only 10 to 15 percent weigh more than what is recommended on standard height/weight charts. Of all psychiatric diagnoses, anorexia carries the highest mortality rate. Fifteen percent of all patients diagnosed with anorexia die from the disease (Council on Size and Weight Discrimination, 1996).

The results of these studies speak to a prejudice that is pervasive, culturally sanctioned and of major consequence for the lives of fat people. When fatness is vilified and fat people are blamed for their fatness, the blame that was once external is readily internalized and becomes personal shame (Crandall, 1991). American consumers of diet products, most of whom are women, spend more than 40 billion dollars yearly in attempts to lose weight and free themselves from blame and shame. "If shame could cure obesity,
there wouldn't be a fat woman in the world" (Researcher and eating disorders specialist Susan Woolley, in Sternhell, 1985, p. 143).

Size is a highly visible attribute and one that, like skin color and visible disability, is noticed immediately. Because size is regarded as mutable (able to be changed) and volitional (within the person's control to change), fat people are marginalized by virtue of being seen as unmotivated and uncaring about their appearance and their health. The combined influences of the fashion, advertising and diet industries together with the negative attitudes of some healthcare practitioners leaves many fat people feeling shamed by their fatness and blamed for their inability to lose weight.

A social climate in which fat people are degraded as a group and fat individuals are blamed for their fatness makes it difficult for fat people to move beyond blame to acceptance on a personal level or beyond marginalization to acceptance on a cultural level. Finding allies in the personal realm and building coalitions in the political world are made exceedingly difficult in a climate where there is little support to stop dieting and focus instead on maintaining ones physical and emotional health regardless of size. Crandall (1994) studied the self-protective role that a positive in-group orientation plays for other stigmatized populations including various racial and ethnic groups. She notes the absence of such sources of positive group identity for fat people.
Purpose of the Study

This section will describe the purpose of the study, the research questions that guide it, and the definitions of important terms used throughout the study.

The purpose of this study is to examine the processes by which some fat women, against significant social pressure to do otherwise, have worked toward a positive acceptance of their size and weight; and to explore these women’s experiences as clients in psychotherapy. The intent of the study is to explore and represent as accurately as possible, the experiences of ten study participants between the ages of thirty and fifty-seven with a body mass index of at least 34 who described themselves as working toward acceptance of their size and weight.

These women were asked to speak about their experiences as children and adolescents whether or not they were fat during those developmental periods, and about their experiences as fat adults. The study presents these experiences and wherever possible, the meanings participants made of these experiences. An example of meaning-making is reflected in the comments made by some of the participants who without being asked to do so, produced photographs of themselves as children. Each of these women commented that as a child, she was told she was fat and needed to lose weight. Upon viewing the photographs as adults, these women commented that they did not regard the pictures as portraying a fat child.
These participants found meaning in various ways. For some, the experience gave new meaning to beauty being in the eye of the beholder. The interpretation two women gave was that indeed they weren't fat at the time the picture was taken but that their parents' comments about their daughter's weight reflected the parents' fears that the daughter would become fat and look like a fat aunt or grandmother. For others, looking at the pictures led them to come to terms with the sense of unfairness they felt as children and as adults that their body types were not valued or appreciated.

All participants had, either previous to, or concurrent with the time of the study, sought help from a psychotherapist. Some participants went to therapy with the idea that they would discuss issues concerning their size. Most went to therapy to address issues other than size and weight. The study presents and describes participants' experiences in psychotherapy and their current reflections upon those experiences.

**Research Questions**

The primary research question focuses on the possible role of psychotherapy in a fat woman's choosing to work toward acceptance of her size and weight. The scope of "choosing" includes the conditions that surround and make possible the initial awakenings that accompany such a choice as well as the ongoing life processes and changes that such a choice entails. For this reason, the interview schedule (see Appendix G) included questions concerning participants' childhood and adult experiences,
experiences that form the basis of any effective psychotherapy. Other research questions include:

- What allows a fat woman to choose to work toward acceptance of her size and shape? Are there commonalities across fat women's experiences as children or adults that form the impetus or create the conditions for later work toward acceptance?
- What are the personal and social consequences of a fat woman's forging a positive personal identity concerning her size rather than accepting a culturally imposed negative identity?
- What is the role of psychotherapy in fat women's process of working toward acceptance of her size and weight?
- Can fat women's reflections on their experiences as children and adults be instructive for parents, teachers and other caregivers?
- Can fat women's experiences in therapy be useful in informing the training of new psychotherapists and the continuing education of experienced clinicians?

Definitions Used in Establishing the Research Questions

This section offers operational definitions of terms that appear in this study and in the literature reviewed in preparation for conducting the study.

Fat
The term of choice for people larger in size and weight than the norm (as defined by height/weight charts) who have decided to work toward accepting,
rather than changing, their bodies. The word "fat" is in the process of being reclaims from all of its negative connotations. Those in the size acceptance movement use it as a neutral term, meaning the opposite of thin, and emphasize the word's many positive connotations (see fat culture).

Overweight

The word used to describe a person whose weight is above that designated for someone of a particular height, according to insurance company height/weight charts.

Obese

A medical term that often connotes pathology. Many in the medical profession equate fatness with disease and do not accept that fat people can be healthy and fit. The term morbidly obese is used by some in the medical profession to describe a person whose weight is 50 percent greater than that prescribed by insurance company height/weight charts.

Body Mass Index (BMI)

A height/weight ratio which sometimes correlates with a person's fat composition and sometimes with a person's muscle composition. Body Mass Index equals weight in kilograms divided by the square of height in meters. The National Institutes of Health consider people with a BMI of 25 or greater as overweight.
Identifying as Fat
A term used to describe both a) the continuum of transformative events (personal, social, political and professional) by which "large" people come to identify as "fat" and b) the outcome of this developmental process.

Fat-Accepting and Fat-Positive
Terms used to describe people or circumstances that foster and support non-discrimination of fat people. Acceptance is understood as a necessary condition for anything greater such as embracing ones size or the celebration of it.

Fat Liberation
A social movement, often likened to the liberation movements of women, people of color, gays and lesbians, and people with disabilities that promotes the civil rights of fat people and moves beyond the concepts of acceptance or tolerance to full cultural, social and legal integration of fat persons.

Fat Culture
A term used to describe the politics, activities, events, artifacts, habits, special needs, clothing choices, humor, idiosyncratic language, professional connections and friendship networks of fat people. There is debate concerning whether all of these constitute true fat culture or simply community among fat people.
Significance and Rationale for the Study

This study is significant in both the theoretical and practical arenas. In the academic literature, the lives of fat women remain relatively unexplored. An extraordinary number of studies have been conducted on the topics of dieting and weight loss. Issues surrounding eating disorders, including cultural standards of beauty that reify thinness, have also been written about extensively. The notion of studying fat women as an empowered class, however, is a relatively new one.

The current study focuses on the experiences of fat women who have made a decision to work toward accepting, rather than changing, their bodies. From this researcher's review of the literature, these women represent an extremely small percentage of American women. Their decision to work toward acceptance characterizes them as resisting cultural norms. Their choice to de-couple the fact of fatness from the notion of pathology and their decision to cease dieting and emphasize instead physical and mental health locate them as members of an avant-garde. The results of this study support the development of a theory of the process by which fat women reach a positive acceptance of their size and the role of psychotherapy in that process.

To date, there are few studies that place fat women in the role of instrumental agent. Packer (1990), Olson, Schumaker and Yawn (1994) and McAfee (1996) surveyed fat women concerning their experiences in the area of medical care. Rothblum, Brand, Miller and Oetjen (1990) surveyed
members of the National Association to Advance Fat Acceptance, the great majority of whom were women, about employment discrimination. Erdman (1991) interviewed fat women regarding what she termed the "spiral" of size acceptance.

Of these studies, only Erdman's methodology employed extensive interviewing. The component of the present study that focuses on the processes by which fat women come to accept rather than change their size and weight, can serve as a complement to Erdman's work. It should be noted, however, that no attempt was made in the present study to categorize these participants' experiences into stages or steps or to formulate a theory of fat women's identity development.

The components of the present study that focus on fat women's experience as children and adults and on their experiences in psychotherapy are without precedent. Prior to this study, no known research had been conducted in which fat women were asked about their experience as clients in psychotherapy or about the life experiences they brought to that therapy.

On the practical level, the results of this study offer a framework for understanding the process by which these fat women work toward a positive acceptance of their size and weight. The information can serve as a knowledge base for fat women already engaged in the process of self-acceptance; for fat women who continue to struggle with the current social mandate that fat women alter their bodies; and for anyone seeking to
understand the cultural, physiological, emotional and spiritual aspects of size acceptance.

Based on participants' responses to inquiries concerning their experiences during childhood and adolescence, the study offers several practical recommendations for parents, teachers, physical educators and other caregivers that work with fat children and adolescents.

Finally, this study offers insight into these participants' experiences in therapy. The recommendations include suggestions for what therapists need to know and do in order to be helpful to clients who are fat women. It is hoped that this information will help inform the practice of therapists who already work with fat women and lend guidance to the process of educating therapists-in-training.
CHAPTER II
REVIEW OF SIGNIFICANT LITERATURE

This chapter will present a review of the literature in two major areas examined in preparation for undertaking this study. The first section focuses on literature concerning the physiological aspects of size. The second section focuses on literature concerning the psychological, social and cultural aspects of size. A review of literature that has emerged from the fat acceptance movement is included in the second section.

Physiological Aspects of Size

This section presents a review of the literature that addresses physiological aspects of size. The section will begin with a description of the paradigm that influenced the efforts of obesity researchers for the better part of the past century. The remainder of the section will emphasize studies that exemplify an emerging paradigm. The tenets of new paradigm are that size is an expression of biological diversity, that genetic influences largely determine individuals’ size; that dieting exacerbates a tendency to gain weight; that being fat is not necessarily harmful to an individual’s health; and that fat people can attain significant levels of fitness.
Traditional Paradigm of the Physiology of Size

The tenets of the traditional paradigm regarding human size and weight are that fatness is due to overeating and insufficient energy expenditure, that diet and exercise necessarily result in weight loss, that being fat pre-disposes an individual to cardiovascular heart disease, diabetes and cancer and that because of this association, obesity constitutes a threat to public health. Increased weight was seen as closely associated with increased mortality and morbidity and weight loss was prescribed as the corrective measure for both improved health and longevity. The genetic bases of size were given little consideration. The concept of setpoint was at first unknown, then ignored, then regarded as capable of being overruled by conscientious dieting and exercise. Exercise was regarded as a complement to weight loss for overweight individuals but the health benefits of exercise, independent of weight loss, were not emphasized.

The traditional paradigm regarding human size and weight is based on the assumption that there is an ideal weight and body size. The field of what has become obesity research is built upon the notion of "overweight." In order for an individual to be overweight there needs to be a concept of ideal weight. The concept of ideal or optimal body weight was developed by the Metropolitan Life Insurance Company (MetLife) which introduced the concept of "ideal body weight" in the early 1940's and "desirable body weight" in 1959 (Gaesser, 1999). Met Life asserted that there was a positive association
between “ideal or desired body weight” and reduced mortality, even though the company’s own research in the 1979 body build study does not support this assumption (Society of Actuaries and Association of Life Insurance Medical Directors of America, 1979).

Under the traditional paradigm physicians, health care and mental health professionals focused their efforts exclusively on patients reaching the ideal or desirable body weight. The assumption and promotion of the concept of ideal or desirable body weight led the pharmaceutical industry to develop weight loss drugs and the diet industry to develop numerous weight loss plans and programs.

Additionally, the focus of mental health practitioners was to assist individuals who wanted to lose weight. These practitioners worked with clients individually in therapy and in tandem with commercial diet plans and university weight loss programs. Academic researchers were sometimes solicited to lend their credentials in order to validate the procedures utilized by the various diet plans and programs.

A January 8, 2001 press release from the U.S. Department of Health and Human Services carried the message from Surgeon General David Satcher that he planned to combat overweight and obesity. No specific plans or programs were specified; the message, however, conforms to the tenets of the traditional paradigm in its insistence that fatness per se is “an important public health problem.” The report also stated that higher weights are
associated with higher death rates. The research studies reviewed in the section that follows challenge and refute both of these claims.

The Emerging Paradigm of the Physiology of Fatness

This section will focus on studies whose findings present evidence that fatness is primarily an expression of human variation. Some of these studies examine the genetic bases of fatness. Some explore the relationship between body weight and mortality, some present evidence of the possible health benefits of obesity. Others examine the effects of dieting on weight and the effects of repeated dieting on a tendency to gain weight. Still others focus on weight cycling and the health risks associated with it. The section concludes with a review of studies that examine how improved health and reduced mortality might be attained independent of weight loss.

The Biological Bases of Weight and the Heritability of Body Size

Traditionally weight and size have been viewed as resulting from a balance between energy input (food) and energy output (exercise). An individual’s genetic pre-disposition toward weight gain was viewed as an obstacle that could be overcome with dieting. The new paradigm takes into consideration hereditary factors that influence an individual’s weight and size. This section will start with an examination of two basic research studies whose elements continue to serve as comparison information for current researchers. The latter part of the section will present studies on twins and
body size and studies on adoptees and body size that have underscored the role of genetics in determining size and weight.

Two studies involving basic research conducted in the mid-1940s and late 1960s are presented below in some detail. These studies are instructive for the information they contain about the eating behavior of subjects who have been "dieted" versus the eating behavior of subjects who attempted to gain weight without ever dieting. In addition to the content interest, these studies are significant in terms of their social dimensions. Current strict guidelines governing the use of human subjects would probably prevent these studies from being initiated or replicated today. Also, these studies were conducted using young male conscientious objectors in 1944 and prisoners in 1964, populations that presumably had never dieted. Studies conducted today will sometimes use subjects who have never been fat as a comparison or control group for the targeted population of fat individuals. It has become increasingly difficult, however, when studying the effects of dieting, to find a population of Americans who have never dieted.

In November 1944 a group of researchers at the University of Minnesota (Keys, Brozek, Henschel, Michelson and Taylor, 1950) brought together a group of 36 physically healthy, emotionally stable, male conscientious objectors in their 20s who had volunteered for the study, the purpose of which was to gather information on rehabilitating the starved populations of Eastern Europe. For six months the men ate a normal varied diet of 3500 calories per day, walked three miles per day, participated in work
detail and had the opportunity to engage in study on the rehabilitation of war-ravaged populations.

At the end of six months, the men received half their caloric ration and the food choices changed to reflect those available to wartime Eastern Europeans: cabbage, turnips, whole wheat bread, potatoes and very small amounts of meat and dairy. On this restricted food regimen the men showed euphoric moods followed by depression. Many grew argumentative and regular meetings were canceled because the atmosphere became tense and strained.

Two months later, all of the men lost at least one fourth of their starting weight and half of their body fat, conditions that constitute starvation. The average basal metabolism slowed by 40 percent. The men's appearance became disheveled and they began to conserve energy by avoiding work, study or recreation. Two volunteers were dismissed after one suffered an emotional breakdown and another cut off the tip of his finger. The men reported that they could think about little else but food and they were observed playing with it for hours on end, eating it in unusual combinations and spicing it highly so as to enhance the flavor.

Three months of planned refeeding began. The men were given an increased ration of food but allowed only the food given to them. During this period the men gained some weight but remained unhappy and preoccupied. Following the planned refeeding period, the men were allowed to eat whatever they wanted. They consumed vast quantities of food, an average of
5000 calories per day. At the one-year mark, all of the men had returned to their pre-study weights or above but only half reported that their interest in food had returned to normal. The others continued to think about food obsessively and had difficulty distracting themselves from wondering what they might eat next. The men recovered their body fat but their muscle tissue remained depleted. At the time of the write-up of the experiment, the researchers reflected that one young man who had rapidly regained weight and exceeded his starting weight, had been close to congestive heart failure prior to medical intervention (Keys et al., 1950).

The second study involved thin volunteers with no known diabetes or obesity in their backgrounds, who were prisoners at the Vermont State Prison. Sims (1968) recruited 50 men who agreed to try to gain 20 to 30 pounds. During the early weeks of the 200 days that the experiment was conducted, the men continued with their usual daily activities, but later were instructed to limit activity in order to facilitate weight gain. Of the twenty prisoners who managed to gain 20 to 25 percent of their body weight, only two found it relatively easy to do so. These two men were found to have previously undisclosed familial diabetes or obesity.

All twenty had doubled their food intake from pre-experiment amounts but could maintain their increased weights only by consuming an average extra 2000 calories per day, spread over five meals. At the height of their weight gain, the men experienced fatigue and lethargy and were disinclined to participate in activities. They dreaded mealtimes and often
vomited after breakfast. When the experiment ended, all the men lost weight easily and rapidly except for the two who had had an easy time gaining (Sims, 1968).

A study involving weight loss attempts and weight gain among twins and a study involving the comparison of adoptees’ weights to their biological and adoptive parents’ weights have confirmed body size as a heritable characteristic. Korkeila, Rissanen, Kaprio, Sorenson and Koskenvuo (1999) analyzed weight patterns among 3536 men and 4193 women in the Finnish Twin Study. They followed subjects at baseline, at six years later and at 15 years later. After controlling for smoking, alcohol use, education, social class, marital status and energy expenditure both at work and at leisure, Korkeila et al. found a positive relationship between weight loss attempts and risk for major weight gain (22 pounds or more). They concluded that “a familial predisposition to gain weight . . . ultimately overpowers even ambitious weight-loss attempts” (p. 973).

Stunkard (1986) divided a population of 540 Danish adoptees into four weight classes: thin, median weight, overweight and obese. He compared adoptees’ weight class to biological parents’ and adoptive parents’ actual body mass index (BMI). Stunkard found that there was a statistically significant relationship between individual adoptees’ weight class and their biological parents’ BMIs but no apparent relation between adoptees’ weight class and their adoptive parents’ BMIs. This effect was consistent across all weight classes from very thin to very fat.
In sum, conditions observed in the above-mentioned studies were the tendency for the body to return to a pre-diet range of weight; the difficulty for men with no obesity, diabetes or dieting histories to gain weight; loss of muscle mass and the addition of fat mass in men who were dieted and refed; preoccupation with food among the dieted population even after weight was regained; and fatigue and lethargy present in both the men who experienced starvation conditions and those who were encouraged to gain weight rapidly. Additionally, the consistent relationship of the weights of twin adoptees' body weights to the weights of their biological parents demonstrates the connection between biological weight and heritability. All these studies speak to the biological bases of weight and a genetic pre-disposition to be thin, average weight or fat.

**Body Weight, Morbidity and Mortality, Weight Loss and Mortality**

In the traditional weight paradigm, increased body weight is invariably associated with increased morbidity and mortality. For example, in his *Shape Up America* program, former surgeon general C. Everett Koop claims that 300,000 deaths per year are attributable to obesity (Fraser, 1997, p. 174). Kassirer and Angell (1998) question the accuracy of that number and its use in what they term “the medical campaign against obesity.” They assert that “the data linking overweight and death, as well as the data showing the beneficial effects of weight loss, are limited, fragmentary, and often ambiguous” (pp. 52-53). Kassirer and Angell (1998) caution that many studies linking increased
weight with early death have serious methodological flaws because they fail to consider or control for confounding variables. They add that some studies have indicated that weight loss can increase mortality.

In their analysis of the data generated by the First National Health and Nutrition Examination Survey (NHANES I) Pamuk, Williamson, Madans, Serdula, Klienman and Byers (1992) looked at the question of whether weight loss improves mortality. While it was difficult to assess whether any individual’s weight loss was voluntary, the researchers did adjust for pre-existing illness along with age, race and smoking in this cohort of 2,140 men and 2,550 women. They found that among moderately fat men and women, the risk of death increased with weight loss. Moderately fat participants who lost 15 percent or more of maximum lifetime weight had more than twice the mortality risk of those in the same weight category who lost less than 5 percent. In higher weight categories, the risk of death increased with the amount of weight lost for women but appeared to have the opposite effect for men.

Andres, Muller, and Sorkin (1993) reviewed the data on all-cause mortality and body weight from 13 major studies, including the Framingham Heart Study and the Harvard Alumni Study. The 13 reports included 11 diverse populations, seven from the U.S. and four from Europe. The highest mortality rates occurred in adults who either lost weight or gained excessive weight during adulthood. The lowest mortality rates were associated with those who had gained a modest amount of weight during adulthood.
Gaesser (1999) conducted an extensive review of studies on mortality and weight in order to examine two hypotheses: that the lowest mortality rates are observed in thin men and women and that weight loss reduces mortality. He concluded that “the preponderance of epidemiological evidence” fails to support either of those hypotheses (p. 1124).

In addition to studies that indicate an absence of a relation between fatness and increased morbidity and mortality, some studies present evidence that fatness may be protective against some diseases. Other research indicated that the findings have conflicting results.

For example, Ballard-Barbash and Swanson (1996) looked at the relation between body weight and risk for breast and endometrial cancers. Their findings are confounding. Heavier women were at decreased risk for pre-menopausal breast cancer but may be at increased risk for post-menopausal breast cancer and endometrial cancer.

However, Kabat and Winder (1992) analyzed data from several studies on body weight in relation to lung disease. They found that independent of smoking status, a higher BMI is associated with lower incidence of all lung diseases, particularly lung cancer. These results held true for both men and women.

Edelstein and Barrett-Connor (1993) looked at the relationship of bone mineral density and body size among 1492 elderly men and women. Low mineral density precedes and accompanies osteoporosis which is a leading cause of morbidity and subsequent mortality in older people. The researchers
adjusted for smoking, alcohol consumption, exercise, use of thiazides to control hypertension and (among women) estrogen replacement therapy. They compared body mass index with bone mineral density in four areas of the body and found that total weight was the best indicator for positive bone density at all sites measured for both sexes. Neither height nor how fat was distributed on the body was related to bone mineral density for either sex.

It is interesting to compare Edelstein and Barrett-Connor’s results with Sartoris’ (1999) research on bone mass in young women. In his work as a radiologist, Sartoris found that only 30 percent of x-rays of women ages 21 –35 showed normal bone mass. Based on the results of his survey, Sartoris theorizes that many young women who choose to avoid the calories in calcium-rich dairy products may be unwittingly setting the stage for osteoporosis later in life.

In summary, the studies reviewed in this section indicate that there are serious concerns for methodological flaws in their failure to consider or control for confounding variables. In studies whose evidence supports the emerging paradigm of body size, this research shows a much more complex picture between body size and morbidity and mortality. Several of the studies failed to indicate a positive relation between body weight and increased morbidity and mortality. Other studies indicate an inverse relationship between body weight and risk for certain diseases.
The Weight Loss Paradox and Health Risks Associated with Dieting

Traditional obesity researchers did not focus on the physiological and psychological effects of dieting, particularly the effects of regaining lost weight. Researchers and practitioners whose findings are consistent with the new paradigm find value in the concept that dieting often results in a net gain of weight. This apparent paradox is explained by the concept of setpoint, which is the set or range that an individual’s weight returns to following illness, holiday overindulgence or changes in energy expenditure (Bennett and Gurin, 1983).

Researchers theorize that exercise (Bailey, 1991; Bennett and Gurin, 1983), smoking and amphetaphine use (Bennett and Gurin, 1983) can reset the range in a downward direction and that repeated episodes of dieting (Gaesser, 1996) can reset the range in an upward direction. The more severe the calorie restriction and the more dieting events an individual engages in tend to result in the highest net gain. The body reacts to what it perceives as the threat of starvation by returning to the pre-dieting weight plus a bit more as insurance in the event that starvation conditions recur.

The attempt to override biological factors has occupied the energies of diet doctors and obesity researchers for the better part of the past century. Albert Stunkard is one such researcher who at one time subscribed to the idea that diets can cure fatness but later concluded through his research that fat people eat no more than thin people and that that reducing diets don’t work.
Stunkard and McLaren-Hume (1959) reviewed the weight loss studies from that period and reached the conclusions that the programs they studied were ineffective and that many were harmful. Still, because they were also concerned about methodological errors and reporting inaccuracies in the studies they reviewed, they designed their own study of 100 obese patients who were given what they considered to be safe low calorie diets prescribed by the nutrition clinic at New York Hospital. They followed these patients for more than two years and found that the weight loss results were actually far lower than in any of the studies they reviewed, especially for female patients. Additionally, in an era when long-term follow-up was unusual, they found that only two patients maintained their initial weight loss at the end of two years.

In a later address, Stunkard (1974) concluded that diets are largely ineffective. He cautioned physicians about making assumptions about the causes of fatness and about dieting as a remedy:

Some of the more enthusiastic behavior modifiers are saying that because obese persons can lose weight by modifying their eating behavior, disordered eating behavior must have been the cause for their obesity. There is just no evidence for such a contention. It is equally plausible that behavior modification may simply be helping someone who biologically should be obese to live in a semi-starved condition (Stunkard, 1974, p. 214).

When Miller (1993) surveyed popular dieting techniques over the last 40 years, he found that diet plans and programs cycle in and out of popularity and that many diets may be hazardous to health. For example, the total fasting that was prescribed from the late 1950s through the 1960s brought
about serious medical conditions including loss of lean body mass, depleted electrolytes, and in some cases, death. The popular Atkins and Stillman diets of the late 1960s and early 1970s sometimes resulted in hyperuricemia, extreme fatigue and re-feeding edema. Despite medical supervision and use of high quality protein and potassium supplements, ventricular arrhythmia claimed the lives of people who were prescribed very low calorie diets of the 1970s known as protein sparing modified fasts.

In the 1980s, a second generation of pre-packaged very low calorie diets appeared, including Optifast™, Jenny Craig™, Nutrisystem™ and The Diet Center™ diet. Many dieters who used these products developed cardiac problems and gallbladder disease. For the past two decades, low fat and fat free foods have prevailed in the diet industry. One such plan is the diet prescribed by Dean Ornish for cardiac health that was soon touted as a weight loss mechanism. Problems that resulted from the low-fat/fat-free phenomenon, according to Miller, included dieters' substituting excess sugar for the missing fat and the onset of gallbladder disease once they began consuming fat again (Miller, 1999).

The health risks associated with the use of diet drugs have been shown to be significant. In the year before the popular combination of fenfluramine and phentermine (fen-phen) was removed from the market, eighteen million people had taken the drugs legally, that is, after obtaining a prescription from a physician (Kassirer and Angell, 1998). The Federal Drug Administration requested manufacturers to remove the drugs from the
market reports from physicians that patients who had taken the drugs had been diagnosed with primary pulmonary hypertension (PPH) a condition that causes blood vessels in the lungs to constrict. The strain on the heart from the effort of working to push blood through those vessels can result in heart failure. Other serious effects of these drugs are brain neurotoxicity and valvular heart damage (Fraser, 1997; Solovay, 2000). An analysis of studies conducted on the use of fen-phen (Levitsky, 1997), showed that the average weight loss for people who had taken fen-phen was only five pounds greater than the weight loss of people who had taken a placebo.

In summary, the traditional paradigm of fatness defines obesity as a disease and prescribes dieting as the cure. These studies examined in this section show that successive dieting leads to a net gain of weight. Some studies have indicated that serious health risks are associated with various diet plans. The most serious health risks are associated with recent diet drugs.

**The Health Risks of Weight Cycling**

In addition to demonstrating health risks associated with dieting, researchers have shown that the practice of gaining and losing weight can also have deleterious consequences. The repetition of this process throughout an individual’s life is known as weight cycling and is beginning to be understood as a serious health concern.

Lissner, Odell, D’Agostino, Stokes, Kreger, Belanger and Brownell (1991) reviewed the 32-year follow-up data from the Framingham Heart
Study. They analyzed all-cause mortality, mortality from coronary heart disease, and cancer in relation to individuals' fluctuation in weight. After controlling for obesity, for trends (up or down) in weight over time, and for five indicators of cardiovascular risk, Lissner et al. found that subjects with highly variable weights had increased all-cause mortality, mortality from heart disease and morbidity due to heart disease.

Higgins, D'agostino, Kannel and Cobb (1993) also reviewed data from the Framingham Study. Their review found mixed results from weight loss and mortality. Men and women who lost weight also had higher rates of cigarette smoking and lower rates of smoking cessation. Weight loss was associated with lowered blood pressure and cholesterol levels; however it was also associated with continued cigarette smoking, cardiovascular disease, diabetes and higher death rates. Similar to the findings of Lissner et al. (1991), maintenance of stable weight was associated with better health.

Traditional weight loss literature maintained that weight loss brought with it the benefit of increased energy and vitality. Experiments carried out by Liebel, Rosenbaum and Hirsch (1995) using human subjects found the opposite to be true. Their results are consistent with the findings of the Minnesota researchers who found their dieted subjects to be lethargic, distractible and uninterested in activities that had previously interested them.

Liebel, Rosenbaum and Hirsch (1995) measured changes in individual's energy expenditure after gaining or losing 10 percent of body weight. They hospitalized obese and never-obese individuals for a period of ten days
during which time they were given a liquid diet calibrated to maintain individual body weight. The researchers measured energy expenditure throughout the day. After the ten days, a subset of participants was allowed to eat self-chosen foods until they gained 10 percent of their body weight. Some obese and never obese participants in the subset were given a very low calorie diet until they returned to their initial weight and some obese and never obese participants in the subset were given the very low calorie diet until they lost 10 percent of their initial weight. A different group of ten obese participants was given the restricted diet until they lost 20 percent of their initial weight.

Liebel et al. found that a 10 percent increase in starting weight resulted in a 16 percent increase in total energy expenditure and that a 10 percent decrease in weight resulted in a 15 percent decrease in total energy expenditure. They found no significant difference in expenditure for those who had dieted to 10 percent below and 20 percent below starting weight, leading them to conclude that maximal adaptation had occurred at the 10 percent level. The researchers point out that their results are consistent with studies such as Framingham and Harvard Alumni that show that body weight tends to be relatively stable over a long period of time.

Leibel et al. concluded that stable body weight and energy expenditure are linked and that the human body is tenacious in its efforts to maintain both. They caution physicians who practice obesity management that “for some obese patients the achievement of what is considered to be a more
healthful body weight many be accompanied by metabolic alterations that make it difficult to maintain the lower weight” (Leibel, Rosenbaum and Hirsch, 1995, p. 627).

This section focused on studies that showed the health risks of weight cycling, that is, the repeated gain and loss of weight throughout the life cycle. Weight cycling is associated with increased all cause mortality, mortality from heart disease and morbidity from heart disease, higher rates of cigarette smoking and lower rates of smoking cessation, and with decreased levels of energy and vitality. Overall, maintenance of stable weight was associated with better health.

**Improved Health and Reduced Mortality Independent of Weight Loss**

Obesity researchers traditionally viewed exercise as a useful complement to dieting as a means to lose weight. As a result, many fat people would exercise only when they were dieting and only in order to lose weight (Packer, 1989). Recent studies have shown that the health benefits of exercise accrue to fat individuals, whether or not they lose weight. These benefits include a lowering of cardiac risk factors, prevention of hyperinsulinemia and diabetes, lowering of blood pressure and increased levels of functional mobility.

Lee, Hsieh and Paffenberger (1995) studied a cohort of 17,321 subjects who were part of the Harvard Alumni Health Study and found that energy expenditure from vigorous activities, but not energy expenditure from non-
vigorous activities, formed an inverse relationship to all-cause mortality. This relationship held for subjects who were 20 percent or more above ideal weight as well as for those at ideal weight.

Barlow, Kohl, Gibbons and Blair (1995) followed for more than eight years 25,000 predominantly white, professional men who had received a preventative medical examination at the Cooper Clinic in Dallas between 1970 and 1989. The purpose of the study was to examine the relationship of fitness to various BMI strata. They found that moderately fit and highly fit men in all weight categories showed lower rates of death than their low fitness counterparts in the same weight categories. These associations remained after adjusting for age, health status, smoking status, systolic blood pressure and fasting blood glucose. The researchers concluded that “[A]lthough physical activity or exercise training may not make all people lean, it appears that an active way of life may have important health benefits, even for those who remain overweight” (Barlow, Kohl, Gibbons and Blair, 1995, pp. S41-S44).

Barnard, Ugianskis, Martin and Inkeles (1992) studied the effects of diet and exercise on 72 subjects divided by diabetes status: diabetic, insulin resistant, and normal/non-diabetic. Their intention was to measure hyperinsulinemia, hypertension, hypertriglyceridemia and obesity as independent risk factors for coronary artery disease. They found significant decreases in insulin, blood pressure and triglycerides across all groups. They noted that of the 24 who began the program overweight or obese, only four
reached normal weight and several remained obese. The researchers found "that normalization of body weight is not a requirement for a reduction or normalization of other risk factors" (p. 440). They concluded that insulin resistance results from a high-fat, high-sucrose diet rather than from body weight itself (Barnard, Ugianskis, Martin and Inkeles, 1992).

In her work as a nurse practitioner for Kaiser Permanente, Lyons (Lyons and Miller, 1999) conducts an exercise class and support group exclusively for large women. She found that in shifting from weight focused therapies to health focused therapies, women in the program moved away from their investment in the "false hope" offered by weight loss programs and ended the continued sense of failure so many had experienced during years of restrictive dieting. Both of these factors, Lyons believes, lessen the incidence of eating disorders. Additionally, many of the participants in the program learned to eat healthier and exercise on a regular basis. Even for participants who lost no weight or very little weight, these changes brought documented positive changes in serum cholesterol and triglycerides, cardiovascular risk factors, hypertension and functional capacity (Lyons and Miller, 1999, p. 1142).

Gaesser (1999) came to a similar conclusion following his review of studies on body weight and longevity. He found that "increasing physical activity and aerobic fitness, independent of weight loss, has been shown to reduce mortality rates by a greater amount than intentional weight loss" and that factors often associated with obesity such as hypertension and insulin
resistance can be ameliorated by means of lifestyle changes apart from weight loss (Gaesser, 1999, p. 1124). As an exercise physiologist Miller (1999) promotes the benefits of exercise for large people. He suggests that health care professionals reframe how they think about health concerns for fat people in the context of beneficial outcomes across weight strata. Rather than ask “How can we make fat people thin?” he suggests that providers ask “How can we make people of all sizes healthy?” (Miller, 1999, p. 1132).

Studies reviewed in this subsection indicate the health benefits of exercise for fat people independent of weight loss. These health benefits included decreased levels of blood insulin, lowered blood pressure, and improved cardiovascular profiles. The health benefits also included improved functional capacity and range of movement as well as an inverse relationship to all cause mortality. Most of the subjects in these studies were men. However, Lyon’s (1999) findings regarding fat women and exercise corroborated these results. Additionally, she found in changing the direction of her work from weight focused programs to health focused programs, fat women who exercise experienced a decrease in disordered eating. These women also moved away from their sense of failure resulting from their previous attempts at dieting.

Section Summary

This section presented a description of the traditional paradigm regarding overweight and obesity followed by a review of the literature on the
physiological aspects of size whose findings contribute to a revised paradigm for viewing size and weight. The review of literature focused on the areas of the genetic bases of fatness; body weight, mortality and morbidity; the paradox and weight loss and the health risks of dieting; and the benefits of exercise independent of weight loss. The next section will present a review of the literature pertaining to the psychological, social and cultural aspects of size.
Psychological, Social and Cultural Aspects of Size

This section will focus on the psychological, social and cultural aspects of size as they are expressed by the traditional paradigm concerning size and weight and as they are expressed by an emerging paradigm of size acceptance. This section begins with a description of the ways in which the stigma of obesity manifests itself across the life-span and in numerous settings. A discussion follows concerning the complex social and cultural factors that maintain and foster this stigma. The next segment presents research on the prejudice and discrimination that follow from the stigma against fatness and on the ways that fat people experience and react to stigma, prejudice and discrimination. The section ends with a review of the literature that has emerged from the fat acceptance movement, which offers a new paradigm by which to consider issues of size and weight.

How the Stigma of Obesity Manifests Itself

The tenets and assumptions that underlie the traditional paradigm concerning weight and size foster a cultural climate that allows the stigma of obesity to flourish. The traditional paradigm holds that fatness is due to overeating and that dieting and exercise necessarily result in weight loss. Fatness is seen as mutable, a disease for which the cure is weight loss. Fatness is regarded as volitional and able to be controlled by abstinence and willpower.
During the century that the traditional paradigm has been dominant in this country (Wann, 1999) the stigma of obesity has become firmly established and accepted. The power of this stigma has increased to the extent that it is demonstrated by children at every age and grade level and by adults in educational, health care, employment and social settings. The studies that follow demonstrate the many ways in which fat people are seen as accountable for their weight and are rejected because of it.

Richardson (1971) studied the reactions of nursery school children to drawings of children in wheelchairs, on crutches, without arms or legs, as facially disfigured or obese. The children reacted most negatively to the drawings depicting amputees and obesity. Levine (1987) found that by second grade, children use negative adjectives including "dirty", "lazy", "sloppy", "ugly" and "stupid" to describe fat children.

Another researcher, Quinn (1987), examined the rating tendencies of 600 high school English teachers, school nurses and school psychologists who graded student essays and made assessments regarding which students would be most likely to receive scholarships and which were at risk for personal and psychological problems. The essays were accompanied by a picture of girl and stated weight levels of 110, 160, and 210 pounds. The school personnel rated the thinnest girls as most likely to receive scholarships and the fattest girls as most likely to be at risk for personal problems and psychological referrals.

Crandall (1994) conducted a series of six studies on anti-fat attitudes using college students as subjects. He found that students who hold anti-fat
attitudes are likely to also believe in a just world, support the tenets of the Protestant work ethic, believe in self-determination, tend to support a conservative political agenda and subscribe to the notion that people get what they deserve. Crandall asserts that these characteristics also describe individuals who make what social scientists define as the ultimate attributional error. Such individuals believe that members of disadvantaged groups are responsible for any negative aspects of their situation.

Crandall compared the ways in which racist and anti-fat attitudes are similar and dissimilar. He found that individuals with racist attitudes and those with anti-fat attitudes ascribe similar stereotypes (lazy, sinful, lacking discipline and self-denial) to members of both groups. Individuals with racist attitudes are unlikely to regard skin color as changeable or within the person’s control. Individuals with anti-fat attitudes universally hold that weight is alterable and that it is within the individual fat person’s control to alter his or her weight. One of Crandall’s studies was designed specifically to measure racist attitudes among the college student cohort. He attributes the relatively low scores indicating racist attitudes not to a lack of such attitudes but rather to a powerful suppression mechanism associated with students’ need to feel politically correct. Crandall posits that no such suppression mechanism operates in the arena of fat prejudice (Crandall, 1994).

The lack of such a censoring mechanism extends to dating services and personal advertisements where weight and size limitations are frequently stated by those who place ads (Goodman, 1995). A Valentine’s Day report on
National Public Radio on dating services and newspaper personal advertisements began with the voice of host Scott Simon jauntily commenting that “fat” and “felon” seem to be the words to avoid when advertising oneself. (National Public Radio, Weekend Edition, February 14, 1998). The anti-fat bias expressed in this coverage is consonant with the findings of Venes, Krupka and Gerard (1982) when they asked college students who they would be least likely to marry. Fat people were rated below embezzlers, drug users, former psychiatric patients and sexually promiscuous persons in terms of their desirability as a marriage partner.

Research indicates that practitioners in the health care professions hold prejudicial attitudes toward fat people. Medical students surveyed by Blumberg and Mellis (1985) rated fat patients as more unattractive, awkward, weak, sad, unsuccessful, difficult to manage and lacking in self-control than normal weight or thin patients. Weise, Wilson, Jones and Neises (1992) found that even when medical students had accurate information about the biological and hereditary bases of obesity, they continued to hold negative stereotypes about fat people including the beliefs that fat people are lazy and lack self-control.

Wertz (in press) surveyed several cohort groups regarding the circumstances under which they would abort a fetus. She found that 29 percent of ethicists and 16 percent of the general public in the United States would abort a fetus if the potential child were known to have severe obesity. Twelve percent of parents of children with cystic fibrosis indicated that they
would abort a fetus if the potential child were known to have severe obesity. Sixteen percent of these parents would abort for moderate mental retardation.

Health consultant Dr. Dean Edell (1992) found that doctors routinely deny life-saving organ transplants to fat patients, claiming that it is difficult to perform surgery on fat bodies. Edell countered that fat people who did receive transplants had no more complications from surgery than thin patients and that the organ rejection rate and survival rate among fat patients was comparable to other transplant patients.

Studies also indicate significant prejudice against fat people among psychotherapists. Using photographs altered to make the same woman appear average weight, 20 percent over average or 40 percent over average, Young and Powell (1985) found that mental health professionals were more likely to ascribe negative attributes to the fattest group. Clinicians who were younger, female or of average weight were more likely to ascribe negative attributes than were clinicians who were older, male or more than average weight. The clients whose images were altered to appear 40 percent overweight were rated higher on agitation, impaired judgment, inadequate hygiene, hypochondriasis, obsessive-compulsive behavior and total psychological function than clients whose images appeared to be of normal weight.

Agell and Rothblum (1991) gave clinicians who were members of the American Psychological Association (APA) fictional case histories that mentioned gender and weight. These clinicians rated obese clients as more
unattractive and more embarrassed, but also as softer and kinder (fitting the "fat and jolly" stereotype, the authors posit) than clients described as normal weight. Abakoui (1998) questioned APA members about how they would treat a male or female, average weight or overweight client based on a case history that depicted the client as weight-dissatisfied. These psychologists were more likely to refer fat clients to a physician and rated the treatment prognosis for fat clients as worse than the prognosis for average weight clients. Although there did not appear to be significant differences in treatment planning for male or female clients, male psychologists were more likely to include decreased weight in their treatment planning than were female psychologists.

In summary, the results of these studies indicate that the stigma of obesity is pervasive and tenacious in its hold on the imaginations of individuals across the life span and among many populations, including health care professionals. The next segment will focus on social and cultural factors that maintain the stigma of obesity and the prejudicial attitudes that both result from and function to perpetuate the stigma.

How the Stigma of Obesity is Maintained

One can never be too rich or too thin. (Attributed variously to the Duchess of Windsor and to French fashion designer Coco Chanel)

The stigma of obesity is maintained and perpetuated by a complex interplay of forces including cultural beliefs, the influence of media, the diet industry and its ties to drug companies and academia, and political pressures that make it difficult for those who wish to embrace an emerging paradigm to do so. This segment will examine literature in these areas that illustrate why the traditional paradigm has remained in ascendancy for such an extended period and why, at the levels of individual action and collective imagination, it has been so difficult to move beyond.

**Cultural Beliefs, Political Pressures and the Influence of Media**

Throughout history there have been changing trends in what was considered beautiful or fashionable (Roberts, 1987; Seid (1989); Fraser (1997). Various body types and various presentations of body parts have been held as ideal. For women, large or small breasts, large or small hips, frail and thin, large and buxom bodies – all went in and out of fashion with the predictability of changing preferences for hairstyles, hats, corsets and bustles.

Seid (1989) provides a social historian’s analysis of these trends and permutations from the time of antiquity to the present. Trends in the idealized body were influenced and mediated by larger societal factors such as the economy, industrialization and women’s entry into the workplace as well as by the dictates of high fashion and personal preference.

For example, the experience of large numbers of peasant and working class populations who immigrated to this country at the turn of the 20th
century embodies the confluence of these factors. These immigrant women looked markedly different from the primarily English middle and upper classes who had already established themselves. The daughters of women who had faced deprivation and starvation seized upon the reducing diet as a way to assimilate, to conform, and to become marriageable (Roberts, 1987).

During the past century, fluctuations in trends concerning ideal body type have become fewer and the contours of the ideal have become more constrained. Seid (1989) points to 1950 as a nodal year when in the midst of post-war expansion, American women, some of whom had worked for the war effort, were called upon to become smaller by means of reducing diets. She considers the early 1950s the beginning of “the war on fat” (p. 103) a war that has continued to accelerate over the past half century.

While it is a relatively recent cultural phenomenon, the cult of thinness has a tenacious hold on the cultural imagination at present. Solovay, (1994) contends that the beauty ideal “no longer fluctuates naturally” because “our culture is now heavily influenced, if not controlled, by . . . the fashion industry, the cosmetics industry, and the diet industry” (pp. 27-29).

Fraser (1997) documented the sustained efforts of the diet industry and the propensity of the media to portray exceedingly thin women as glamorous. Fraser posits that these industries found fertile cultural ground in American Puritanism that views fatness as immoral. Taken together these efforts have resulted in what she terms the “inner corset” for women. Women have internalized cultural messages concerning body size to the extent that they
live constrained lives. Women who are dieting monitor each morsel of food for its potential effect on the waistline. Exercise is seen only in terms of contributing to weight loss. During a century when women have successfully overcome constraints in the areas of education and employment they continue to expend enormous energy in the service of staying within culturally proscribed boundaries regarding beauty and body size (Fraser, 1997, pp. 16-49).

Berger (1972) explored the objectification of women, with special attention to the male gaze via the mediated images of women’s bodies. As an art historian and critic, Berger distinguishes between being naked and being nude. “To be naked is to be oneself. To be nude is to be seen naked by others and not recognized for oneself” (p. 54). Berger maintains that the propensity to treat women as objects to be viewed and the tendency to paint women’s naked bodies as nudes, are far more common in western European and American art than in art of other cultures.

The phenomenon of paying excessive attention to appearance is comparable to what Wolf (1991) calls the Professional Beauty Qualification (PBQ). Wolf maintains that while beauty has always been a form of social currency, with women’s successful entry into the workplace, beauty “literally became money” (Wolf, 1991, p. 21). She contends that women work at jobs where they feel the need to work twice as hard as men in order to succeed. Many women return from work to a second shift of child care and housework. Wolf’s “third shift” consists of all the planning, worry and
money that women put towards responding to the pressures of the Professional Beauty Qualification.

Excessive attention to the creation and maintenance of beauty was also documented by Faludi (1991). Faludi chronicled negative societal reactions to women’s social and economic gains of the 1960s through the 1980s. She suggested that the backlash to the gains that women had made evidenced itself in a variety of ways including an increase in breast implants, liposuction, and other elective body altering surgeries.

Bordo (1993) employs the dual lenses of postructuralism and feminism to examine Western philosophical thought, media representations, of the female form and the phenomenon of eating disorders. Bordo asserts that “throughout Western religious and philosophical traditions, the capacity for self-management is decisively coded as male. By contrast, all those bodily spontaneities - hunger, sexuality, the emotions - seen as needful of containment and control have been culturally constructed and coded as female” (p. 206).

Brown (1985) asserts that the mere fact of a fat woman’s presence violates several prohibitions on women in a misogynist culture. In such a society, women are negated as subject and as agent and therefore not allowed to be powerful or visible. Women are not permitted to exert self-interested energy or command literal or metaphorical space. Fat women are regarded as larger than life and inherently threatening.
In a similar vein, Pipher (1994) interprets anorexia as cultural metaphor. She posits that when women starve themselves they are acquiescing to cultural expectations that women be thin and non-threatening. Pipher that the bodies of anorexic women signal the messages: “I will take up only a small amount of space. I won’t get in the way” and “I won’t be intimidating or threatening” (Pipher, 1994, p. 175).

Goodman (1995) contends that in a misogynist culture that deifies thinness, fat women serve as anti-role models for other women and as anti-status symbols for heterosexual men. In a fat-hating culture no one wants to be fat. The social costs of being fat are greater for women than for men. Thin women engender envy and admiration in others and confer status on lovers with whom they are associated. Fat women, however, are treated as failed sexual objects and represent anti-status/sex symbols for men.

Manheim (1999) documented the discrimination she experienced as a fat actress in theater school, as a stage actress and in the television and film industries. In her analysis of fat people on television and in films, Goodman (1995) found that fat characters are likely to be vilified. When fat characters are used as a vehicle for humor, the joke often leaves fat characters with compromised dignity and self-esteem. There are few positive roles for fat men and women on stage, on television or in films.

The swiftness with which these cultural messages are transmitted is illustrated by a study conducted with Fijian teenagers (Becker and Burwell, 1999). Fiji’s traditional culture has embraced generous body size as an
indication of health and prosperity. Signs of undereating are viewed with alarm and carry a culture-specific designation known as *macake*, or “going thin.” Prior to 1995, Fiji had no television signal. In 1998, just 38 months after just one television channel carrying American, British and Australian programs began to be broadcast on the island, the researchers found sharp increases in dissatisfaction with body image and eating disorders among Fijian teenage girls.

Between 1995 and 1998, the percentage of Fijian teenage girls who reported vomiting in order to lose weight increased by a factor of five. In the 1998 study three-quarters of the Fijian girls reported feeling too big or too fat in relation to female television characters. One respondent said in reference to the teenagers they saw on TV, “We want our bodies to become like that . . . so we try to lose a lot of weight.” Becker and Burwell note that Fijian teenage girls are 14 times more likely to have dieted than are older Fijan women.

Finally, Wolf (1991) offers commentary on the public nature of women’s bodies and the essentially political nature of weight gain, feared or actual:

“...[F]emale fat is the subject of public passion....” Furthermore, women and men understand that it is not about cholesterol or heart rate or the disruption of a line of tailoring, but about how much social freedom women are going to get away with or concede” (p. 187).

In summary, over the last century cultural beliefs, political pressures and media have influenced the interpretations of women’s body size. Historically there have been natural fluctuations in what was considered
ideal; the ideal no longer changes but is a static idealization of thinness. A culture in which the size of women’s bodies is proscribed and regulated results in women feeling that they must pay excessive attention to their appearance in order to succeed.

The Diet Industry and Its Ties to Physicians, Obesity Researchers, Pharmaceutical Companies and Academia

The diet industry and its affiliations with diet doctors, obesity researchers, the pharmaceutical industry and academia all contribute to the stigma of obesity. Conversely, the continued growth of these enterprises is dependent on the stigma of obesity being perpetuated and maintained.

Fraser (1997) offers a critical examination of what she regards as the highly profitable but ethically bankrupt diet industry. A white woman in her mid-thirties who is moderately fat, Fraser decided to “go undercover” and visit diet doctors, participate in weight-loss clinics and spas, and attend medical conferences on obesity. Her motivation was to experience first-hand the workings of this country’s 40 billion dollar per year diet industry. The 40 billion dollar figure is used by the Council on Size and Weight Discrimination in its 1999 educational materials.

In investigating the methods and messages behind many popular diets plans, Fraser found that only a small number offer sound nutritional advice and that many of the very low calorie plans primed dieters to gain back more than they had lost. She concluded that at best, such plans are costly in terms of wasted money and energy and at worst, harmful to the user’s health.
Among the diet plans Fraser places in the harmful category are those containing unspecified and unstandardized amounts of ephedrine, a heart stimulant; senna, a diuretic that in large dose can cause arrhythmia and electrolyte imbalance; and phenylpropanolamine (PPA), a stimulant used in diet pills that can significantly elevate blood pressure and lead to stroke. PPA has been banned from use in almost all developed countries. It has been removed from cold medicines in this country but continues to be sold over the counter in such products as Dexatrim and Acutrim.

In addition, Fraser interviewed Richard Simmons, Susan Powter and Dean Ornish. She attended Simmons’ exercise class and arranged to eat a meal with Powter and Ornish as part of her respective interviews with them. Fraser concluded that the underlying message common to each of these diet "gurus" is that dieting not only makes one a smaller person but also a better person. Simmons allowed as he does not think it possible for fat people to like themselves. Susan Powter equated weight loss with acquiring power, sexual and otherwise. "My motivation was not, and still isn’t, health," she told Fraser. "My motivation was to look better than my husband’s girlfriend." Fraser inquired of Ornish why someone like her, a healthy women with very low blood cholesterol who exercises and eats a vegetarian diet, should lose weight. He replied that there probably wasn’t good reason but added that had he titled his book "How to Help Heart Disease, Cancer and Osteoporosis" rather than Eat More, Weigh Less, it would not have been number one on the bestseller list.
Fraser examines the ways in which the complementary and profitable interrelationships between diet doctors, obesity researchers and the marketers of diet drugs and diet plans influence the American psyche and economy. First, Fraser asserts, the country’s 40 billion-dollar diet industry is maintained by diet doctors and obesity researchers with “thinking disorders” who lend their so-called expertise to weight loss programs and products. “Anorexics look in a mirror and see a fat person looking back. Obesity researchers look at research that shows diets don’t work and come to the conclusion that people should keep on dieting” (Fraser, 1997, p. 214). She contends that diet doctors and obesity researchers need to maintain these thinking disorders in order to preserve their lucrative ties to the diet industry.

Second, because diet and pharmaceutical companies fund nearly all obesity research, researchers who oppose dieting experience great difficulty in getting their research funded. Diet and pharmaceutical companies pay significant sums of money to people they identify as experts, underwrite the medical conferences they send these “experts” to, and pay for advertisements in the journals that publish their articles. Some of these same researchers sit on the boards of Weight Watchers™ and Jenny Craig™ and on the boards of medical journals where they assert their influence concerning which articles are accepted for publication.

An example of such conflict of interest involved American Home Products, the company whose subsidiary Wyeth-Ayerst manufactured and marketed the weight loss drug combination fenfluramine-dexfenfluramine
(Fondimin and Redux, known as fen-phen). Without disclosing that they were paid consultants to Wyeth-Ayerst, obesity researchers Gerald Faich and JoAnn Manson wrote an editorial for the August 1996 New England Journal of Medicine stating that the health risks posed by the drug were minor. In September 1997, Wyeth-Ayerst complied with the FDA request to withdraw the drug from the market following reports that many patients who took the drug had experienced valvular heart damage, primary pulmonary hypertension or brain neurotoxicity.

Finally, diet and pharmaceutical companies take advantage of government and university affiliations to shore up claims that fatness is unhealthy and that dieting is the cure. For example, former Surgeon General C. Everett Koop started Shape Up America! with contributions from more than 30 corporations, some of which gave more than one million dollars. The H.J. Heinz Company, which owns Weight Watchers™, was a major contributor to Koop’s endeavor and subsequently gave Koop the Heinz Award for his work in public health related to obesity. The award carried a personal gift of $250,000 (Solovay, 2000, p. 214).

Pharmaceutical companies often recruit university-affiliated researchers to endorse claims for particular products. For example, in order to create market demand for fen-phen, its manufacturer Wyeth-Ayerst Laboratories hired the European medical journal publisher Excerpta Medica to write ten articles promoting obesity treatment and the use of fen-phen. Wyeth-Ayerst paid Excerpta Medica $20,000 for each article. Without
informing obesity researchers of Wyeth-Ayerst's involvement, Excerpta Medica in turn hired university-affiliated researchers to do final editing and add their names to the articles. Some articles were withdrawn before publication when the components of fen-phen were removed from the market but others were published in peer-reviewed journals without disclosing the sources of funding or possible financial conflicts of interest. (Dallas Morning News, May 23, 1999).

Americans like to think of the National Institutes of Health (NIH) as offering objective reports based on balanced research and investigation. The panel that produced the report Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults (NIH, 1998) was chaired by Dr. Xavier Pi-Sunyer, an obesity researcher at St. Luke's/Roosevelt Hospital Center. Dr. Pi-Sunyer is the former executive director of the Weight Watchers™ Foundation and currently serves on its board of directors.

It is not difficult to understand why fat people and people who are so afraid of becoming fat that they binge and starve themselves are so vulnerable to the claims of weight loss doctors and diet programs. Joe McAvoy, a psychologist who is an eating disorders specialist and founder of the Association for the Health Enrichment of Large People (AHELP), calls the entanglement of doctors, researchers and funding corporations the "diet-pharmaceutical-industrial complex" (Fraser, 1997, p. 224). Kassirer and Angell (1998) call upon fellow physicians to resist joining what they term "the
medical campaign against obesity” and to instead “speak out against the public’s excessive infatuation with being thin and the extreme, expensive, and potentially dangerous measures taken to attain that goal” (p. 53).

**Prejudice and Discrimination Fostered by the Stigma of Obesity**

Because the stigma of obesity manifests so broadly, prejudice against fat people often goes unnoticed and unquestioned. When fat people are systematically excluded from positions of visibility, their absence is rarely noted. For example, airlines maintain strict weight limits on flight attendants. Fat actresses who are successful are the exception (Manheim, 1999). Corporations hire fat people to work behind the scenes but not in positions of visibility (Rothblum, 1987). In an atmosphere where fat prejudice is so pervasive, people in a position to practice discrimination often feel justified in doing so.

**Discrimination in Education, Employment and Health Care Settings**

In a survey of members of the National Association to Advance Fat Acceptance (NAAFA) regarding employment Rothblum (1987) found that more than 40 percent of men and 60 percent of women experienced job discrimination based on weight. The discrimination took a number of forms: interviews that focused on size or weight, harassment on the job, being told to lose weight, being passed over for promotion and denial of benefits. Comments from respondents included being told they would not be hired
because they did not fit the image of the organization and being asked not to sit on office furniture so it would not break. Rothblum found that the fattest of respondents held jobs with low prestige and experienced difficulties with self-confidence when applying for jobs or asking for a raise. Many sought jobs in telemarketing or writing from home in order to avoid uncomfortable social interactions. In all aspects of hiring and employment, there was a positive relationship between weight and incidents of discrimination.

It could be said that members of NAAFA, a social and political organization of fat people, would be more attuned to incidents of discrimination than other fat people. However, when Rothblum (1996) surveyed readers of Weight Watchers™ Magazine about discrimination on the job, the results were similar to those of the NAAFA survey. One third of respondents reported that supervisors had made negative comments about their size. Forty percent reported having been the target of jokes or harassment by co-workers. The severity of abuse was in direct relationship to weight category. Many had chosen telephone or self-employment as a way to avoid negative social interaction.

In his review of cases involving weight-based discrimination, Roehling (1999) found that fat people experience discrimination at every stage of the employment cycle including hiring, placement within a company, wages, promotion, discipline and termination. He also found that in studies where there is an interaction between gender and weight, fat women are evaluated more negatively than fat men. In studies that looked at wage
differences, Roehling found that mildly fat men actually earn more than their standard weight counterparts but that fat women earn far less in all weight categories than their male counterparts in the same weight categories (Roehling, 1999, pp. 982-985).

Packer (1990) and McAfee (1996) gathered extensive data on the discrimination experienced by fat women in their interactions with healthcare providers. Packer (1990) found that fat women were made to feel insulted and embarrassed by their interactions with doctors and that conditions they sought treatment for were downplayed or overlooked because of disproportionate concern about their weight. In her survey of fat women concerning their experiences with medical personnel, McAfee (1996) found that fat women are more likely than thin or average-weight women to experience serious complications, and in some cases die, from treatment that was postponed because women were told to "come back when they lost weight." Fat women were more likely to suffer harm from procedures that were improperly administered because of lack of knowledge on the part of the practitioner about how to administer treatment to large bodies.

Several studies have documented discrimination against fat students in educational settings. In 1994, the National Education Association (NEA) released a report on size discrimination in the schools. The Report on Discrimination Due to Physical Size found that "[F]or fat students, the school experience is one of ongoing prejudice, unnoticed discrimination, and almost constant harassment. From nursery school through college, fat students
experience ostracism, discouragement, and sometimes violence. Often ridiculed by their peers and discouraged by even well-meaning education employees, fat students develop low self-esteem and have limited horizons” (National Education Association, 1994).

The NEA’s conclusions are consistent with those of other studies. A survey of the membership of the National Association to Advance Fat Acceptance (Rothblum, 1989) showed that half of the 445 respondents reported being the objects of fat jokes and were called derisive names based on their weight during junior high and high school. Many reported being left out of social and dating situations and being ridiculed in gym class and sports settings. Twenty-three percent of the male respondents reported being physically assaulted or threatened with violence as a result of their size.

Crandall (1994) found that fat students are less likely to attend college even when they have competitive test scores and that fat women are more likely to pay their way through college than other men or women. Crandall concluded that even when parents are able to help with college expenses, they insist that fat daughters exhibit self-reliance and self-control. Rothblum (1990) found that fat students were more likely than their thin peers to be refused letters of recommendation from faculty.

A legal case that found its way to the U. S. Supreme Court illustrates how institutions of higher education can discriminate against fat students. At 18, Sharon Russell started Salve Regina College making her way on scholarships and school loans. After doing well in classes during the first year
she applied and was accepted into the nursing school. At the beginning of her second year, Russell was told she would not be allowed to begin the clinical rotation unless she lost weight. College administrators drew up a contract stating that she would lose two pounds per week to be verified by her presenting them a Weight Watchers™ weigh-in card. Russell was unable to keep to the terms of the contract and was dismissed from the college. When informal measures failed, she sued the college for discrimination, infliction of emotional damages, invasion of privacy and breach of contract. After several reversals Russell prevailed and was awarded tuition and other damages solely on the basis on breach of contract. (Regina College v. Russell (89-1929), 499 U.S.)

In summary, these studies indicate that the stigma of obesity and anti-fat prejudice evidence themselves in overt discrimination against fat people. The research showed that size discrimination occurs in educational settings at all levels. Fat adults also experience significant size discrimination in health care environments and in the workplace.

Legal Action Against the Parents of Fat Children

Anti-fat prejudice and discrimination extend to the parents of fat children. Two high-profile cases illustrate circumstances in which the courts were called upon to determine whether the parents of fat children were criminally negligent for their children’s fatness. These cases are described in detail because they constitute new legal territory and because they illustrate
two of the tenets of the traditional paradigm of size and weight: that fatness is volitional and mutable. In these cases it is the weight of a three year-old and a 13 year-old that are seen as mutable. The children’s weight is assumed to have resulted from volition on the part of the respective parents.

In 1997, Marlene Corrigan was charged with felony child abuse and endangerment in the death of her 13 year-old 680 pound daughter, Christina. In this well publicized case, it was never made clear whether the mother was being blamed for over feeding her daughter when she was young, “allowing” her daughter to gain weight as a teenager, or failing to keep her in school and engaged in social activities. Solovay (2000) contends that the facts that did emerge make it clear that Marlene Corrigan had sought help at every stage of her daughter’s life. The circumstances described here were made known during the trial.

When Christina was a baby, her mother took her to a clinic because she was having seizures. Christina was given Phenobarbital, a drug that depresses the central nervous system, with the result that it temporarily suppresses appetite but often leads to rapid weight gain when discontinued or when the body acclimates to the drug. The mother was then told to put Christina on a diet, an action that the endocrinologist who testified for the defense characterized as irresponsible on the part of the prescribing physician. This same endocrinologist testified that the high weights Christina reached at every point in her life were each indicative of severe metabolic abnormality and impossible to achieve by overeating alone.
Rather than refer Christina and her mother to an endocrinologist or geneticist, medical personnel at their health care plan insisted at every visit that Christina’s weight was due to overeating and consequently prescribed numerous weight-loss diets. The mother testified that she banned calorie-laden foods from the home, invested in numerous weight-loss programs, bought exercise tapes and encouraged her daughter at each of these endeavors. At the age of eight, Christina weighed 240 pounds. During those first eight years of her life, Christina had been to doctors’ offices nearly 100 times.

At the age of 12, Christina dropped out of school because she could not physically navigate the campus of the junior high school she would like to have attended, despite anticipating the continuation of verbal abuse to which she, like so many fat children, had been subjected since starting school. The court record affirms that the mother had notified the school well in advance of the anticipated date of Christina’s arrival at junior high that her daughter was unable to navigate either the several flights of stairs from the sidewalk to the main entrance or the stairs within the campus’ many buildings.

School officials told the mother that because obesity is not protected under ADA, they could not accommodate her daughter. When the mother inquired about home-schooling, she was told that she could hire a teacher privately but could not teach Christina herself as she was not certified. At the time Marlene Corrigan was single parent who was supporting two children and caring for elderly parents. Because she could neither afford to become
certified nor hire a private teacher, Marlene Corrigan bought grade-appropriate reading materials and workbooks and had Christina write reports on what she had read.

At the end of a trial that had taken on circus-like dimensions, Marlene Corrigan was found guilty of misdemeanor rather than felony negligence and was sentenced to probation and community service. *People v. Corrigan*, No. 161417-1, DA No. X 97 000238-6. Municipal Court of California, County of Contra Costa Bay Judicial District (July 15, 1997).

In a case similar to People vs. Corrigan, the parents of three-year old Anamarie Martinez-Regino had brought their daughter to the doctor numerous times because they were concerned about her unusually large size. The Martinez-Reginos maintained that they had followed closely all instructions from Dr. Monika Mahal, Anamarie’s pediatrician, and were bewildered when Dr. Mahal recommended that Anamarie be removed from their home in August 2000.

At three years old, Anamarie was three-and-a-half feet tall and weighed 120 pounds, which meant that she was 50 percent taller and three times heavier than the average child her age. Unlike the Corrigan trial, which was covered extensively by the media, the judge in the Martinez-Regino case imposed a gag order on all involved and the proceedings were conducted in private. Consequently, few details are available concerning what lead Dr. Mahal to believe that the parents were complicit in causing Anamarie’s unusual size or to issue her consequent recommendation that the child be
placed in the protection of the New Mexico Children, Youth and Families Department.

Anamarie was returned to her parents’ custody two months later with the judge stating that there would be no findings by the court as to the propriety of intervention by the state or concerning allegations of child abuse on the part of the parents (NAAFA Newsletter, December, 2000, pp. 1, 4).

What fat rights activists find most disturbing about these cases involving allegations of child abuse is that even when these parents sought help from medical practitioners concerning their child’s size, the parents were blamed for the child not losing weight. Doctors often use weight loss as the sole determinant of successful treatment of a fat adult. In these two cases involving children, the children’s failure to lose, or stop gaining, weight formed the basis for criminal charges against the parents. The assumption was made these parents were over feeding their children, something that Marlene Corrigan and the parents of Anamarie Martinez-Regino deny.

A number of people who have critically examined these two cases have offered the opinion that if anyone is to be seen as criminally liable, it would be the doctors who failed to refer these children to geneticists within the first year of life. Some fat activists have begun to question whether cases such as these have significantly increased the sense of culpability that many people have attached to parents of fat children. Having a fat child has long been regarded by many as representing failure on the part of parents. In the Corrigan and Martinez-Regino cases the emotional and legal stakes were
raised to a far higher level: having a fat child who did not lose weight brought allegations of child abuse for the Martinez-Reginos and Marlene Corrigan. (Personal conversations with members of the Council on Size and Weight Discrimination, October 2000 through February 2001.)

Solovay (2000) contends that such increased activity in the courts is a natural and predictable outcome of a culture that does not interrupt fat prejudice in many of its major institutions including schools, medical settings, work environments and even the courts themselves. To illustrate the last, she points to two cases where appeals courts failed to prohibit attorneys from preemptorily striking potential jurors based on their size (Solovay, 2000, pp. 92-96).

The Negative Sequelae of Stigma, Prejudice and Discrimination Against Fat People

It is not just so-called extra pounds which the fat woman is trying to lose when she submits to a diet; she is also trying to escape the extra emotional weight dumped on her back in the form of social condemnation. (W. Charisse Goodman, 1995)

If shame cured obesity, there wouldn’t be a fat woman in the world. (Susan Woolley, in Sternhell, 1985)

The effects of the stigma of obesity are far reaching and evidence themselves in a variety of ways. The fear of fatness is ubiquitous and people of all sizes experience the effects of the stigma of obesity at least indirectly. The emotional, financial and social costs associated with the quest for thinness have been documented. Eating disorders have reached epidemic
proportions in this country. Anorexia has the highest mortality rate of any psychiatric disorder (15 percent).

Szekely (1988) explored the psychological sequelae of eating disorders including dissociation and the loss of a sense of self. She concluded that “by dieting, starving, bingeing and purging a cleavage occurs between ‘body’ and ‘I’; women’s bodies become psychologically split, divided, dismembered – first from without, then from within” (1988, p. 139).

Pipher’s (1994) experience as a clinician confirms Szekely’s observations of dissociation among her clients:

In all the years I’ve been a therapist, I’ve yet to meet one girl who likes her body. Girls as skinny as chopsticks complain that their thighs are flabby or their stomachs puff out. And not only do girls dislike their bodies, they often loathe their fat. They have been culturally conditioned to hate their bodies, which after all are themselves (Pipher, 1988, p.139).

Many women turn to vigorous exercise as a means of weight control. (Lenskyj, 1993 and Lindeman, 1999) found that women who exercise compulsively are at risk for developing eating disorders, particularly bulimia and anorexia. Lenskyj notes the sad irony that after women finally won the right to engage in recreational and competitive sports, because of cultural pressures to be thin, many women found themselves emotionally enslaved to the physical activities they had fought hard to be part of.

In a culture that idealizes thinness, everyone experiences the stigma of obesity but only fat people experience unremitting prejudice and
discrimination. The research studies that follow document the emotional, social and economic costs of actually being fat.

Woolley and Garner (1991) observed that characteristics among fat women who lost large amounts of weight were similar to characteristics of women who had starved themselves at or below normal weight: high rates of binge eating, lowered caloric maintenance requirements, increased depression, impaired concentration, and preoccupation with food and weight. Tenzer (1989) found depression and lowered self-esteem among fat women who had dieted repeatedly.

As a result of experiencing fat bias and discrimination from health care practitioners many fat women, including nurses, do not seek needed medical care. In their study of hospital nurses Olson, Schumaker and Yawn (1994) found that overweight nurses delayed and sometimes avoided seeking medical care. Women in higher weight categories, compared to their lower weight counterparts, were more likely to report that they delayed medical care because they did not want to be subjected to a lecture or derogatory comments about their weight.

Goodman (1995) describes how fat people, like members of other outsider groups, fall into the "show me" trap of trying to prove over and over that they don't possess the negative qualities that are attributed to them. "Equal opportunity and simple decency are made contingent upon such proof" (Goodman, 1995, p. 21). In order to escape social condemnation, fat people subject themselves to all manner of diet programs, refuse to eat in
public, take weight loss drugs with dangerous side effects and, out of desperation, volunteer for gastric surgeries in order to lose weight.

Rand and McGregor (1991) interviewed patients who had undergone gastric restrictive surgery about whether or not they would have traded their former obesity for a different disability or condition. Gastric restrictive procedures entail abdominal surgery, the aftereffects of which include severe, unpredictable diarrhea, significant ongoing gastric distress and the necessity to carefully monitor which foods are ingested over the course of the patient’s lifetime.

Previous research indicated that people with disabilities tend to choose their own disability when presented with a range of theoretical choices. Respondents in previous studies explained that they reclaimed their own disability because they were familiar with it, had learned how to cope with it, and often felt that the other conditions presented were “worse” than their own. Rand and McGregor found the opposite effect with gastric surgery patients: none reclaimed obesity when paired with being deaf, dyslexic, diabetic or having heart disease. Only ten percent reclaimed obesity when paired with being blind and only eight percent reclaimed obesity when paired with having a leg amputated.

Crocker, Cornwell and Major (1993) studied the effects of positive and negative commentary from an attractive male on the affect and attributions of overweight college women. Overweight and average weight women did not differ significantly in the extent to which they attributed a positive
reaction to their weight but the overweight women were far more likely than their average weight peers to attribute a negative reaction to their weight. Among stigmatized groups, a self-protective measure that often accompanies such an attribution is the questioning of the motives or attitudes of the other person. These women attributed the negative reaction to their weight but did not question or blame the other person for his reaction.

Crandall (1994) interprets these findings as indicating that self-protective measures employed by other stigmatized groups are largely absent among fat people because they lack a positive incentive to identify with other fat people. They do not see identifying with other fat people as enhancing their self-image or self-esteem. Additionally, some may see themselves as able to leave the group through dieting and exercise.

The lack of incentive to identify with other fat people is demonstrated by a study linking fatness in adolescence with poverty in early adulthood, and by research indicating that the stigma of obesity causes fat people to be downwardly mobile.

Gortmaker, Must, Perrin, Sobol and Dietz (1993) surveyed a randomly selected group of 10,000 young people between the ages of 16 and 24 at baseline and again seven years later. They found that for the women in the group, being overweight in adolescence, more than having asthma or musculoskeletal deformities, was associated with less education and lowered family income in young adulthood. The women who had been overweight as adolescents had completed fewer years of schooling, were less likely to be
married, and had lower incomes and higher rates of poverty than women who had not been overweight. These effects were independent of aptitude test scores and the socioeconomic status of their family of origin.

These conclusions are consistent with Rothblum’s (1992) finding that rather than poverty causing obesity, obesity causes poverty. She posits that the widely held assumption that fat people get that way because they lack information about nutrition or the financial resources to eat well, simply isn’t true. After reviewing the results of studies concerning anti-fat bias, including her own work on employment discrimination, Rothblum concluded that “First one is obese, and because of the low prestige associated with obesity, one drifts into a lower social class” (Rothblum, 1992, pp. 66-67).

The stigma of obesity and fat prejudice manifest themselves in the actions of parents concerned that their child might become fat. McAfee (1983, writing as Mabel-Lois) describes being taken to diet doctors beginning at age four, being prescribed amphetamines for weight loss from the age of six and attempting suicide at age nine in order to escape feeling guilty about her weight. At 15, a diet resulted in the loss of “85 pounds, most of my friends, my resistance to disease, my entire nervous system and my personhood. I was thin, pretty and high as a kite all through ninth and tenth grades” (1983, pp. 62-63). McAfee describes her withdrawal from amphetamines as a harrowing experience involving severe depression. Two years later when she explained to a doctor that she had been addicted to diet pills, he
encouraged her to take them anyway stating that they would worry about her addiction after she lost weight.

McAfee survived her many years of food restriction and amphetamines and the severe depression that ensued. During the mid-1990s, a 15 year-old boy in Georgia, a 12 year-old boy in Florida and a 13 year-old girl in England committed suicide as a result of repeated and unrelenting verbal abuse (and in the case of the 15 year-old, repeated beatings) on the part of their classmates. Investigation into the deaths of these three young people brought to light not only how common such mistreatment is in school settings but also the extent to which teachers and other adults do nothing to interrupt the harassment to which fat children are routinely subjected.

Educators such as Aronson (1997) have questioned whether more could be done to prevent suicides such as these and what parents and teachers might do in order to interrupt harassment of fat children. In each of the above cases, the child had recently commented to parents and others that he or she could no longer tolerate the actions of classmates. Schools in which fat children are not protected from harassment based on their size could be seen as constituting environments where those children de facto receive an unequal education. Many fat students, rather than endure verbal abuse from peers, and in some cases, from teachers and coaches, have chosen to remain at home to be home-schooled or pursue the GED (Solovay, 2000).

In summary, fat people as a group have gone to extraordinary lengths to minimize or avoid the consequences of the stigma of obesity, anti-fat
prejudice and size discrimination. Fat people have attempted weight loss using low calorie diets, exercise programs, prescription weight loss drugs and gastric surgery. Fat women who diet repeatedly show impaired concentration, increased depression and lower self-esteem. After experiencing anti-fat prejudice in the medical profession fat nurses avoided necessary care. Parents of fat children have placed their children on diets, allowed doctors to administer amphetamines and had their children hospitalized because of their size. Some fat students have dropped out of school because of teasing, bullying and physical violence. Three suicides are known to have resulted from uninterrupted fat bias in schools.

Beginnings of Resistance to the Old Paradigm and Emergence of a New Paradigm Concerning Size and Weight

This section will include a description of the beginnings of what has become known as the fat acceptance movement and of the literature that has its foundations in that movement. The size acceptance movement and the literature it inspired represent the initial stirrings of resistance to the traditional paradigm, which held that fatness is mutable and volitional, that fat people eat more than thin people, that fatness results from out-of-control behaviors that should be mastered, and that fatness indicates physical and mental ill health. The tenets of the emerging paradigm are that size is an expression of human diversity, that fat people as a group eat no more than thin people, that repeated dieting exacerbates a tendency to gain weight and
that fat people can be as physically and mentally healthy as others in the population.

**The Fat Acceptance/Fat Liberation Movement**

What is known as the fat acceptance movement began with a group of fat people and their allies in the Los Angeles area during the late 1960s and early 1970s. This group, known as the Fat Underground, had learned much about community organizing, guerilla theatre and the strategic use of media resources from the Black and Chicano civil rights struggles and from the women's liberation movement. Their message was one of personal and social liberation from the dictates of the traditional paradigm concerning size and weight. The emphasis was on liberation rather than acceptance and the claiming of civil rights. While they did engage in educational efforts with other fat people they did not concern themselves with educating the public about the plight of fat people. In short, the Fat Underground did not ask for understanding or acceptance. They did not rely upon (and most likely did not have at their disposal) research on the physiological bases of obesity as evidence that fatness is not mutable or volitional. Their stance, rather, was one of claiming civil rights as a matter of human dignity and social justice (Largesse Press, 1994).

Some members of the Fat Underground went on to found the National Association to Aid Fat Americans (NAAFA) in 1969, a social, political and activist organization for fat people and their allies. NAAFA's name change
in 1989 to the National Association to Advance Fat Acceptance reflected a growing emphasis on public education in order to reduce fat prejudice and size discrimination. NAAFA now has regional chapters and several special interest groups including a Fat Feminist Caucus, a Fat Men’s Group and the Lesbian Fat Activist Network.

A number of other fat activist organizations have been established in order to serve the interests and needs of fat people and their allies. The Council on Size and Weight Discrimination (CSWD) provides information on all aspects of size discrimination including assistance to people facing employment discrimination. The CWSD also maintains a network of educators who do direct education in schools on issues pertaining to fat kids and provide materials to teachers who wish to include this information in their curriculum. Largesse: The Network for Size Esteem provides a variety in information concerning size acceptance issues. NOLOSE: National Organization for Lesbians of Size serves as a source of support and advocacy for fat lesbians. The International Size Acceptance Association acts as a clearinghouse for information on size activism across the globe.

Fat Culture and the Difficulty of Building Community Among Fat People

In the last fifteen to twenty years, the number of products and services available to fat people has increased markedly. There are now publications, websites, conferences, clothing outlets, support groups and a variety of organizations dedicated to the needs of fat people.
Wann (1998) contends, however, that these services and activities constitute a fat community of sorts but that this country or any other is far from having what could rightly be termed fat culture. She asserts that the hegemony of thinness has been with us for nearly one hundred years but that only recently have a very small percentage of fat people begun to resist this repression. Most fat people continue to participate in and support fat prejudice by living in “the fat closet” and “cling(ing) to the false hope of one day passing for thin . . . .” For most fat people, it is too difficult to overcome a culture of thinness. That culture’s underlying message is that being thin is better than being fat in every respect. Its implied promises are that everyone can become thin and that when fat people become thin, they will be happier.

Wann asserts that a true fat culture can come to fruition only when there is a critical mass of fat people willing to resist fat hatred. Only then can there evolve a common language with which fat people can “refuse our oppression” and celebrate all that is wonderful in a nascent fat culture. Then, like Jewish culture, black culture, queer culture and deaf culture, there will be a sense of coming home to a set of shared experiences and understandings that support pride and positive identity (Wann, 1998, pp. 121-122).

Wann’s position regarding fat culture is consonant with Crandall’s assertion that fat people could benefit from willing membership in a group in order to avoid self-rejection and taking on the negative values and actions of the dominant culture. Crandall cites by comparison Fanon’s work on the effects of colonization on the psyches of the colonized (Crandall, 1994, p. 891).
Fanon described the social constructs of colonization which result in subjugated peoples identifying with the dominant culture to the extent that they internalize the rules and values of that culture, including values that require them to engage in self-denigration and self-hatred (Fanon, 1968).

**Personal Stories of Transformation**

A number of fat women have documented their journeys of fat acceptance. The women’s stories that are encapsulated here are testimony to the extraordinary strength and courage required to resist the traditional paradigm that insists they must alter their bodies in order to be healthy, happy and successful. These women have begun instead to embrace an emerging paradigm concerning size and weight that allows for a diversity of body sizes and emphasizes healthful choices rather than weight loss.

Diane Ceja chronicled her struggle in coming to terms with inhabiting a large body as the daughter of a mother who took her to a diet doctor, encouraged participation in many weight loss programs and steered her toward a career as a dietician as a way to lose weight. In spite of Diane’s successful career as a dietician, writer, instructor, and counselor, her mother could focus only on her weight and questioned how she could be seen as credible in her field because she was fat. Diane describes her process of learning to accept herself and her efforts to parent her own daughter as “... a mother who supports rather than obstructs, who encourages rather than
limits, and loves her child for who she is rather than what I or others would like her to be” (Ceja, 1994, pp. 81-85).

“My memories of childhood are a blur of physicians and nutritionists, each pushing a different diet at me. Success was measured by the results of weekly weigh-ins.” So writes Beth MacInnis of her experiences in a family that focused enormous energy on her weight and size. When she was thirteen a psychiatrist had her hospitalized so she would lose weight. The desired weight loss did not result but the effects of that trauma remained. MacInnis’ transformation to a fat liberationist included her writing a feminist analysis of fat oppression. (MacInnis, 1993).

Wann (1998) attributes having grown up fat as contributing to her sense of independence and her developing communication skills. Her many accomplishments include two degrees from Stanford, world travel, an extensive social network, and an exercise routine that has resulted in very positive indicators of cardiovascular health. Still, she went out of her way to ensure people liked her despite her fatness, however, until a personal epiphany occasioned by her boyfriend telling her he was embarrassed to introduce her to friends and being refused insurance on the basis of her weight. The sense of outrage that ensued inspired her to start a magazine called Fat!So?. That magazine and the book of the same name that followed represent major contributions to the size acceptance movement (Wann, 1998, pp. 9-12).
Fat Acceptance Literature

A number of writers have focused on providing theoretical and practical information to people who wish to a) cease trying to lose weight and focus instead on accepting their size and shape and b) create and maintain lifestyle changes that support health. The authors reviewed below each acknowledge the difficulty of undertaking these goals in a culture that is unsupportive and often hostile.

Kano (1985) debunked the myths that fat people eat more than thin people, that being fat is unhealthy, and that dieting necessarily results in weight loss. Her focus was on overcoming eating disorders and on improving body image for women of all sizes. Importantly, Kano decoupled fatness from pathology in the realms of both physical and mental health.

Hutchinson (1985) acknowledges all the ways women have attempted to escape being regarded as only their bodies in a culture that overvalues the physical self: covering up with layers of clothing, attempting to become smaller by dieting and exercise, avoiding intimacy, holding back from nourishing oneself, or going outside the bounds by eating everything available. A practicing psychotherapist, Hutchinson draws upon her background in psychosynthesis as well as Zen Buddhism and the Feldenkrais Method of body awareness to produce exercises intended to mend the body/mind split and allow women to begin to accept their size and shape.
In her clinical practice Freedman (1988) saw many women mired in what she terms “body loathing” resulting from negative comments made by loved ones or from repeated failures to achieve weight loss by dieting. She posits that in order for a woman to begin to address her compulsive need to overeat, she must stop dieting. She calls upon women of all sizes to work on many levels: first, to be aware of the powerful messages of the media and diet industry and their role in fostering negative body image; second, to muster their personal resources to heal and reclaim their bodies; and third, to use their collective power to begin to reverse cultural trends.

Ornstein and Sobel (1989) warn against “the rise of healthism” (p. 13) and “medical terrorism” (p. 21). They encourage people to find out what gives them psychic, sensual and spiritual pleasure. Regarding food and eating, they stress the importance of knowing how to eat healthfully with indulging in the sort of deprivation that inevitably results in weight cycling.

Johnson (1995) explores the meanings and consequences of fatness in its many manifestations - personal, familial, social, economic and political. She maintains that rather than collapse under the pressure of prejudice and discrimination, fat women can work toward self-acceptance through self-care and by creating their own ideals of beauty.

As an antidote to the culture of dieting and constrained images of beauty, Fraser proposes the “anti-diet” plan (1997, pp. 285-296). Her plan includes learning how to eat in a way that is both free of guilt and supportive of physical health. Additionally, she proposes moderate, pleasurable exercise,
dressing in a way that complements the personality and paying attention to what the body needs in order to function well. Finally, Fraser encourages resistance to the culture of dieting by suggesting that women refrain from watching media or purchasing products from companies that promote extreme thinness, organizing against fat prejudice through national organizations and by putting size issues in the forefront of feminists agendas.

Common to each of these volumes is the conviction that steps can be taken to resist and counteract the cultural messages that require women to diet throughout their lives and to live in a state of emotional and physical deprivation. Variously, these authors propose action on the personal, social and cultural levels in order to transform individuals, institutions and cultural and political beliefs regarding the body, how it may be displayed and how it is to be nourished and cared for.

**Use of the Legal System by Fat People to Further Their Interests**

Publicity surrounding legal proceedings has often served to bring to public awareness incidents of prejudice and discrimination. Civil rights groups calling for equality based on race, gender and sexual orientation have utilized the courts to seek remedy for current injustices and build legal precedent upon which others may seek protection. Since the mid-1980s, an increasing number of lawsuits have been brought on behalf of clients who claimed they had been harmed by products or services intended to make
them lose weight and clients who alleged that they had experienced discrimination based on their size.

**Legal Action Against Manufacturers of Diet Drugs**

As of December 2000, there were more than 11,000 individual lawsuits, in addition to a class action suit in New Jersey, against manufacturers of the fen-phen combination brought on behalf on individuals who claim they were harmed by the drug. Complainants contend that their use of physician-prescribed weight loss drugs resulted in pulmonary hypertension, valvular heart disease and neurotoxicity of the brain. Five individuals in Mississippi who claimed that their use of fen-phen had brought about these medical conditions brought suit together against American Home Products and were awarded more than 30 million dollars each. A Texas jury awarded 36 year-old Debbie Lovett twenty-three million dollars in her suit in which she alleged that her use of fen/phen had seriously damaged her heart valves. A state law that caps monetary damages resulted in her receiving less than ten percent of that amount but signaled to the manufacturers and marketers of weight loss drugs that juries had made the connection between use of the drug and serious and irreversible medical problems (Fabrey, 2000, pp. 48-49).

Solovay (2000) expresses hope that that the legal action brought against diet drug manufacturers might serve as a caution for promoters of weight loss plans and even doctors who prescribe diets. She maintains that individual doctors who prescribe diets to their patients should be prepared to defend the
efficacy of those diets in court. Solovay contends that doctors need to refuse relationships with the manufacturers of diet drugs and instead advocate on behalf of fat patients by supporting efforts aimed at the attainment and maintenance of good health. Ideally doctors need to not only stop acting prejudicially but actually take the lead in educating the public in ending discrimination against fat people.

Legal Action in Cases Involving Employment Discrimination

During the 1990s, plaintiffs in weight-based employment discrimination cases began to seek protection under the Section 504 of the 1973 Rehabilitation Act and under the Americans with Disabilities Act. A number of plaintiffs have been successful in obtaining or winning back jobs they were denied or fired from on the basis of their weight. The two cases described below illustrate the principle upon which such cases turn, that is, perceived disability vs. actual disability. A discussion follows concerning the philosophical arguments surrounding the use of this tactic.

A federal appeals court judge upheld a jury's decision to award Bonnie Cook $100,000 in damages after the Rhode Island Department of Mental Health, Retardation and Hospitals refused to re-hire Cook as an attendant unless she lost weight. Cook had resigned two years earlier for personal reasons with an excellent work record. She did well in the interview but was denied the position on the basis of her weight after a pre-employment physical exam. Cook maintained that she was qualified and fully capable of
meeting the physical demands of the job. She sued under Section 504 of the Rehabilitation Act because she was perceived as having a disability by her would-be employer. Under Section 504, as under ADA, someone is defined as disabled if the person actually has a disability or if the person is regarded as having a disability that substantially limits one or more major life activities. (Solovay, 2000, pp. 139-145)

Dwayne Richardson passed the civil service exam for train operator for the New York City Transit Authority, but was denied the opportunity to demonstrate that he was physically able to do the job after being disqualified on the basis of his size. Following six years of legal action that failed to afford him access, Richardson sought help from the Council on Size Discrimination which alerted him to legal precedents including Cook v. Rhode Island. Cook’s successful action turned on her employer’s perceiving her to have a disability, despite her protestations to the contrary. Richardson acted as his own counsel at a meeting with Transit Authority executives and won the right to demonstrate he could do the job. He passed that test and now works as a train operator. (Information provided by Council on Size and Weight Discrimination, 2000.)

Should Fatness Be Construed as a Disability?

Furthermore, employment discrimination cases such as these bring to the fore the question of whether fatness can or should constitute disability. Many supporters of fat rights contend that fatness is not a disability and
legally should not be construed as such. They assert that fat people have
struggled to be regarded as normal and as being equally capable of performing
a variety of jobs, given the opportunity. Prejudicial attitudes and
discriminatory actions, particularly on the part of employers and the medical
establishment, are what disable fat people, not their fat bodies. Being regarded
as disabled would have a stigmatizing, rather than equalizing, effect.

Those who contend fatness should be able to be construed as a disability
regard protection offered under the Americans with Disabilities Act (ADA) as
the most expedient, and perhaps the only, solution to discrimination based
on size. They contend that the ADA offers the sole source of protection from
discrimination in a culture that condones fat bias. They contend that a
significant cultural shift in attitudes will not occur in the proximate future
and point to the sheltering effect of ADA as offering accommodation and
relief despite the origin of an individual's disability. For example, if a person
is unable to walk and uses a wheelchair, he or she is afforded accommodation
and protection from discrimination regardless of whether the reason for the
inability to walk results from a genetic defect, an auto accident, a recreational
climbing mishap or a suicide attempt. Proponents of fatness-as-possible-
disability regard ADA's willingness to offer protection regardless of the cause
of disability as obviating the arguments of those who regard fatness as
mutable or volitional.
Can Anti-Fat Bias Be Regarded as a Hate Crime?

Another legal direction is the potential for actions involving fat bias be regarded as hate crimes. As of this writing, the cities of Santa Cruz and San Francisco, California, the District of Columbia and the state of Michigan have in place statutes that forbid discrimination based on size. These statues were designed to protect the rights of fat people in areas such as education, employment, housing and business transactions and are being heralded as an important addition to the social and legal landscape against which discrimination issues are examined.

At this time, there are no laws constraining the actions of those who display malice or act in a violent manner toward fat people. Laws governing hate crimes, that is, hateful actions that arise out of prejudice and bigotry concerning race, gender or sexual orientation are slowly increasing in number. There is as yet no protection at federal, state or municipal level, for fat people who are similarly victimized. There are many including Solovay who contend that fat people need to be added as a category of persons protected from hateful actions based on their size because such actions are directed at fat people solely on the basis of who and what they are (Solovay, 2000).

Psychotherapy

This section will present literature from the field of psychotherapy. The section will begin with a review of literature by authors who embrace the
traditional paradigm concerning body size. A review of literature by authors whose work espouses an emerging paradigm follows.

**Traditional Paradigm Concerning Body Size**

The traditional paradigm regarding fatness and mental health maintained that fatness was an expression of psychopathology. Weight loss was regarded as an indication that the fat person could master his or her impulses to act out aggression against others or act in a self-destructive manner. Maintaining weight loss was seen as indicative of the fat person having developed insight into the problems that caused overweight. Fat people's emotional problems were regarded alternatively as stemming from their being fat or their fatness as resulting from their having emotional problems. Indications that a fat person was self-accepting were seen as a function of denial of health dangers associated with obesity and therefore as self-destructive.

For example, psychologist Irvin Yalom's (1989) reaction to watching a fat woman eat betrays his assumption that fat people eat more than others and are undeserving of treats such as ice cream.

> [W]hen I see a fat lady eat, I move down the ladder of human understanding. I want to tear the food away. To push her face into the ice cream. ‘Stop stuffing yourself! Haven’t you had enough, for Chrissakes?’ I’d like to wire her jaw shut. (pp. 88-89).

To his credit, Yalom displays his prejudices in the context of difficult situations in the therapeutic relationship he is attempting to come to terms
with. Unfortunately for fat women who may become his clients, his prejudice regarding fat women mirrors that of the larger society. Yalom describes his feelings toward fat women.

I have always been repulsed by fat women. I find them disgusting: their absurd sidewise waddle, their absence of body contour — breasts, laps, buttocks, shoulders, jawlines, cheekbones, everything. Everything I like to see in a woman, obscured in an avalanche of flesh . . . How dare they impose that body on the rest of us? (p. 88)

In another example Jungian analyst Marion Woodman (1980) maintains that the libido of a fat woman is focused on food to the near exclusion of all else and that the fat woman’s size represents her fear of sexuality and alienation from her true femininity. This alienation can progress to the point where fat women’s bodies betray them. Woodman relates a story about two former research subjects who died from “cancer of the female organs. [T]he obesity was a concomitant of their own inability to relate to their own femininity . . . [T]he unknown demon, which possessed them for a lifetime in their obesity, ultimately showed its true face in their cancer” (p. 57).

Even feminist therapist Susie Orbach (1978) fell prey to the assumption that fat women eat more than thin women and that fatness results solely from overeating. Her work in the area of eating disorders continues to be hailed as ground-breaking in that she encouraged compulsive eaters to give up dieting and focus instead on learning to eat in response to hunger rather than stress. She correctly identified eating disorders as a feminist issue but
erroneously equated fatness with eating disorders. She also confounded fear of fatness with the state of being fat.

Unfortunately, her interpretation of feminism influenced many mental health professionals, particularly women who considered themselves feminists.

Feminism argues that being fat represents an attempt to break free of society's stereotypes. Getting fat can thus be understood as a definite and purposeful act; is it a directed, conscious or unconscious, challenge to sex-role stereotyping and culturally defined experience of womanhood (Orbach, 1970, pp. 5-6).

If one substitutes the words "eating compulsively" or "eating disorders" for Orbach's "being fat" and "getting fat," her messages about the etiology and cultural context of eating disorders remains. Because fat women's presence may serve to represent unlawful acts of breaking free for other people, this phenomenon needs to be recognized as projection. Other people's projections are simply that. They do not reveal fat women's conscious or unconscious motivations, much less the complex interplay of factors that contribute to making an individual fat. Compulsive eating needs to be considered together with the constellation of physiological factor documented in research studies on the physiology of fatness that were reviewed at the beginning of this chapter.

Emerging Paradigm Concerning Body Size

A growing number of psychotherapists have begun to address the need to re-conceptualize issues pertaining to size and weight. As a result of
exposure to information concerning the biological bases of fatness and the health risks of weight cycling and on the basis of experience with their own clients, some therapists have decided to change the way they conduct therapy with clients of all sizes. These therapists have given special consideration to the way that fat women are viewed and the ways in which the needs of fat women might best be addressed in the therapeutic relationship.

After leading weight loss groups for several years, Chrisler (1989) began to regard the structure and methods employed by these groups as conflicting with her training as a feminist therapist. She concluded that feminist therapists should not engage in weight loss counseling because “taking on a client for weight loss counseling reinforces the cultural stereotypes and implies the therapist’s acceptance of the beauty and fitness cults” (Chrisler, 1989, p. 34).

Brown (1989) challenges other feminist therapists to examine their anti-fat biases. She found that “[M]any feminist therapists, when exposed to the concept of fat oppression, will quickly recognize it within themselves and resolve to change, yet still feel bound to its dictates” (Brown, 1989, p. 25). She recommended that until therapists engage in sufficient self-examination of their attitudes and behaviors concerning fat oppression, they refrain from seeing fat clients, asserting that it may be unethical to do so.

Woolley and Woolley questioned whether obesity should be treated at all (1984). They concluded that binge eating and depression were the results rather than the causes of obesity and that therapists’ singular attention to
weight loss often overlooked far more important issues. Woolley and Gardner (1991) recommend that therapists refrain from weight loss treatment altogether because “[I]t may provide patients with failure experiences, expose them to professionals who hold them in low regard . . . and divert their attention from other problems” (1991, p.1251).

Tenzer (1989) identified successive dieting as disordered eating and began to offer groups where fat women could find support for ceasing dieting and focus instead on healthy eating. Tenzer found that many group members were successful in moving away from blaming themselves for what they had been told was a lack of willpower and were able to make positive changes in terms of accessing medical care and establishing supportive relationships within and outside of the group.

Erdman (1995) emphasizes the importance of women seeking support for the major life change represented by the choice to cease dieting and the move toward acceptance. She proposes a model for starting and maintaining a support group for women who wish to undertake this difficult work. Breisch (dissertation in progress) proposes size acceptance as the appropriate model for therapy with fat women.

Collectively, the work of each of these mental health practitioners and theorists has begun to loosen the hold that the traditional paradigm of psychotherapy has held on the American imagination and psyche. Because women so often turn to counselors for help with problems, it is important that members of the counseling community have begun to re-conceptualize
the "problem" of fatness. The emerging paradigm regarding psychotherapy with fat women represents a shift from curing pathology and losing weight to emphasizing physical and mental health regardless of size.

Section Summary

This section presented a review of the literature on the psychological, social and cultural aspects of size. The section began with a description of the many ways in which the stigma of obesity manifests itself among children and adults and in educational, healthcare and employment venues. It was followed by an analysis of the cultural influences that maintain and perpetuate the stigma of obesity. The personal, financial, and social costs of the pursuit of thinness were explored, followed by an examination of systemic prejudice and discrimination against fat people.

The section concluded with a description of the elements of an emerging paradigm regarding size and weight. These elements include personal testimony concerning the effects of fat prejudice, the emergence of a fat culture, the successful use of the legal system to combat discrimination based on size, and on efforts to emphasize on physical and mental health regardless of weight.
CHAPTER III

METHODOLOGY

The first section of this chapter will describe the boundaries of the study, the choice of research methods and sampling strategy and working definitions concerning fatness. The second section will focus on the design of the study including selection of participants, development of the interview guide, data collection and data analysis.

Setting the Boundaries

The purposes of this section are to clearly identify the population of interest and to closely circumscribe the boundaries of the area of inquiry. The study is necessarily limited by its intended focus, by the level of engagement with participants demanded by the use of an in-depth phenomenological approach and by the choice of sampling strategy.

By design the present study focuses on women rather than men. Consistent with the observations of several researchers that the issues experienced by men and women concerning appearance and body size differ considerably (Wolf, 1991; Faludi, 1991), this study focuses on fat women, rather than fat men. The study will further focus on fat women's experiences as participants in the psychotherapeutic process. Finally, the study's design is circumscribed by the requirements that participants be at least thirty years old and engaged in the process of acceptance of self in relation to size and weight.
The objective in setting the lower age limit at 30 was to insure that a participant had sufficient life experience upon which to reflect and for the fact of her fatness to have been a reality for a significant amount of time. The decision to study women 30 years of age and older reflects the assumption, based on numerous conversations with fat women, that the experiences and expectations of younger fat women are qualitatively different enough to warrant their exclusion, at least for this time in political and cultural history.

**Research Methods**

The areas of investigation addressed by this project, namely issues faced by study participants, the process by which these women work toward acceptance of their size and weight, and their experiences in psychotherapy, are best explored by a study which is naturalistic and employs phenomenological interviewing. In order to examine and understand a) the process by which these women work toward an acceptance of their size and weight and b) the experiences of these women in psychotherapy, it is necessary to employ research methods appropriate to the task of eliciting detailed information about each participant's experience and the meaning she makes of that experience.

Phenomenology both as theoretical perspective and research paradigm proceeded from the perceived inadequacy of logical positivism to explore and explain human experience. Logical positivism provides the theoretical perspective that underlies methods to "test hypothetical-deductive
generalizations" (Patton, 1990, p. 37) employed primarily by the natural sciences. The positivist perspective holds that an \textit{a priori} theoretical hypothesis can be tested under replicable conditions by objective unbiased observers using quantifiable methods and that those observations are statistically generalizable to other similar subjects of inquiry (Taylor and Bogdan, 1984).

Several critics and theorists (Glaser and Strauss, 1967; Miles and Huberman, 1984; Marshall and Rossman, 1989) have commented on the inadequacy and inappropriateness of employing the tools of the positivist -- hypothesis, \textit{a priori} theorizing, deduction, quantifiable measures -- to describe the breadth and depth of human perception, motivation, experience and meaning-making. Deconstructionists and constructivists from several disciplines (Foucault, 1983; Irigaray, 1985; Hill-Collins, 1990) decry the notions of objectivity, the static data set, the unbiased observer. These critics of the positivist tradition hold that all knowledge is constructed from and colored by the subjective experience of both the observer and the observed and that necessary and continuous interactivity between the two negates "observer" and "observed" as distinct entities.

Lincoln and Guba (1985) contend that "[p]ositivism leads to an inadequate conceptualization of what science is" and "thoroughly confuses two aspects of inquiry that have often been called the 'context of discovery' and the 'context of justification'" (p. 25). In focusing almost exclusively on the latter, positivists knowingly or unwittingly excluded from study a vast
arena of worthy topics, the exploration of which would prove unwieldy for the proscribed confines of the statistically quantifiable.

**In-depth Phenomenological Interviewing**

In contrast, (Taylor and Bogdan, 1984; Patton, 1990; Gitlin, 1994) offer the theory and methods of phenomenological inquiry as typically more appropriate to the study of human experience. "The phenomenologist views human behavior, what people say and do, as a product of how people define their world" (Taylor and Bogdan, p. 9). Patton (1990) notes the ability of qualitative methods employed by phenomenological researchers to uncover "depth and detail" in individuals' experiences that can "take the reader into the setting that was observed" (p. 26).

Lincoln and Guba (1985) term as naturalistic and phenomenological research that uses the human as instrument, respects tacit knowledge and experience, makes use of qualitative methods and inductive data analysis, contributes grounded theory about the subject under consideration, allows the design of the study to emerge as it proceeds, and negotiates outcomes or findings with the study's participants (pp. 187-213). These considerations are further examined in the section on the design of the study.

A principal tool of phenomenological research is the interview. "Telling stories is essentially a meaning-making process" (Seidman, 1991). Interviewing allows people to tell their stories about the topic under consideration and enables the researcher to capture the nuances of meaning
an experience or set of experiences may hold for particular individuals. Gitlin (1994) and Rubin and Rubin (1995) emphasize the interactivity between researcher and participant that is possible with phenomenological interviewing. Gitlin (1994) comments on the idea of applying the notion of interactivity to a process that can be educative for both researcher and participants. Gitlin proposes "a dialogical process where participants negotiate meanings at the level of question posing, data collection, and analysis" (p. 185).

The rigors of in-depth phenomenological research, involving successive individual interviews followed by a focus group interview, necessitated limiting the number of participants. In addition to an initial telephone interview to insure that participants met design and availability criteria, the design called for each participant to be interviewed for a total of approximately five to six hours (two individual interviews that lasted from 90 minutes to two hours and one two-hour focus group interview). This schema represents an adaptation of Seidman's (1991) framework for in-depth interviewing of individuals and Vaughn, Schumm and Sinagub's (1996) use of the focus group interview.

The goal of the focus group interview, according to Vaughn, Schumm and Sinagub (1996) is to "create a candid, normal conversation that addresses, in depth, the selected topic"(p. 4). Focus groups are particularly well suited to conducting exploratory research when there is little previous research on a given topic (Vaughn, Schumm and Sinagub, 1996, p. 6) and are compatible
with the tenets of qualitative design in their ability to embrace multiple views of reality, support the inquirer/respondent relationship and recognition that truth is influenced by the perspective of the individual to a set of issues within a particular context (pp. 15-16). This last consideration, that of the nature of truth and the importance of context, has bearing on the notion of generalizability.

The goal is not to generalize to larger populations. Rather, the goal is to describe findings within a particular situation. Thus, with focus group interviews, the intent is not to elicit principles or tenets that can be extended to a wider population. The goals are to conduct an interactive discussion that can elicit a greater, more in-depth understanding . . . and to document the context from which those understandings were derived (p.16).

**Sampling Strategy**

Patton (1990) discusses two major sampling strategies: random and purposeful. A researcher chooses random sampling when he or she wishes to generalize from the findings of the study at hand, from the information gathered from those who actually participated in the study to a larger population of interest, using the methods of statistical reliability as parameters.

A researcher chooses purposeful sampling when he or she wishes to shift the focus of interest from generalizing to a larger population via statistics to understanding specific cases in great detail. The information gleaned from the purposeful sampling required by in-depth phenomenological interviewing has its own internal validity. (Lincoln and Guba, 1985) use the terms credibility and confirmability.) The methodology
that guides in-depth interviewing promotes validity by requiring that a series of interviews be conducted over a period of time, that the contextual placement of participants' words be carefully preserved, and that an individual's experience and comments be compared with those of other participants (Seidman, 1990). The findings generated by purposeful sampling are generalized (Lincoln and Guba term this transferability) when members of that population of interest describe and confirm experiences similar to those reported by study participants.

**Design of the Study**

This section will describe the design of the study including selection of participants, pilot activities and the development of the interview guide.

**Selection of Participants**

Participants for this study were located via three avenues: posters that described the study and invited appropriate and interested women to call for more information; referral by colleagues who were familiar with the proposed project; and an advertisement in *Radiance*, a national magazine dedicated to the interests of large women.

Criteria for participation in the study were as follows: women needed to be at least 30 years old; be fat (have a body mass index of 34 or greater); be engaged in the process of working toward accepting rather than changing her size and weight; and have been or currently be a client in psychotherapy.
Indicators that a potential participant was engaged in a process of self-acceptance regarding size and weight included, but were not limited to, her stating that she was doing so; her stating that she had stopped dieting because it diminished her health or caused her to repeatedly gain weight; her stating that she described herself as "fat" rather than as "overweight" or "obese" in a way that indicated a positive connotation of the word "fat"; or her identifying herself as a member of a support group or organization that promotes the rights of fat people. Participants who were currently in psychotherapy were asked to sign a statement verifying that they had discussed their potential involvement in the study with their therapist prior to participating in the first interview.

Initial responses from potential participants were followed by a telephone conversation during which the purpose and procedures to be followed in the study were fully explained and questions regarding possible participation were invited and addressed. During that telephone conversation, it was possible to insure that potential participants met the criteria listed above and to ask each participant about her particular demographic information regarding age, ethnic and racial identity, sexual orientation and class background. A goal of the study was to include women from a range of ages and of diverse racial and ethnic backgrounds and sexual orientations.

An unexpected development was the inclusion of three therapists as study participants. Each of these women had been sent posters that advertised
the study and were asked to post or distribute to clients or other women they thought might be interested. Each of the three therapists called to say that they themselves were interested and asked if it were possible to join the study as a participant. The addition of these women enriched the study in ways the researcher had not conceived during the proposal stage of the project. Like other participants, each related her unique experiences of living as a fat women in a fat-phobic culture. Because all three had been a client in therapy at some point, they could offer perspectives on psychotherapy from the vantage point of both client and therapist. Additionally, they were able to offer insight into the attitudes of fellow therapists regarding size and weight.

**Pilot Activities**

A number of pilot activities were carried out in preparation for developing the design of the study and the interview guide. Four women were interviewed individually: one fat heterosexual therapist, one fat lesbian minister/educator, one fat lesbian therapist and one thin lesbian therapist. Additionally, a focus group interview consisting of five fat women, all of whom identified as "fat," rather than "overweight" or "obese" and were active in size acceptance issues on both a personal and political basis for a number of years. Three of these women identify as heterosexual and two as lesbian.

The inclusion of these women's sexual orientations speaks to the parallels many in the fat acceptance movement see between the processes of
coming to terms with one's sexual orientation and the decision to accept, rather than change, one's body. A conscious decision was made, however, to exclude the term "coming out" from this study, so as not unduly lead participant's responses; to be respectful of the differences in coming to terms with sexual orientation and with body size; and to acknowledge the discomfort some gay men, lesbians and bisexuals have with a term they consider to have served its purpose but at this point in social and political history echoes too strongly the hidden or closeted aspects of gay experience.

Throughout each of these pilot activities, both the individual interviews and the focus group, participants were enthusiastic about the topics at hand and graciously forthcoming with information and anecdotes garnered from their own experience and that of women with whom they had worked. Each of these lively sessions contained moments of thoughtful seriousness and unfettered commentary as participants rose to the occasion of offering ideas and insights based on often poignant experience.

Through these preparatory, pilot activities the need for tools that would focus thought and discussion became evident. The experience of conducting these pilot interviews led to the development of the interview guide, an information sheet on efforts at weight loss and nodal events which lead to working toward acceptance, and a short description of each episode of therapy. All were sent to study participants prior to the first interview.
Development of the Interview Guide

To develop the interview guide, an extensive list of questions about the process of size acceptance and about fat women's experience in therapy was generated. Ideas for this initial list of questions derived from several sources: the review of literature conducted in preparation for comprehensive exams; participation in a support/study group for fat women; and the pilot activities conducted in preparation for designing this project.

The initial list of questions underwent several revisions during which questions were grouped and regrouped by topic and by theme. From this revised list, a subset of questions that emerged as most important, overarching or global was highlighted. The remaining questions were grouped as possible prompts under one of the more global questions. Finally, all questions were rearranged in an order designed to best support conversational flow during participant interviews.

All participants were asked the overarching questions. The secondary group of questions appeared under the overarching questions only on the interviewer's copy of the interview guide. The secondary questions were used as prompts for more information when appropriate during any particular interview, depending upon the participant's responses to the more global question. In order to test the usefulness of the interview guide as a research instrument, two individual interviews were conducted, one week apart, with a pilot participant.
Data Collection

Ten women, including the pilot participant, were interviewed for the study. The first two interviews were conducted with individual participants and lasted between ninety minutes and two hours. The first interview focused on each participant’s experience as a fat woman, on her decision to work toward acceptance of her size and weight, and on the meaning that process holds for her. The second interview focused on each participant’s experience as a client in psychotherapy; the interplay, if any, between her experience in therapy with her process of working toward acceptance of size and weight; and her perspective on what therapists need to know in order to work effectively with fat women as clients.

The third interview was a focus group interview, attended by five of the participants and lasting slightly more than two hours. Because it became clear that it would be impossible to discern, given the considerations of confidentiality, a) if any of the seven non-therapist participants had been previously or currently were clients of the therapist participants or b) in any of the therapist participants were clients of each other, the therapist participants were excluded from the group interview.

In preparation for the group interview, each participant was sent a group summary of the themes that emerged from individual interviews. This group summary was drawn up in synopsis form, without attribution to any one participant. Participants were asked to review the group summary
material and compare the themes and patterns described there with what emerged from her own interviews. The purpose of the focus group interview was to allow each participant the opportunity to compare and share her perspectives, experiences and process of working toward acceptance with other members of this highly selected group; to utilize the potential for a group to clarify and deepen the understanding of the issues under consideration; and to expand the resources, both emotional and material, available to any individual member.

Given the nature of open-ended, phenomenological interviewing where the focus is on the depth and breadth of an individual's experience, it was important to make the most of limited interview time. Toward that end, materials intended to focus recollection, elicit experience relevant to the purposes of the study and stimulate participants' narrative processes were mailed to participants prior to the relevant interview. Those materials are the time-line sheet regarding significant events regarding dieting/weight loss and the decision to work toward acceptance of size and weight (Appendix E); a brief description of experiences as a client in psychotherapy (Appendix F) and the interview guide (Appendix G).

In a letter accompanying these materials each participant was asked to focus on those questions which most represented her life experience. In order to be as inclusive as possible, the interview guide contained a question which asked the participant to speak about issues relevant to her experience that may have not been mentioned in the guide.
Receiving these materials in the mail prior to the interviews helped participants focus their thoughts on the issues at hand, thus acknowledging the necessary time constraints imposed by the interview format; and assisted in the processing of potentially emotionally evocative material, should participants need to do so, by providing time between receiving the materials and the scheduled interviews. In addition to providing this time for preparation and processing of information and emotions, participants' receiving materials before the interviews insured that there were no surprises during the interview process and gave each woman maximum control over deciding which questions she would focus on when asked to speak about her experience.

During the interviews, a reflective journal (Lincoln and Guba, 1985) was used to record salient words, ideas, themes or modes of expression. Significant aspects of non-verbal information contained in the interview including tone and tenor, body language, and any emotional charge elicited by particular questions were recorded as well as impressions of the physical surroundings with an eye toward how they might effect the interview process. Immediately following the interview, impressions of the interview itself were recorded. Any ideas or insights that emerged from this immediate and focused recollection were added to the notes taken during the interview.
Analysis of Data

Audio tapes of each interview were transcribed verbatim. A file was maintained for each participant containing notes from the initial telephone conversation, the completed consent form, data sheets on dieting and the process of working to an acceptance of size and weight, audio tapes of the interviews, transcriptions, field notes and all other relevant information.

Participants were sent a copy of the verbatim transcript for review. Each participant was asked to read for accuracy, add comments that she thought might clarify or enrich what was written, and delete any portion she felt she did not want to be a part of the interview record. On returned transcripts, participants offered minor clarifications but requested no deletions of material for privacy reasons.

Each transcript was read several times in order to become closely familiar with each participant’s story and develop an in-depth knowledge of the data. All transcriptions were photocopied in order to preserve the original document and maintain copies on which to write notes and highlight themes. The verbatim transcriptions were analyzed in order to draw out themes and issues relevant to the research questions as the participants had given voice to them in their own words.

Methods and procedures garnered from Rubin and Rubin (1995), Seidman (1991) and Vaughn, Schumm and Sinagub (1996) were employed to analyze data from individual interviews from the focus group interview. Necessarily, the process of developing categories for the coding and analysis of
data was highly interactive with issues and themes that emerged from the material. Themes and patterns as they emerged from individual interviews were coded as were connections between and among participants' stories. Technical difficulties resulting in episodic lapses in the recording of the group interview were compensated for by making use of notations made to an outline for that interview during the interview itself.

Role of the Researcher

Several writers have commented on the nature of objectivity and on the impossibility of eliminating bias from any research project (Spradley, 1980; Lincoln and Guba, 1985; Gitlin and Russell, 1994). Just as no research participant is a tabula rasa or empty vessel, no researcher can shed himself or herself of the life experience he or she brings to the task. Some theorists would argue in fact that it is precisely the depth of a researcher's knowledge and experiences that lends richness and provides a focus not otherwise available. Wirth (1949) proposed that "insight may be regarded as the core of social knowledge. It is arrived at by being on the inside of the phenomena to be observed . . . (Wirth, in Patton, 1990, p. 58). McCracken (1988) exhorted researchers to use "self as instrument" (p. 19) and to compare data to ones own experience, rather than to a theoretically objective standard.

My interest and involvement in the issues of fat women and in psychotherapy are significant. I was fat off and on during childhood. Before deciding to work toward acceptance of my weight and size, I had a lengthy
history of dieting and subsequent weight gain. My membership in a fat women's support group played a key role in coming to terms with what it means for a fat woman to accept rather than change her body. As a clinician, prior to the current study I had maintained a significant, if anecdotal, research interest in the issues and experiences fat women bring to therapy, as well as in the dynamics of the therapeutic process when either client or therapist, or both, are fat women.

Collectively these experiences have reinforced the importance of neither appropriating nor ascribing personal attributes to the experiences of other fat women. Utilizing the research methods described above, participants' issues, experiences, and perspectives are presented as accurately as possible using each participant's own words, her distinctive mode of expression, her sense of place and her individual capability to give voice to experience. Additionally, a system of member checks was built into the design of the study to insure that what was reported as the experience of any particular participant was done so accurately.

Following completion of individual interviews and after receiving comments and clarifications from each participant, the data was analyzed for emergent themes and salient issues. Each participant was asked to review the material concerning her individual interviews for accuracy, for clarification and for possible deletion of anything she may not wish to have included in the group summary. Prior to the group focus interview, each participant received a group summary, which served as the focus of the group interview.
Field notes recorded in a research journal maintained a record of interviews and their logistics as well as a detailed commentary on the "meta" considerations of the interview process: non-verbal communication, the tone and tenor of the interview, comments on the physical surroundings and possible connections between and among participants as the interviews proceeded.

Finally, the services of a peer debriefer (Lincoln and Guba, 1985, p. 308) were engaged. This peer debriefer was a disinterested party who ably played the role of devil's advocate and sounding board for processing the material contained in the interviews. She helped maintain focus on organizing the material, a focus that was invaluable when it was time to analyze themes, patterns and individual differences as they emerged from the data.

**Trustworthiness**

Lincoln and Guba (1985) contend that the trustworthiness of naturalistic inquiry can be assessed by the presence of components that contribute to its having "truth value," applicability to other contexts, consistency in terms of replication and neutrality (as opposed to objectivity) on the part of the inquirer (p. 290) as researcher. In order to insure trustworthiness in the present study, the following strategies were employed:

- Interviews were conducted using the guidelines of in-depth phenomenological interviewing which call for prolonged engagement with participants via persistent interviewing. Two lengthy in-depth
The individual interviews were spaced at least a week apart, thus promoting internal consistency of material. The group interview took place one month following the final individual interview.

- The research design was reflective, interactive and accommodating of new information as it emerged during the research process.

- A series of member checks was included to insure that the questions being asked incorporated participants' experience; that the analysis of themes reflected what participants said and meant to say during interviews; and that participants' responses to one set of interviews helped guide the process of the next.

- A focus group interview was incorporated into the design. Following the two individual interviews, participants were sent a summary of group themes and asked to comment on, clarify or amplify these themes during the group interview, thereby contributing to the credibility of the study.

- A plan was enacted for the continuous analysis of data both within a particular interview and among and between all interviews beginning during and after the pilot interview, and continuing interactively throughout all participant interviews.

- An audit trail was established and maintained, including initial forms, tapes, raw data, transcripts, analyses, summaries and the research journal.

- The participation of a peer debriefer was engaged to assist in acknowledging researcher bias, processing reactions to the material and remaining focused on the process of collecting and analyzing data.
CHAPTER IV
PRESENTATION OF THE DATA

The purpose of this chapter is to present the findings of in-depth interviews with ten women whose body mass index was at least 34, who self-described as fat, who identified as working toward acceptance of their size and weight, and who had been clients in psychotherapy either previous to or concurrent with their participation in the study.

The overarching questions that guided this research are: How do women who describe themselves as working toward acceptance of their size and weight reflect upon life experiences that relate to fatness; and what is the influence if any of psychotherapy on the process of working toward acceptance? Interview questions focused on participants' childhood and adult experiences relating to fatness, possible influences on the decision to work toward acceptance, and participants' reflections on their engagement in psychotherapy. The findings are organized in four areas: childhood and family of origin, adulthood and independence, the process of acceptance and experiences in therapy.

The first section presents themes from participant interviews concerning family of origin, including caregivers' attitude toward fatness, the role of food and eating, being "dieted" as a child, and the possible presence of positive adult models. The second section presents themes from participant interviews relating to adulthood and independence including the themes of
attempting weight loss, sexuality, relationships with partners and raising children. The third section presents themes relating to participants' process of working toward acceptance of size and weight, including factors that influenced that choice and meaning-making about personal and cultural issues. The fourth section describes themes relating to participants' engagement in psychotherapy, the possible influences of psychotherapy on participants' process of acceptance and participants' views on what therapists need to know and do in order to be helpful to clients who are fat women.

**Childhood and Family of Origin**

This section presents findings about participants' reflections on their families of origin and on childhood experiences that have influenced how they feel about themselves as fat adult women.

**Participants' Recollections of Being Labeled Fat as Children**

Nine of ten participants were either fat or told they were fat as children. One participant, Louise, was neither fat nor told she was fat. Of the nine others, only one, Celia, could point to an actual time in her childhood -- inactivity precipitated by a broken leg when she was eight -- when photographs indicate she indeed became "plump."

Significantly, eight of ten women in the study were told by caregivers that they were fat but when as adults these participants examined old family photographs, each discovered that she was not fat. Other adults who viewed
the photographs concurred with that observation. Of those eight participants, only one, Leigh, could name an actual age -- eight, when she was called a \textit{couchon} (pig) -- when she began to think of herself as fat. Seven participants could not remember a time when they did not think of themselves as fat, which they attributed to having been told they were fat for as long as they could remember.

Rita, Chloe and Ruth tell remarkably similar stories about being told they were fat.

\begin{quote}
I always thought I was fat because that's what I was always told. But when I look back at pictures, I look like a normal kid. I didn't look like a fat kid. (Rita)
\end{quote}

\begin{quote}
I don't ever remember not thinking I was fat. It's not like something I had some revelation about -- it's something I've always thought about myself. I think my mother told me I was fat from a really early age. (Chloe)
\end{quote}

\begin{quote}
I don't remember ever not (being told) I was fat. As I look back at family photographs of me from the time I was a year old until late into my teens, I look and say that's a very normal-sized girl. And yet, the programming I got and the response I got from the adults around me was that I was humongous and grotesque, and had to watch it or I was going to be even worse. My idea of myself was very definitely as fat and ugly, but when I look (at the photographs), I say there's a lovely young girl. (Ruth)
\end{quote}

Clare and Lilly connect being told they were fat to their caregivers' fear that their children might become fat.

\begin{quote}
I was always told I was fat but looking back at pictures, I see that I wasn't. I think my mother, and significant women in my family, would keep saying that to me more out of fear that I would become fat. (Clare)
\end{quote}

\begin{quote}
When I look back at pictures of myself at that time, I don't look fat at all. I walked around with this internalized self-concept that...
that I was fat and I felt very self-conscious. My concept of myself as fat was very ingrained. I have a lot of resentment and I'm feeling pretty angry about that. Because it seems so wrong. I think it was a false kind of image placed on me out of my mother's own anxiety of (my becoming) fat. (Lilly)

These reflections indicate a clear discrepancy between participants' actual body size as children and their perceptions and memories, which turned out to be inaccurate, of themselves as having been fat. Some participants attributed this discrepancy to caregivers' fear that their children would become fat.

Participants' Reflections on the Attitudes and Actions of Their Families of Origin

The nine participants who had been told they were fat as children described having their size regarded as uniformly negative. Fat was seen as unattractive, unhealthy and evidence that the child could not control her eating. Participants in the study described having food regulated or denied, made to feel that they were not acceptable unless they lost weight, and being told they would be undesirable as partners and employees when they became adults.

Two themes common to each of the women who had been told they were fat as children are: growing up in households where fatness was feared and denigrated; and being told that they would be undesirable as partners and employees.

My father has always been big but it was okay for a man to be big. His sisters were all big women and he hated them, so of course
they were all fat bitches. That's who they were. . . My mother was the one to tell me that if I wanted to get anywhere in life, if I wanted a decent life, if I wanted to get married, if I wanted kids, I had to be thin. . . . Nobody wants a fat secretary. Nobody wants a fat wife. . . I was never going to be happy and horrible things would happen. I heard that very young. (Rita)

My (adoptive) father was fat and it was a huge source of tension in my parents' relationship. The tension of it was so intense. (My mother) was always trying to control his food and telling him he was going to have a heart attack. A lot of that got deflected off onto me. People in the culture I grew up in were just incredibly, incredibly scared of fat. Everyone is in this country but these people really made a lifestyle out of it. Any hint that I was possibly heading in that direction (of being fat) needed to be taken care of immediately, and gotten under control. I was going to be like my father. I was afraid to use my body because I was always afraid I was going to have a heart attack. Now, how many five-year-olds have heart attacks? Not a lot. (Chloe)

The nine women who had been told they were fat as children all reported having their eating regulated, and in some cases, having food denied. Part of growing up in households where fat was feared involved parental self-regulation of food and regulation of children's food intake.

I look at never having any food in the house growing up, feeling always deprived of food. My mother was always trying to starve herself to be thin. (Clare)

My food intake was restricted all through my childhood. My natural setpoint never set in my early years. My food was doled out -- I didn't have a natural selection of food. When I was ten they started putting me on diets but even earlier it was like I was on a diet all the time because everything was controlled and measured out. (Emma)

I was five or six when (dieting) started -- all the way up until I left home at 19. That's a long time . . . When I was nine, my mother took me to a nutritionist who told me that (sweets) were made for active people . . . not for people like me. So from then
on, they were okay for the other kids but not for me. I wasn’t allowed. (Rita)

When I was 13 or 14, my mother suggested that I go on Metrical Diet and she started buying those little candies -- I think they were called Aides -- you were supposed to eat to suppress your appetite. (Lilly)

Several women spoke about puberty as being particularly difficult. This critical time was made all the more difficult as a result of their family’s negative attitudes and actions toward their size.

At 10 1/2 I started getting breasts and hips, earlier than the other girls. I was developing. It was (simply) the beginning of puberty. But I had internalized so much shame from my parents. They were shameful and I was shameful about what I looked like. (Emma)

It was difficult growing up and having comments made about (being) fat because it made me very self-conscious just going out, especially in the summertime if I wore a bathing suit. Not fearing the public comments but my own family’s comments. The last time I wore a bikini was in 7th grade and I was told I should not wear one anymore because it wasn’t attractive. I know I wasn’t overweight at that point. (Clare)

There’s this picture of me when I was 13. I was thin -- I had a flat stomach. I was wearing a half-shirt and a pair of shorts. This picture is really significant. I had scratched my face out because I hated myself so much. I thought I was fat, that I had this really fat face, but I wasn’t fat. (Leigh)

Clare and Lilly describe the interplay of being told they were fat with family members’ discomfort with their tomboy behavior and activities, spending more time with boys than with girls and dressing in a manner considered unfeminine.

I was never the pencil-thin girl. I was always solid, muscular. Where I view that as healthy, my parents view that as unhealthy
and fat. I was also a tomboy and always doing more boys' activities. I had boys for friends and dressed more the way a male would dress than a female. My parents would tell me, "You need to dress more femininely if you're going to be accepted." I always hated being very feminine. I felt very uncomfortable. (Clare)

I can remember when I started getting my period, when I was 11. My mother . . . wanted me to stop playing sports and stop playing with boys as much as I did. In fact, she forbade me to do it. I did it anyway and ended up getting in trouble for it. I was a tomboy for a long time and I was very comfortable in my body. I didn't necessarily want my body to be thin and frail looking. I played sports (and it didn't) serve me to look like I could just be pushed over . . . My mother really wanted to tell me what looked good and what didn't look good and she mostly wanted me to tow the line in terms of some prescribed feminine value. Which translated to thin. (Lilly)

Leigh speaks about the combined effects of poverty and family dynamics around food. In order to visit her husband during lengthy stays (spanning much of Leigh's childhood) in psychiatric hospitals, Leigh's mother would send the children to their grandparents. The grandfather Leigh alludes to is the same one who called her a couchon (pig) for eating what he perceived to be too much.

We grew up very poor. I remember always feeling like there was never going to be enough food because we grew up with so little. There was shame in getting USDA, the government food, and I never wanted to ask for anything. I always felt so ashamed that my body needed food. My grandfather would always say, "Don't eat that, you'll get fat." My grandmother would always make these really nutritious meals (but) she had all these strict guidelines about what you couldn't eat. I always remember feeling like I didn't want to eat at all. I just wanted to retreat and say I wasn't hungry. I didn't want to ask for anything. I was always ashamed to ask for more. (Leigh)
Rita recalls making the connection, as a child, between being told her size was within her control and feeling that she "wasn't good enough" by anyone's standards: her mother's, the nutritionist's or God's.

When my mother took me to the nutritionist, I remember looking at the weight on the chart where I was supposed to be and I was nowhere near there. I remember thinking I wasn't good enough. I didn't have enough self-control. I was greedy.

Even my experiences at church were very negative because of my weight. It was a very controlling church and I didn't have enough self-control. It wasn't a matter of God not caring what people look like -- in this church, God cared what we look like. God wants us all to be thin, size 8, preferably. (Rita)

Women in the study who were told they were fat as children described experiencing relentless scrutiny of their bodies and their food intake. In some cases, caregivers themselves were dieting or monitoring the food intake of other adults as well. These women were told as children that they were unattractive, that their size was within their control, and that as adults they would be undesirable as partners and employees.

**Participants' Recollections of Feeling Shamed and Blamed**

Each of the women in the study reported feeling negatively affected by the widely held belief that one's size is a conscious choice and merely a matter of self-control. If a person's weight is a matter of self-control, blame for fatness can be assigned to that person. Participants describe feeling blamed for their size and the shame they felt at being fat and being unable to change it.
Certainly growing up, feeling blamed was a daily issue and the way I would respond would be to feel real bad and to be terribly anxious and to cry a lot. (Ruth)

The primary way I felt about being fat was just shame... from at least kindergarten. That sense that I should hide myself or I shouldn't have a body. I felt like I wasn't good enough... and that I must be doing something wrong... my body was really, really bad, really ugly, and represented something bad about my character, some hideous flaw in who I was as a human being. Clearly the good people weren't fat. (Chloe)

Clare shares a similar sense of shame and blame and describes how it was confirmed by the annual ritual of shopping for back-to-school clothes. Clare is one of the participants who was told she was fat as a child but photographic evidence indicates otherwise.

(I remember) being ashamed of the way I looked and always feeling like what's wrong with me that I can't lose the weight. People (in my family) asking me why it didn't bother me that I was fat.

I remember trying on back-to-school clothes... My mother or my grandmother would say, "Well, we have to buy a bigger size now because you're fatter."

The natural growth and development of a child over summer was regarded as abnormal and within the child's control. For several women in the study, being told that their size was unattractive and undesirable caused them to feel shamed. Being told that their size was within their control caused them to feel blamed for not being able to control it. These feelings of shame and blame caused many to feeling essentially flawed and inadequate.
The "Protective Presence" of a Positive Role Model

Nine of ten women in the study characterized as negative the attitudes of their primary caretakers toward participants' size and weight. The tenth participant, Louise, was neither fat as a child nor told she was fat. Of the nine, three study participants described relationships with a family member other than parents as positive and supportive, and in some cases, life-changing.

Rita describes the support of one aunt in particular, her father's sister, who is a very large woman. Rita experienced her aunt as "classy" and "comfortable about her weight."

I remember one day when I was a teenager she was fitting me for a bra and we were talking about being large women. That’s when I thought that being big was a really classy thing. She seemed happy all the time and she seemed comfortable about her weight in a way that my mother who was thin, wasn’t. I never saw her dieting. She seemed a lot happier - that’s the way I wanted to be.

So I wanted to be more like her. I thought I had a conscious choice at that point to decide (my size) and if I had to decide, I didn’t want to look like my mother. I didn’t want to be a size 10, 120 pounds. I wanted to be the classic 250 pounds because (my aunt) seemed so happy. She had a husband who just adored her. I always saw them as loving and doting. They never had any arguments about her weight that I saw. I figured well, with all this horrible stuff that (my mother told me) was supposed to happen if you’re fat, I don’t see it happening to (my aunt).

Ruth describes the similar support of a grandmother who was, in many ways, her primary support and caretaker.

Now the flip side of that [treatment by her parents] is that I had a grandmother. At home, I wasn’t liked for being the size and shape I was. Grandma liked me. Grandma loved me. Grandma
was also soft and round and very much more -- well, she was what all of us would like to think of Grandma's as being. You know, soft and round and baked (laughing). Food was not fun except at Grandma's house. At Grandma's house, there were home-baked goods and there was good food. She clearly enjoyed cooking it and doing for her family and so there was this kind of split -- I learned early that my parents' house was not the way the world is, but it was the world I had to live in. I would MUCH rather be like her than the people I was born to. I sure look more like Grandma than the rest of them at this point ... I almost cannot remember a time when I was not wanting to be Grandma's daughter instead of my mother's.

Emma describes the support of an aunt and a grandmother, both large women who played important roles.

When I was ten, I started going to my grandmother's house for lunch (at the school lunchtime). She considered me a thin child. This was an immigrant Jewish family, of Eastern European origin, and a child who was a good eater was the kind of kid you wanted. My grandmother, who was a large woman and considered herself a great cook, took it upon herself, made it her mission, to fatten me up a little and get me to like food. She would have a spread for me, with several types of food. "Varieties," that was the word she would use in her Hungarian-Bronx accent. "Let's count how many varieties." One day we had twelve different foods. It was okay to eat at my grandmother's house. It's such a wonderful, comforting memory.

The two women who were most important in my life were larger size. My grandmother died when I was 11 so she wasn't there to temper my mother for my teenage years. My favorite aunt, Aunt Ruby, was the one who stood up for me when my mother would criticize me. My mother had no boundaries and would tell anybody anything. "She's so fat, she's so fat. She's on a diet, she's gotta lose weight. She'll never find a boyfriend." Aunt Ruby would say, "Leave her alone, she's beautiful, leave her alone." I was about a size 16, like her, and I was pretty and I know I looked nice. Even if I wasn't pretty, so what, you know?
Miller (1994) in her work on the continuing harmful effects of child abuse explores the importance of the "protective presence" of an adult who offers solace and shelter to a child who has experienced abusive treatment at the hands of family members. The experiences of the three women in the present study who recall such an adult echo the importance of that individual as a role model and as someone who could provide a "protective presence" in a familial climate of extraordinary emotional vulnerability.

This section focused on study participants' reflections of childhood experiences regarding size and weight. These reflections included the negative attitudes of their families of origin toward fatness; for some, being called fat when photographic evidence indicates otherwise; having food regulated and controlled; feeling shame at being told that their body size was unattractive and unacceptable; feeling blamed for not being able to control their size; and for some, the presence of a kind and protective adult.

**Adulthood and Independence**

This section presents themes from participant transcripts regarding issues these fat women faced as they came into adulthood and achieved independence. Their stories demonstrate how familial and cultural influences from childhood and adolescence continued to shape how they experienced themselves as fat women. They also describe the recapitulating effects of their encounters with size prejudice and discrimination as adults.
Continuing Effects of Family Members' Negative Attitudes on Current Relationships with Family of Origin

Eight of ten participants characterized current relationships with members of their families of origin as continuing to be problematic concerning size issues. In some cases, strained relationships persist despite participants' significant attempts to set appropriate boundaries and to work through long-standing difficulties.

Clare describes the continuing discomfort she experiences, even when nothing is said directly about her size or weight.

Whenever I'm with my family, nothing is said (about my weight) but the look is there sometimes and the unverbalized message is always there. So there's discomfort at just being who I am with them.

Lilly speaks about setting boundaries with her mother and sister. Her mother is able to respect those boundaries but her sister continues to remark on Lilly's size.

My relationship with both my mother and my sister have come to showdowns about this. I told them in no uncertain terms that (my weight) was unacceptable as a topic, that it was much too personal and that they really needed to stay out of it. I said to my mother that I felt that her relationship with me around my body size had been very damaging over the years and that I . . . wanted her to stop. And she did.

The last time my sister visited, she said something (about my weight) and I said, "You know, I get the impression that you somehow associate my weight or my size with whether or not I'm doing all right, whether or not I'm happy, and it really bothers me that you would think that whether I weigh what I weigh now or whether I weigh 50 pounds less or 50 pounds more is any indicator of my level of well-being in the world." She got pretty defensive. That was about a year ago.
Emma describes her parents' misattribution for a condition common to people who have diabetes. Her parents are in their late 80s. Her father is a retired physician.

Even to this day, the blame continues, the blaming me for my body that happened throughout my history with my parents. With diabetes, you get what they call a "diabetic mouth." I've been having some dental work done for it. My father and mother blame me for the dental work and say it's because of the candy bars I ate when I was 10 and 11.

Rita describes the continuing effects of what she terms elsewhere as abusive treatment when she was a child.

I'm not around my family that much. They made such a big deal (about my size) in my growing up years that I feel really separated from my family. It definitely gave me some very resentful feelings toward my mother . . . and it ruined our relationship totally . . . She wouldn't dare bring up (my size) to me now. She knows I would completely explode.

These participants comments underscore the powerfully negative effects of early mistreatment, and the strained relationships with some members of their families of origin that have resulted from negative childhood experiences.

Participants' Experiences of Prejudice and Discrimination Based on Size

Nine of the ten women in the study cited situations where they had experienced prejudice or discrimination based on their size. Participants described experiences involving prejudice or discrimination with health care
providers, with employers and potential employers, and in a variety of other circumstances.

**Health Care**

Emma describes health care practitioners' assumptions that she had eating problems and her efforts to find a "size-friendly" doctor.

For years, in my 20s and 30s, there was always the assumption by medical practitioners that I was eating of out of control. They never checked out my eating history. Whenever I'd go to the doctor, I'd be handed a diet. Or get weighed -- now I always question, "Why are you weighing me?"

I decided to shop around for a doctor and find one who was size-friendly. I called to interview this doctor -- I thought that was good, she was giving me her time. I told her where I was (on size issues) and asked her where she was. She seemed to be a size-friendly doctor. She said she had read some of the literature I would like her to have read to educate herself on the subject and she seemed to understand about setpoint theory.

She became my primary care physician and everything was fine until my cholesterol went up a bit. She said, "You could take cholesterol medication, and the good part of it is, a side effect is losing weight." It was as if I had never talked to her. I know that the doctors I see will "yes" me about my politics, but then I'll hear that a good friend of mine seeing the same doctor is being put on Fen-Phen or Redux or encouraged to diet.

Rita talks about a recent pregnancy and the assumptions that are made about her health based on her weight.

Usually the expectation with healthcare providers is that I'm overweight so I must have blood pressure problems and cholesterol problems and all this other stuff. And then when it's discovered that I don't, they look at me differently. Especially with this last pregnancy -- I just gave birth a month ago. The male doctor I had was letting me know that if I didn't watch my weight gain during the pregnancy I could have a heart attack during delivery or I could have a stroke. I felt like he was trying
to scare me. None of it happened. I didn't have an elevated blood pressure, I didn't have diabetes, I didn't have any of the stuff that he talked about. And I had a very normal delivery and a very normal baby, so I think that they just don't know, and they blame me. You know, let's lay on the guilt on the fat women and blame them.

I ended up seeing a woman in the practice and she was a lot more open-minded. I'm not going to say they told me to go ahead and gain as much weight as I wanted. They didn't say that. But I think at some point they realized that okay, this is how her pregnancy is going, so let's ease up off of the weight issue. I think that health care workers in general still don't have a clue about fat women's bodies. Once they realize you're educated, then they realize they can't say too much because they don't want to be sued.

Mariah describes her experiences with doctors who equate health with thinness, having doctors attribute workplace injuries to her weight, and recent encounters with healthcare practitioners she has seen for help with multiple sclerosis.

All my life doctors wanted me to lose weight, so I would look prettier and I would be healthier. It's just this automatic assumption that if you're healthy, you're thin. As I got older and started dealing with more doctors and going to gynecologists, it just got to be more disgusting — how that was the criteria for health, whether or not you were thin. And I would feel, "But I'm so healthy, how can you say this about me if I'm healthy?" And at times when I haven't been healthy, they would put so much off on my being fat. It was just appalling. One time I had a knee that kept swelling and another time a shoulder that kept swelling, both from work on production lines. I would go in to (the doctor) to ask about it and they would say to me, if you would just lose weight, that problem would go away. I don't think my weight had anything to do with the fact that my shoulder was killing me. I think it had to do with repetitive motion problems on freaking line work.

A holistic practitioner did a guided meditation with me to look at what the weight was so I could take the weight off... One of the theories holistic practitioners have is that because people
with MS can't digest saturated fats, we should have all the fats off our body because fat holds in heat (that isn't good for the MS). But the way they look at it is wrong. Heat is produced by hormones. They look at it as fat equals fat equals fat. They assume that because I have fat on my body that I'm hot. I'm not hot. I'm cold all the time. My MS doctor doesn't care about weight. He's fat himself \. He just said I want you to eat healthy.

Chloe describes her difficulty in seeking health care based on past experience, her unfortunate interaction with a feminist health center, and a curious experience with an eye doctor.

I have been very afraid to go to the doctor because of my size, because doctors played so much a part in my dieting history. So, I haven't experienced a lot of discrimination at the doctor's, mostly because I haven't gone because I've been afraid. When I started going again, I made damn well certain that I was going to people who were okay with my size and weren't going to give me shit about it, because I couldn't handle it. I was really clear with people up front. If you give me shit about my weight, I will not get the health care I need. I don't care if you think I'm going to die tomorrow of obesity or whatever. Just don't go there.

I remember one time I called a feminist health care facility. I was going to go for the first time in years, and what I wanted to do was to meet the doctor before I actually had the appointment, to get to know this person and see if I wanted to go ahead with it. They wouldn't do it. I wrote them a letter saying I hadn't been to the doctor in five years, that I'm a fat woman and that I reached out to a feminist center because I thought they would understand that some people are not getting the health care they need because of the shitty treatment they've gotten. You've just set me back and who knows when I'm actually going to (get to a doctor) now. They never responded at all. I can't believe I went to the doctor at all after that.

When I went last year to get new glasses, I asked the eye doctor if were any eye exercises that he might recommend. He said, "Oh no, but I might suggest some exercise for your weight." How did that conversation happen? It was ridiculous. Ridiculous. I said, "Well, you know, I exercise four times a week, and I don't really
know how (my weight) is relevant to my eyes." He didn't say anything.

Clare maintains that doctors have a difficult time knowing how to treat fat people and describes her response to a doctor's suggestion that she go on a particular diet.

My feeling is that (doctors) have no clue as to what possibly could be going on with fat people. The doctors I saw were very thin and I thought, possibly had a prejudice towards being overweight. Maybe that's why they went into the profession they're in -- they were gonna save all the fat people. Recently my psychiatrist suggested I go on a particular diet that she said worked for her. I basically told her it was another fad diet in my opinion and that unless I see some definitive research that proves something beneficial, I'd just as soon not try it. I really believe that they're unhealthy -- diets. And I've come to believe that just because someone's a professional, it doesn't mean they know what they're talking about. I really have to do what I think is best for me.

Ruth describes how her behavior at the doctor's office has changed and how that has contributed to successfully changing the tenor and balance of her interactions with health care providers.

You know what I've learned? That sometimes (the difficult interactions) had a lot to do with me . . . Which is not to say that it was my fault that those interactions went the way they did, but I think there's a co-evolution (with doctor and patient) that has to do with the culture surrounding these transactions. I think fat people could learn that they have more to say about what happens than maybe they think they do.

For example, every time you go to the doctor they'd (tell me) to get on the scale. I'd get on the scale. Then, depending on who the new nurse or whoever was, somebody would go, "Tsk, tsk, tsk." Since I got more confident, I say, "I don't do scales." It's just amazing. I don't have to deal with that anymore. The more clear I've become and the more matter-of-fact I've become, the strange dynamic (has changed) around this whole issue. I go in
without worry. So, when physicians say to me, "You know, you're really carrying too much weight." I'm able to say, "Yeah, I know. And furthermore, I'm 50 years old and I know all about this and you really don't have to talk about it. I know the plusses and I know the health risks and I've done everything I know how to do. Now my choice is not to worry about that anymore and focus instead on all the other ways I can be healthy." The whole (tension) just evaporates.

Employment

Four participants described prejudice or discrimination based on weight or size in the employment arena, including instances of not being hired, being discriminated against while employed, and having fears of being discriminated against in the profession for which one was training be confirmed by someone already practicing in that field.

Rita describes being denied employment because of her weight, and not contesting it. She compares her reaction then to what she feels she would do if the incident happened now. Rita is clear that had the denial of employment been based on race, she would have contested it but that she felt there was no recourse for discrimination based on size. It is important to note that at present, only one state, Michigan, has a statute that prohibits discrimination based on size.

There was one job about nine years ago where I was flat out refused right in my face. They told me I was over their weight limit. This was a private duty nursing job. I thought they were talking about the amount of weight I could lift. And then the manager told me no, you're over our weight limit. Not anything about my skills or what I could do. At the time I kept thinking I should do something about that but then I kept thinking it wasn't serious enough. If they had done that based on my race, there would be some validation for doing something. For some reason I thought that, okay, all right, this
is the way it is. I really thought they could do this. It was kind of
the period at the end of the sentence of the stuff I heard growing
up: if you want to keep your career, you’d better be thin. If it
happened now, I’d be very graceful and very nice and then I
would proceed to do something about it. Definitely. At that
point then I really didn’t think there was very much I could do
about it.

Leigh talks about being treated differently by employers during her 25
years in the restaurant business, and about not going into the hairdressing
business after training for five years. She describes an assumption she feels is
made by potential employers, linking fatness to ones ability to control oneself.

I was in the restaurant business for 25 years, waitressing. I was
one of the fastest waitresses there but because I was fat I’d get put
out back a lot, where the tips weren’t as good. . . . There was a
point in time that I wanted to be a hairdresser. I worked with a
guy for five years and he taught me everything. And then he
said, "No one’s gonna hire you because you’re fat." It didn’t
matter whether I had skill or anything, it mattered what I looked
like. Which is why I didn’t go into hairdressing.

If you go for a job interview, people look at you and say, oh
you’re fat. If you’re not in control of your weight, you must not
be in control in any other aspect of your life.

Mariah describes situations where her size was an issue in the
workplace, in secretarial positions when she was younger, and more recently,
in fitness and health care positions. She explores the idea that fat people stay
in a job because they fear not getting another.

Before I was self-employed, being hired or fired had to do a lot
with my weight. At one point I overheard one of my friends
saying, oh I always hire fat people because they’re loyal. And I
thought, well to some degree that’s true, that we’re loyal because
we might not get any other jobs. So if the job treats you well
enough, you might want to just stay there because people are not
interested in hiring you when you’re fat.
When I was doing secretarial work there were times I didn't get the job because of the way I looked. I did not fit the bill for who would be at the front desk, the receptionist/secretary person. I just knew I didn't look right for them. Bank teller jobs -- my looks did not get me into bank teller jobs.

When I was 18, I did have a job as the front secretary and receptionist for an oil company and I gained weight there. I overheard them talking one day about the pretty face and too bad she doesn't lose some weight. They didn't kick me out of the job or anything, but I felt the pressure that I knew at some point, if the office got bigger, and more customers started to come in, I could be in trouble. I felt lucky that it was an oil company and not many people came in there.

If I wasn't self-employed in my work as a fitness and health care consultant, I would not be hired. I know I'm not hired for (an expensive spa) because of my size. Because (that spa) has invited all the lesser teachers, lesser in terms of less knowledge and years in practice. They've invited (a very thin woman with far less experience) again and again to train people because her look is right. I know I was also bypassed for going to Santa Fe when there was a (specific exercise program) convention and one of us got to go. It was not me, because I didn't fit the look. It was very insulting because I have so much knowledge and capacity. People were always shocked when they would see me exercising, and some would say, wow, you're so strong. They'd be shocked I could do all these things that they couldn't do because they assume only thin people can do them. I love blowing all the stereotypes, but after awhile it hurts a lot to watch people go past me and get a lot of the treats and the goodies of their career based solely on their size.

Lilly, who works as a psychotherapist, relates a story about being afraid she might not be hired in an academic environment because of her size combined with her looking lesbian, and having her concern about size confirmed by a practicing professional in her field.

There was a point where I decided I wanted to see a male therapist and I wanted to see a Ph.D. because that was my goal, to be a Ph.D., and I wanted to talk to somebody who was in that
One of the feelings I had was that I might be discriminated against for jobs because of my size. At work I was noticing that other therapists were making the kind of comments that therapists make in clinical meetings about people who are overweight. I was beginning to feel more and more the potential for discrimination, that if I wanted to be in the academy, that I would probably get passed over because of how I looked.

At the time I was dressing in a way that gave away my sexual preference. The fact of my weight in addition to my sexual preference made me feel there was a tremendous likelihood that I would get passed over for jobs because people would think my size was some sort of indicator of some deeper psychological problem. I discussed this with my therapist, who said he thought I was right, that that could happen, that he didn't agree with it personally but that a lot of people did think like that. He thought that people often got passed over for tenure track positions on the basis of how they look and that certainly people who are overweight have a lot more trouble looking as good as people who are not.

Prejudice in Situations Other Than Health Care and Employment

In addition to the health care and employment arenas, participants cited instances of prejudice and discrimination in other areas.

Rita describes the difficulty she encounters simply going for a walk.

I find going for a walk difficult. I always find that young guys will yell something out of a car or truck as they're passing by. The most I can do is ignore it, because it's usually a fleeting comment. They always say it as they're leaving.

Leigh speaks to the effect on her self esteem of trying to fit into student chairs at her community college. Leigh returned to school at age 38 and thus far has a 4.0 grade point average. She also shares a story about the sense of violation she felt at receiving anonymous mail.
I got a real dose of self hatred this January when I went back after the Christmas break and tried to fit into one of those desks. I could barely fit into it and I just wanted to leave the class. It's very uncomfortable for me. It's a Women in History course and I love the class but it's really hard for me to sit in that desk for an hour and 50 minutes and pay attention. I sit in the back because I don't want people focusing on the way I look.

Somebody sent me something in the mail for a new diet drug and wrote across the top, "Leigh, this would really help you." I was so angry that they didn't have the nerve to write their name on it — no return address, nothing. But they knew who I was. I felt so violated. The next day I was looking at people thinking, was it you, was it you? It was horrible.

Ruth describes situations where it was assumed she eats more than other people.

With all the various diets and eating plans I (was) on, the assumption by the leader would always be that I was eating too much. And then they'd be shocked to find that often my daily intake was under 1,000 calories, which it continues to be. My daughter's experience has been very affirming for me. When she was worried about her weight a couple of times, we went to the pediatrician or nutritionist to quiet that. After looking at her diet and her exercise, they would say she must have the slowest metabolism in the world. Neither of us has a thyroid problem but it's just plain true that neither of us eats a whole lot. . . I've had it happen where people who are new in my life, as they get to know me, are surprised at how little I eat. Which means that they were assuming something else.

Emma relates a story about an interaction where it was assumed by a woman in a left-of-center political group, where tolerance of all individuals is purportedly greater, that fat people deserve no sweets.

I was active in the political left. There was a woman, very active in women's studies in the area, who came up to me during a women's caucus meeting a of our Marxist Leninist group. She had found a box of Sara Lee cake in my apartment, picked it up and said to me, like I was a little child, "Do you know that if you
stop buying food like this you wouldn't have a problem with food and weight?"

If it happened today, I would probably say, "Hey, I know you don't mean to be intrusive but this is really violating my boundaries and you are making a lot of assumptions." Back then, I knew what she said wasn't true but I was stunned and went numb and I felt very shameful.

Mariah speaks about the lack of appropriate boundaries she has experienced in the grocery store, and in other public places. She relates a story about inappropriate comments and behavior on the part of a trusted teacher and mentor.

It's really astonishing to me the boundary that people feel doesn't exist when you're fat. In restaurants you can feel the waitress or whoever serves the food making judgments. In grocery stores, I've actually had people make comments about the food in my cart. I want to say what gives you the right. I think it's somehow attached to the idea of intelligence, that if we're fat, we're stupid or have mental health problems and that gives them the right (to violate) that boundary.

If I take up too much room on the bus or plane or anywhere, I can feel (the disapproval) coming off people. How they look at me, make me feel like I'm not supposed to take up this much space, this much room in the world. If you bump into somebody and you're fat, it's like "Oh, how dare you!" It's almost as if they might catch it, like it's some kind of illness.

My Shiatsu teacher was on me all the time. It was horrible. She thought my health could not be good unless I was really thin. (She would say) I didn't look good and men wouldn't want me unless (I was) thin. The times I did lose weight, she would say things like, "When I walk behind you now, that's a really nice view of you." It felt so abusive, really emotionally abusive for somebody who was my teacher, mentor and healer to be constantly badgering me... She wanted me to move to her place so she could control how much I ate.
Participants' Recollections of Being Rewarded for Weight Loss

Eight of ten participants told of being applauded and rewarded for dieting and weight loss, by family members and others close to them. As a result of a cultural overemphasis on thinness as the preferred body type and the tendency to equate thinness with physical and mental health, interviewees recalled the ways in which they were praised for dieting and for losing weight.

Celia speaks about her mother and sister dieting, their encouraging her to do the same, and being rewarded for losing weight.

My mother and my sister, who's five years older than I, were always doing some diet or another, usually Weight Watchers. They were always doing something and they were always telling me I should do something. They would always remind me that I was fat. My sister especially would tell me, you better start doing something now because who's gonna want you. Get yourself on Weight Watchers, you know, that's the cure.

When I was younger, around the age of 10, I remember clearly my mother said to me, if you lose 10 pounds, I will buy you that mohair sweater you want. I remember that clearly, it was this really nice mohair sweater. That's all she said to me. I went out and lost that 10 pounds and I got my sweater, and then the weight came right back on, but there was no education around it. I don't think she had a clue even how to deal with it.

Ruth describes a dieting contest between her two sisters and the family habit of commenting on weight loss that continues even now.

Both of my two younger sisters are obsessed with weight. The middle one is anorexic, bulimic regularly and still is, into her 40s. The youngest I haven't seen in 20 years but I understand that she's obsessed with weight as well. It's between the two younger ones - I opted out of this contest. Who was thinner was
real important. It was a measure of their worth and it was a measure of how well they were treated by my parents, so they competed a lot to be thinner. And the first thing out of any of their mouths, out of any of the family's mouth when they see you is either, "Oh, you've gained weight" or "Oh, you've lost weight, you look good." That's part of the family dialogue. I just bought out of that whole game and said I'm not gonna talk about this. I'm not gonna engage in the contest - it's too hard.

Lilly describes losing weight a significant amount of weight preceding her father's death some ten years ago.

Right before my father died, I lost an enormous amount of weight. After I gained that weight back and then some, I realized that the motivation had been partly to gain his approval before he died. . . . He liked it. He was pleased -- my whole family was. It's almost the first thing that my mother says to me -- well, for a number of years, it was the first thing she said to me. She called me weekly on the telephone and (asked if) I lost any weight, whether or not I was trying to lose weight.

Leigh shares her family's reaction to her losing nearly 100 pounds.

Back in 1989, I lost almost 100 pounds. I remember when I lost all that weight, I felt that they accepted me more. That I was finally okay. I hadn't changed as a person -- I was still the same person but in their eyes, I was finally okay. They weren't embarrassed to have me around.

Clare describes a similar reaction from family and friends and makes a connection to the attitudes of family members regarding fatness when she was growing up.

When I did lose weight one time, people were much nicer to me and that really pissed me off. People just made such a big deal about losing weight. Like I should get this trophy or something. You know it struck me, growing up that it didn't matter what type of person I was or the values I had. What mattered was whether or not my appearance was acceptable to the people that were supposed to care about me.
Chloe relates a story about being applauded for behavior her mother perceived as dieting but was actually a simple dislike of potato chips. Chloe offers her analysis of the cultural meanings of eating and not eating.

We got rewarded for certain behavior. Part of it was being a girl--there's a bigger difference in the need to be thin when you're a girl. My brother was allowed to eat anything but if I, without suggestion, removed a piece of bread from my sandwich, then that was good and I was showing my restraint. I remember one time eating lunch at a department store and I didn't like potato chips, I ordered a hamburger, and I asked them not to put on the potato chips. You would've thought that I had contributed to world peace. My mother said, "She didn't order the potato chips!!!" She thought I was doing it because I was conscious that I was a slob, and (was ready) to get over it. Meanwhile, I just really didn't like potato chips. But she called her friends and she told my father when he came home. She told them I was so good --- restraint was really valued. Oh, my God, yes -- not needing anything.

Not needing -- I think that's one of the metaphors of food. You weren't supposed to have any needs, you weren't supposed to need anybody or need anything, and you weren't supposed to need food in some way. You weren't supposed to be base and human and actually need physical sustenance to get through a day. Not needing anybody and not needing food and not having it control you. The assumption is if you're fat then food has control over you, that you cannot not satiate your wants. Being fat reflects endless want and endless gratification of your own wants.

Mariah, whose weight fluctuates significantly when her multiple sclerosis is active or in remission, describes an encounter where an acquaintance thought of her as smarter when she lost weight.

I had one woman in particular come up to me (after I lost) so much weight and say, "I used to think you were really stupid. Now I see you're really smart." I said, "No, all I am is thinner." It was astonishing! All of a sudden my intelligence was greater. I've had that happen over the course of the years since then
where I've experienced that all of a sudden my IQ goes up if my weight goes down.

Emma speaks about feeling simultaneously visible and invisible, feeling like she was "passing" as thin, and the fear of regaining weight after being richly praised for losing weight. She relates a story about losing so much weight she was unrecognizable to some people including her young daughter, and the confusion she felt concerning who she was as a person, as a result of being rewarded for a weight loss she knew she could not maintain.

After losing a lot of weight, I was down to a size 10 and had never been that small. I had a sexual awakening and I also had an awakening of what it felt like to "pass" in society. I would meet people that I hadn't seen in months and they would say things like, "I hardly recognize you, you look so good." I felt this mixture of visible/invisible. I knew about setpoint and I knew what my history was — I always gained weight after a diet. I was scared shitless. If people thought I looked good now, they are saying that I looked awful before and if I gain weight I am going to look awful again. It scared me so much. I was living on this absurd diet of chicken breast, a spoonful of salad oil and two Ak-Mak crackers.

Everyone was being polite around me. Nobody ever stopped me on the street when I was 180 or 200 pounds to say, "I hardly recognize you, you've gotten so fat. You look awful." Could I show my face if I gained the weight back? Did I have that much self-esteem? It raised so many issues for me. It scared me so much.

One day my nine year old daughter saw me coming towards her after school and didn't recognize me until I got really close and let her know it was me. That had to be traumatic for her — it certainly was a shock for me. It felt like, "Who am I? Am I fat Emma, am I thin Emma, am I thin-now-fat-tomorrow Emma?"

Study participants' recollections of familial and societal rewards for weight loss speak to the nearly universal tendencies to equate thinness with
health and to encourage fat people to "do something about" bodies that are seen as unattractive, unhealthy and unacceptable. Some interviewees described family dialogues about who is losing and who is gaining weight that continue into the present.

Participants' Reflections on Sexuality and Size

Five of the women in the study spoke about the negative effects of early messages about their size had on their sense of themselves as sexual. Some interviewees described experiences they felt served as helpful antidotes.

Celia, whose family to this day continues to make remarks about her size, describes feeling ashamed of her body, even when her husband was clearly attracted to her.

I didn't feel good about myself. I felt ashamed. It was hard for me to expose my body. When I first got married, I remember my husband wanting to see my body naked and it was just awful for me. He was fine. He thought my body was beautiful but I couldn't quite trust that. It never felt comfortable. Since then other men have told me how attractive my body is but again, I've never trusted that. After we separated, I started dating again. It was just as hard, even more so. I had to do it all over again.

At 50, Ruth reflects on the relative ease she has derived from being with the same partner for more than 30 years.

I think about how it would have been different for me if I hadn't found someone at 17 who thinks I'm terrific. He's watched me go up and down the size rack many times and really doesn't care. He finds me sexy and interesting and he's very physical and physically affectionate. Would my whole life have been different (without this)? Probably. Because I've had all that, I haven't had to be on the market. I haven't had to have my
sexuality determined by how I looked. And in all fairness . . . I think that that spared me a great deal. I feel that it's a real blessing.

Mariah speaks about a sexual relationship with a man following her marriage and about how coming out as lesbian brought an appreciation of the diversity of women's sizes.

After I separated from (my former husband), I started seeing a man I'd been friends with for a long time. I felt a lot of love and care from him and it felt like it didn't matter how big I was. I found out that sex could be really fine if somebody's really open and they love you and they're with you because you're you. He told me that he would see me with (my former husband) and think (my husband) was so lucky. He told me he had always seen me as so sexy. It started to really open my mind to there being another way of looking at my size and how I perceived it. I began to feel more beautiful and started thinking, well, maybe I don't have to feel so terrible about myself.

He was the turning point in a lot of ways. He was also bisexual. In addition to helping me open up my size acceptance, he helped open up my sexuality. Coming out as lesbian also gave me a new way to accept my body as fat because when I started really looking at women, I realized, "Oh my God, we are everything, every kind of imaginable shape and size there is -- we've got it." I realized that I was only one piece in this vast array and it depends on who I'm sitting next to whether I'm fat or thin. It's all relative.

Chloe speaks to the negative impact of cultural messages on her sexuality and self-esteem and decries the unfairness of a cultural standard of beauty that excludes fat women.

One of the things I hate most in terms of the impact being fat has had on my life is around self esteem and sexuality. I'm really afraid of expressing my sexuality in a world . . . where I know that a lot of people think my sexuality is disgusting. The thought that a fat woman might come on to them or even have sexual interests is unthinkable. I really hate that. That makes
me really sad and it feel like it limits me and it limits other people.

I don't feel particularly courageous around sexuality. I get really sick of the dominant culture... It's been painful for me and I think it's painful for everyone whose beauty is denied on a cultural level, so that it seems an impossibility. It's taken a long time for me to work through that stuff to even be able to name it without feeling it's terrible and I must be wrong.

Emma speaks of the affirmation of beauty she gained from sexual relationships following her divorce and about the difficulty many fat women have speaking about sexuality, including those in her fat women's support group.

I had a number of lovers who really loved my body. I learned the trick that whatever your body is like, you can have great sex. I knew that once you get over the freeze of somebody-is-going-to-see-that-I'm-fat, like they can't tell by your clothes, and once you're done posing your body in bed, that sex can be great -- it can be a nice give and take. That was a big learning for me and it was very affirming and boy did it help my self-esteem. I always knew that I was beautiful and that my body was beautiful. It may not be culturally the norm at this time but I knew it was the norm at other times and in other cultures. I knew that, and I had it affirmed by lovers, and then I had it affirmed by the fat rights movement.

Along the journey, I was in a fat women's support group. That made a big difference in terms of how I felt about myself. Even there it was hard though because aside from one other woman in the group, everybody else was so ashamed of their bodies and their sexuality. It was really hard to get to another level on those issues. After five years together as a group, people still had that shame about sexuality. I wanted to move on -- I wanted to move past shame and into a more celebratory place.

Sex and sexuality are difficult issues for many people raised in North American cultures. Participant narratives indicate that this difficulty is
greatly potentiated by prevailing cultural standards that regard fat women’s bodies as unattractive and sexually unappealing. Some participants related experiences that acted as correctives to, as Chloe described it, having their beauty denied on a cultural level.

**Partners' Attitudes Concerning Participants' Size**

Four participants told of partners whose obvious displeasure at their size had negative effects on the relationship. One told of her husband’s frequent references to his former wife’s size. Two women, one in a heterosexual relationship and one in a lesbian relationship, describe losing weight for their partner, only to find that the partner was not concerned about their size.

Louise speaks about her husband’s references to his former wife’s failures at dieting and his lack of understanding of physiology and the effects of dieting.

When I first married my husband, I weighed less than I do now but was still above normal weight. My husband used to talk about his first wife who had gained weight over the years and became heavy, how she always went on diets and was not successful. Now remember I do therapy with eating disorders clients so I've got this view of the world and this knowledge (about physiology and the role of successive dieting in weight gain). So when he would talk about her failures at dieting, it was very apparent to me that he had no clue about physiology and weight. He had no clue that diets don’t work -- he thought that you go on a diet, you lost weight, you go off a diet, you gain. So he made comments about her. He has never said anything to me directly but there’s clearly an implicit relationship to my sense about my weight. No real pressure -- he wasn’t nagging me saying, "Come on, you're gaining weight." He would never do that, but I know he must have some feelings about it.
Lilly speaks about her former husband's assumption that fat people remain fat because they want to and that weight is a mutable and volitional, unlike his disability over which he was clear he had no control.

I think that people make a lot of judgments about people who are overweight. My second husband was born without his left hand and he was extremely self-conscious about that. There was a point in our marriage when I just had two babies in three years and my weight was higher than it had been. He told me that he just didn't understand people who are overweight, that he walked around feeling so self-conscious about his lack of a hand and that there was nothing he could do about it so that he didn't understand at all how people could walk around being overweight and not want to do something about it.

The implication and certainly the explicit message was that it was really about self-control and that it was a lack of self-discipline and control that caused a person to be fat and that lack of control and self-discipline were bad character flaws.

Emma's and Mariah's stories about leaving their husbands contain elements that echo what many participants were told as children -- that fat women are unlovable and destined to wind up alone.

When I left my husband at the age of 32, I became a single parent with three kids. My husband, who had been very emotionally abusive and somewhat physically abusive, told me that no man would ever be interested in me again because I was fat. I was so beaten down at that point, that I left the marriage thinking that I would be alone for the rest of my life and that nobody would want me. (Emma)

At one time after I had lost weight, he said to me, "Now that you're looking so much better because you lost weight, I can't wait for you to firm up." I felt like, firm up? Damn, I can't win no matter how much I'm doing. I was in the marriage for eight years. He really did not like my being fat and he would say things about it. When I left him, he said, "I stayed with you even when you were huge." I was not huge. And he said, "I
made love to you even though you were so fat." And I said, "Is that how you saw it? No wonder I didn't want you near me very much." It was just terrible. (Mariah)

Chloe describes the painful breakup with a man she had been in a relationship with for 10 years, and what she feels is required of someone to be the partner of a fat woman.

Paul is someone who values his openness, and I think he struggled with feeling attraction to me, and feeling different because he was attracted to me. I think he questioned what it meant about his sexuality if he was attracted to a fat woman. Because he prided himself about being a very open person who could love a wide range of people, my size provided a challenge for him. But he was really ambivalent about it, and I think I kept hoping that he would get over his ambivalence (but) he didn’t.

There was something about what being a relationship with me would reflect about his own sense of sexuality and sexual prowess. He was attracted to me, but he really wasn’t sure if conventionally beautiful people would be attracted to him. And when he found that that was possible, he felt like he had to go after that for his own self-esteem... I didn’t fit the image of the kind of person that he thought he wanted to be with and he questioned if he could live with that. He decided that he couldn’t. He left the relationship to be with a very thin woman, which is a really, really hard issue, and very painful.

When I think about it now, I realize Paul just wasn’t up to the challenge, the active resistance one needs in order to be with a fat person. He just didn’t have the sense of self to live that life. It takes a lot of courage in this world and it takes a lot of self-esteem. That’s a hard choice for people. I think he just wasn’t given the heart and the mind and the spirit to really take that challenge and take it home.

Lilly, in a lesbian relationship, and Clare, in a heterosexual relationship, describe losing weight only to find that their partner did not prefer they be thin.
I was in a relationship where I lost 40 pounds and got really sort of pissed off at my lover that she wasn’t making more comments about how much weight I’d lost and how much better I looked. Then it occurred to me that it really didn’t matter to her and that she was happy if that was what I wanted to do, but that it wasn’t a criteria by which she was judging me as being either attractive or not attractive or healthy or not healthy. That was a real eye-opening experience for me. And now that she’s involved with another woman who’s also a larger woman, it occurs to me that it probably wasn’t ever an issue for her the way it was for me. I maybe even tried to put it on her as her issue but it wasn’t. (Lilly)

My size has never been an issue for my husband. When we first got married, I tried to project that onto him and he finally said he didn’t have a problem with my being overweight. I didn’t believe him at first because I thought he has to think (the way other people think) about weight. But I realized he really doesn’t. It doesn’t matter to him. His attitude has always been, well if you lose weight and it makes you happy, fine, but don’t do it for anyone else... So it was my stuff around it. He never had a problem with it but I would try and project it onto him. (Clare)

Women in the study variously described the ways in which fatness is sometimes as an emotional weapon in relationships; the difficulties of being in a relationship with an otherwise loving person who, in Chloe’s words, “wasn’t up to the challenge, the active resistance it takes” to be the partner of a fat person; and, for two participants, how their own internalized fat phobia sometimes caused them to mistakenly project onto partners the idea that partners’ prefer they be thin.

Transgenerational Issues Concerning Size

Several participants described the transgenerational nature of the transmission of negative attitudes and beliefs concerning size and spoke to
their desire to insure that negative biases and stereotypical beliefs not be transmitted to the next generation. They shared observations about what it means to have a child who is fat and what it means for a child to have a parent who is fat.

**Having a Child Who is Fat, Having a Parent Who is Fat**

Four participants offered reflections on what their fatness meant for their parents, what their being the parent of a fat child means for them and others, or what their being fat means for their children.

Lilly's father preferred thin women. Her mother weighed 112 when they married and gained 20 to 30 pounds over that many years.

He always gave her a hard time about it. So I think that any tendency I have toward roundness or squareishness was perceived by her as, if she couldn't control her own size, then she should be able to control my size.

She likes to say that her concern is about my health. I don't believe that for a minute... How I look reflects on her. And so if I'm what she thinks of as thin, or not fat, then I'm more acceptable and somehow a better person to her.

Louise, a therapist who works with clients who have eating disorders, is well-versed the biological determinants of size and in the dynamics involved in the cultural obsession with thinness. Louise reflects on her own feelings as the mother of a young woman in her mid-twenties who is quite fat and suffers from depression.

It's not as if I care if people are fat. I don't walk down the street and gasp. But if it's your children -- it's a funny relationship you have with your children. They are your emissaries to the world,
to the next generation. And they are a reflection of you, and of how good you've been with them. They go to the future in terms of your hopes and your dreams and they're in (the present) as a message to you and to the rest of the world about were you good, did you do a good enough job.

So when I look at (my daughter) she knows and I know that I'm much too focused on how she looks. What's primary is the way she looks. I find it hard to have a daughter who is fat. I makes me feel as if I have done something wrong as a mother. (Because she overeats) and doesn't respect herself, it makes me confront what I perceive to be a failure... I would like to be able to say that I don't care about the way (my daughter) looks but I can't.

Members of Clare's family of origin make remarks about her nineteen year-old son's large size as a negative reflection of her parenting abilities.

They tend to comment on my son now, as a reflection of me as a parent. So, I still feel personally attacked around the weight issue. There's a great deal of focus on what I should be doing or saying to help him that I'm not doing or saying.

Even young children perceive what it means to be fat. Rita's nine-year old daughter witnesses fat kids being teased at school and she has been teased because of her mother's size.

My kid will come home and tell me about kids at school being teased because they're fat. She's been teased because of (my size) too.

These participants' various observations about being the parent of a fat child and having a child whose parent is fat demonstrate significant emotional complexity. As these women work toward acceptance of their size and weight they are called upon to continually process their reactions to the attitudes of their parents concerning their own size, the size of their children, and their parenting abilities. Additionally they remained aware of their
children's attitudes concerning having a fat parent and their own attitudes concerning having a child who is large.

**Food, Eating, Weight, Size Oppression - Interrupting the Generational Cycle**

Six participants spoke about the importance they placed on raising their children in an environment that differed from their family of origin concerning issues such as food, eating, their children's body image and teaching the next generation about size acceptance.

Lilly describes her love of cooking and how she has worked to normalize cooking and eating for her children.

I love to cook. I enjoy it a lot. It's a very relaxing activity for me. It's very symbolic of nurturance to me, and I'm happy to say that none of my children have any particular eating problems. So that's an activity that's normalized in my family now that wasn't necessarily normal in my family of origin.

Ruth speaks about how she has worked to make mealtimes pleasant. She expresses the joy she feels at having a daughter who feels comfortable with her body, as well as the wistfulness that accompanies the realization of what her own body would probably be like, had she not repeatedly dieted and regained more weight as a result.

I've tried very hard not to let food be an issue. People don't have to clean their plates. I do ask them to sample a new thing. If they don't want to eat something, it's fine with me. If they do want to eat something, it's fine with me. I'm more focused on the dinner table as a time to convene the family. That needs to be a time when we catch up with each other, where we enjoy each other.

Part of what has been very freeing for me is watching my daughter grow. She has my body. She has the same body and
she's absolutely lovely. And what she doesn't have is all the worry around it. She's about 5'5" now. She's probably a size 12, she's a double C, and she's gorgeous. She's just gorgeous. And when I look at her, I say, you know, that's what it could have been for me, if they just left me alone. (She's) someone who feels good about her body, who's comfortable with it.

Celia speaks about her daughter's relationship to food and her ability to care for herself.

I'm thinking of my two daughters and how they view food and how they take care of themselves. More my older daughter -- she'll be 21 next week and she's been on her own for a few years. Right now she's away at college. She's doing okay with food and it's good to see. I think some of this rubbed off on her. I've done something right. She cares about what she eats but more how she feels, not how she looks. That's good.

Emma speaks about the importance of developing school and parenting programs on size issues as they affect children.

Fat children really need a lot of attention and a lot of myths dispelled and a lot of education in their schools. There are people who are working on this issue quite beautifully, such as the Council on Size and Weight Discrimination, but there needs to be more of it, and it needs to be incorporated into the curriculum.

I think the thing about children is a big issue. . . . When you're raised in a way that is oppressive and you're told you're not okay, most people come out of that not having a lot of social skills or relationship skills or self-esteem. You have to start with that -- how you parent children, how you help people who have children. I think that's important. I think my life would have been very different if somebody had said, "Will you feed her? Look at this lovely child you have. Look, she's hurting, can't you see that?"

Clare speaks to the relationship between learning to accept herself and being able to help her son accept himself.
I saw the way my son was picked on when he was very young. People in my family and others would comment that he was fat and he wasn't, he was just solid. He developed eating disorders. He is actually fat now and I think a lot of my wanting to accept myself the way I am, and realize that I'm okay, is about seeing if maybe I can help him accept who he is.

Rita, someone who at one time could not eat in public, speaks about the importance of teaching her daughter to be comfortable in a restaurant and with eating generally. Rita also describes her efforts at teaching size acceptance to her daughter.

(It's important to) show your kids that they can be comfortable in a restaurant. I have a nine year old and I never let on to her that you shouldn't eat certain things in public. Because I don't want her burdened by that -- I don't think it's right to have that burden.

And the other thing is, I don't want to raise someone who's going to grow up -- and even though she's not big -- and run around and tease people. Oh no, no, no. Not my kid. There's a certain amount of responsibility I want to teach her about, that we all have a part in this, as far as change is concerned. If she tells me about a fat kid getting picked on at school, I let her know that was your mother, and how this little kid must feel. I let her know it's absolutely unacceptable to join in any sort of behavior like that. And that she can tell someone. I'd say it's the same as if (that kid) was being beaten up, because teasing causes as much pain as if she was being hurt physically. So she understands that she can do something about it and that it's wrong to laugh and tease anyone because of their body size.

Taken together, participants' comments demonstrate the emotional complexities to be sorted out as they work toward acceptance of their size and weight. Many continue to contend with the negative attitudes of their families of origin toward their size. For some, these attitudes carry over to
participants' children and are expressed as a reflection of child-rearing ability. Some participants' children have been teased because they have fat parent.

Six women expressed the importance of finding ways to interrupt the transmission of fat-phobic attitudes to the next generation and described ways in which they have worked hard to insure that the home environment concerning food, eating and size issues is different for their own children. Emma spoke about the importance of school and parenting programs that support fat children.

**Working Toward Acceptance**

This section presents findings regarding participants' process of working toward acceptance of their size and weight. Many began with a consideration of their personal histories in an attempt to articulate what they perceived to be the origins of their current size and weight.

**Participants' Attributions for Their Size and Weight**

When they were interviewed, participants made various attributions for their present size and weight, including genetics and heredity; successive dieting; depression; biological changes such as puberty, pregnancy and menopause; overeating at certain periods; and being fed a very high calorie formula as a low birth weight baby.
Ruth describes a combination of biology, family dynamics around food and eating, using food as a protective devise at puberty, and the effects of successive dieting.

I come from a lot of big people, tall big people and people who are more than normal weight by actuarial tables. So there's biology and there's having come from a family where food was an enormous issue. People were always concerned about how much everybody else was eating, and whether they were eating the right thing, and not wanting their kids to be fat because they were fat, and controlling people through food. So food was never a non-issue. It was never just a fact of life. I developed early so I was a big-breasted young woman at the age of 11 or 12 and it was terrifying to me, both because of the response I was getting from my peers, and also my father didn't know what to do with it either and was quite inappropriate. So I learned pretty early that having extra weight would keep that attention away.

As an adult, I have been on every diet known to humankind at one time or another. Every time I dieted I gained more weight. Every single time. Every time that I dieted and stopped dieting, I'd stay at the weight I had dieted to for awhile but then I'd gain everything back plus ten more pounds.

Mariah and Celia talk about sizes of siblings in their families being varied as a result of heredity.

There was my father and myself and my sister Sharon who all identified as fat, and we are all much more metabolically alike. And then there's my mother and my brother and my other sister who are all more metabolically alike. So we were split right down the middle, the thin side of the family and the fat side of the family. (Mariah)

I think a part of it is hereditary. Looking back at all the various family members, on my mother's side of the family, they were all large except for her but she was 5'10" and big-boned. Her father was very large. On my father's side they're all average-sized, so with my siblings, we're all a mix. (Celia)
Lilly describes having been a low birth-weight baby who was fed a high calorie formula, and her size being the result of what she perceives as her genetic heritage.

I was born a very low birth-weight baby, and I was essentially starving to death inside my mother's body because the placenta had torn away, so I was only 3 pounds, 15 ounces when I was born. In her effort for me to survive, my mother gave me as high calorie formula as she could find, with Karo Syrup and all the things they did in the 50s to try and make sure babies gained weight. My mother had three miscarriages before I was born, so there was a lot of anxiety about whether I would survive or not.

I have a picture of (myself) standing next to a cousin of mine who must have been about five or six and I was three. I had on a pleated grey skirt and a white Buster Brown sweater and I looked very square. I didn't look fat but I looked like this little kid who was very square in the look I had. The sizes I wore were probably more than what made my mother comfortable but I think my size is attributable to body type more than anything else and my body type is really pretty consistent with the body type on both sides of my family.

Rita speaks about the role of genetics, dieting and depression in determining her body size and shape.

I think it's mostly genetics that primarily determine your size and shape and there's not much that will change that. I was dieted as a child and as an adult I've been on diet after diet after exercise program and I always come back to the same three numbers. I think there's a reason for that. It's mostly genetics... Depression, too. I think depression isn't necessarily a state of mind as it is a whole state of your being. I think it's not just a matter of I'm tired today as it is a whole state of (my) whole being. My metabolism is depressed. My ability to heal after surgery or illness is slowed.
Leigh, who has struggled with bulimia for 17 years, speaks about her eating habits as they relate to the meaning of food and eating in her family of origin.

I think I've always had an unhealthy relationship with food. My family always used food as comfort. It was a comfort thing. It was reward, it was punishment, it was anything but fuel for the body.

Emma, a size activist who is familiar with the literature on the causes of fatness, attributes her own size and shape to heredity and successive dieting.

Both of my parents and my sister, who is my only sibling, are really tiny people. But my grandmother, who was one of my caretakers, was a large size woman. She also had enormous breasts like I now do. My Aunt Ruby too - she was also what we call "zaftig" in my people. I've seen pictures of women in my family a few generations up and they have my body. They all have my body, so it's not like I was the first and only one to be busty and big. Also, I have a history of dieting and dieting and gaining more weight each time. The effects of dieting on metabolism are really well documented in the literature.

I think if they had left me alone (and not made me diet) I would have been in the average range it would not have been an issue. There are lots of people who are fat who eat "normally" and don't eat high fat, don't eat high sugar. I know there are thin people who eat high fat all the time and but they metabolize it differently. (What we eat) doesn't necessarily reflect in our body shapes.

Louise cites a number of determinants for her size: genetics, the legacy of slavery for African Americans, class influences, pregnancy, menopause, lack of activity and loving to eat.

Part of our genetic history is the poor diet that existed in slavery. We were given ribs and leftovers and the (high fat) foods. Also,
even though many of us are now middle class, most of us didn't come from that -- I think that less affluent people are often less educated or one step behind in learning about health news. So there's a class factor in terms of whether you belong to a health club, whether you're out playing tennis, or whether you're working all the time and taking care of your kids and not having a lot of time to think about or (being able to) spend time working on your physical appearance.

I don't think we give enough credence to genetics. It's just very clear that in my family both my parents were heavy before they became really old and then went into thin mode. My father always had a big belly, which I have, and he would always say in his West Indian style, "I'm making baby." ... Another of his expressions was "I don't stinge my stomach," meaning I don't have fancy clothes or a fabulous car but I always eat what I want. I'll never shortchange my appetite. By no means was he an overeater - he just had a very healthy, enjoying approach to food. I wasn't fat as a child and I grew up in a time when people were not, as young people are now, so focused on thinness. I never gave it a thought until I had my first child and gained weight and it was hard to lose from then on. But growing up, I never thought about weight, never thought about eating one way or the other.

And also we know that at all the critical change points in women's lives - puberty, pregnancy, menopause - fat is added to the body. I know that experientially and I know it from reading. I'm not a compulsive eater but I do enjoy food and I always have. I never had any sanctions against it like the young kids do now. I never thought that if you ate, you were doing something bad - that never entered into the picture. Oh, and lack of exercise -- I wish I could do more.

Clare and Chloe, both adopted, ponder the role of genetics. Chloe also considers the effect of dieting on her metabolism.

I used to think it was psychological. Now, having seen a picture of my biological mother, I'm leaning more toward genetics. In the picture, she was probably around my age or a little older. It just felt so good to see someone I look like, really look like. To see that there is a connection, a human connection. We have the exact same shape. At first I was joking with myself because I was thinking she looks this way after having 10 children and I
look this way after having one. The picture was a side view of
her -- from the neck down we look identical. (Clare)

I imagine that people are fat in part because of genetic reasons.
I'm adopted and don't know my birth family so that's sort of a
wild card in my past. I dieted from a really young age and I really
believe it had an impact on my metabolism and my growth and
development, having food regulated in such a strange way and
having it limited - I think it had a real physiological impact.
(Chloe)

Some of the women now working toward accepting their size and
weight learned about the genetic determinants of size and the exacerbating
effects of dieting from reading books such as Dieters Dilemma (1982). Most
had already intuited these ideas from their many and repeated attempts at
weight loss and experienced a great sense of liberation and vindication at
learning the science of setpoint that underlay their "gut feelings."

Whatever combination of attributions any individual offered for her
present size and weight, it is clear that putting this piece of personal history
into perspective was a crucial first step in considering the option of accepting,
rather than changing, her body.

How Participants Viewed Themselves Before They Considered
Working Toward Acceptance

Several women described how they regarded themselves, their bodies,
their self-esteem and their sense of the possibilities open to them previous to
the time they began to work toward accepting their size and weight.

Mariah speaks about the cycle of self hatred that attended the feeling
that she had to lose weight.
Part of me felt like I should just die, just give up because there's no place in the world for me. It's just not acceptable for people to be fat. I always felt, what's wrong with me? I don't have any will power, I must really hate myself. All the things that were put on us -- fat people have no self control, fat people have bad self esteem -- I really believed them. I thought I must have low self esteem which then only fed my thoughts of feeling like I should just die.

Leigh describes the sense of bankruptcy she felt after several personal losses and the role of losing weight -- in this instance, 100 pounds -- to please others.

I had built nothing for myself. I had counted on everybody from the outside giving me what I'm giving myself now through school, through spirituality, through mediation. I (realized) I had lost all that weight for someone else.

Emma describes feeling distant from her body.

I didn't know my body. I didn't feel like a sexual being or like a fluid person whose body could be tested to do many things. I didn't feel that I could learn to love my body or dress it up or adorn it. Like a lot of fat women, I was waiting for that magical day when I would be thin I thought that would happen.

Clare talks about the shame about her body she used to feel.

I was ashamed of the neck down and didn't want to look at myself unless I really had to. I didn't want to look at my body (directly) or in the mirror.

Ruth describes the dissociation of mind from body and her efforts at compensation, strategies common to the stories of women who grew up fat (Schoenfielder and Wieser, 1983; Donald, 1986; Stinson, 1994; Goodman, 1995).
I remember actually saying that a body is something that carries a head around. I was just too difficult to think about it in any other way. I think there was some functional dissociation going on, that in order to be successful in other areas, I just had to dissociate from my body as something important and overachieve in other areas.

Rita speaks about her propensity to attribute her size as the reason for things not working out.

I always felt that (being fat) kept me from doing what I really wanted to do. I thought that my weight was the reason my marriage didn't work or my job wasn't working out.

Chloe and Louise describe feeling that their fatness was temporary, that one day they would be thin. Chloe, now a divinity student, was told as a child that because she was fat, she would have a heart attack as did her father. In this vignette, Louise muses on realizing she would probably not lose weight and thinking of herself as someone who doesn't have much will power.

I think I assumed that losing weight was a prerequisite to human success. There wasn’t a way to find human happiness without losing weight and I could never have success in the outside world unless I was thin. I thought that being fat was temporary and that one day the victory would be mine.

I was also very scared. I was very afraid of being fat. I thought that something really awful would happen if I didn't lose weight in time. I felt a lot of shame and a lot of fear that if I didn't become thin at the right moment, something catastrophic would occur. I think it's partly (because) I was told since I was five that I would have a heart attack like my (adoptive) father. (Chloe)

As a young mother, I certainly felt that being fat was temporary. That feeling isn't completely gone. For example, just this week, I was saying to myself, "So you realize that you will probably never lose this belly" and remembering some old lady at the health club, very frail, in her eighties, who had a stomach. She told me she had talked to her doctor about it and he had told her
she would probably never lose it. I remember thinking at the time, why does she care about that, she's eighty years old. When I was remembering that this week, I said to myself, you know why she cared -- because you're fifty-three years old and you still care. And you realize that you're probably not going to lose that weight. I think of myself as somebody who doesn't have a lot of willpower. (Louise)

In a note written a number of months following the interviews, Louise wrote that she had joined Weight Watchers. Louise's journey is consistent with Erdman's (1990) findings about what she terms the spiral of acceptance. It is not unusual for people who can clearly articulate information from studies about genetic predisposition for fatness and the effects of successive dieting, to reach a point where they decide to diet once again. Often, women who once again choose to diet -- in order to lose weight, as opposed to choosing to eat healthily -- self describe as having no willpower.

Influences on Participants' Decision to Work Toward Acceptance and the Interplay with Size and Weight Issues

Study participants cited many, sometimes disparate, influences on their decision to work toward acceptance of their size and weight. Prior to conducting interviews with study participants, it was anticipated that several might belong to the National Association to Advance Fat Acceptance or read publications whose readership is comprised primarily of fat women; only two women, however, cited those as influences.

Six participants cited the influence of people they know who served as role models or sources of encouragement. Leigh names her physician as
someone who has helped her recover from bulimia and come to terms with her size. Lilly mentions her acupuncturist who insisted Lilly see herself as beautiful. Clare and Leigh cite the powerful influence of women's studies faculty, both for their presence as large women themselves and for course content that focused on the connections among class, gender, race, and size. Mariah mentions meeting a woman in her area who is known for her work on size activism.

Chloe cites the influence of her former partner of ten years.

Our relationship was (characterized by) a real spirit of self-exploration and self-acceptance and love. Being well-loved for the first time in my life made a huge difference, a huge difference.

Rita noted her appreciation of being able to see large women, such as Kathy Bates and Camryn Manheim, in films and on television. She and Emma mentioned enjoying watching Two Fat Ladies Cooking as fat women who were unapologetic about their size and their enjoyment of food and cooking. With notes of irony and self-appreciation, Ruth describes finally being able to take advantage of the encouragement to love and accept themselves she has offered clients in her more than twenty years of being a therapist. Mariah cites a plethora of influences: movement and breath work, meditation, dance, feminist writings, and her sense of herself as a spiritual entity. Here Mariah speaks about spirituality and her belief in the role of grace:

What's been really helpful is having a relationship with something more spiritual that wasn't about anybody else or
what anybody else thought, or even what I thought, about my body. Having that has been my saving grace. I really believe in grace. Sometimes when I dance, I feel this amazing energy descend on me that makes me feel blessed. This energy goes through my body and fills me. In now's moment, my body doesn't matter and size doesn't have anything to do with it. What I think of my body doesn't have anything to do with it. There's something else beyond all that.

Three participants mentioned their involvement in Twelve Step programs and other self-help groups as having been helpful in gaining a greater appreciation of themselves, a significant element being an improved regard for their physical selves, a lessening of the compulsion to diet and support for the notion that they might not only accept but perhaps find joy in their large size.

Emma mentioned having been a member of a fat women's group that met for five years for the purposes of mutual understanding and support, reading books about genetic predisposition and the metabolic effects of repeated dieting, and participating in various activist events such as speaking at local colleges. She attributes her participation in that group as having advanced significantly her own understanding of size related issues and the consequent fostering of self acceptance of her size and weight.

Two participants indicated the role that an awareness of their African American heritage played in their decision to work toward acceptance of size and weight. Louise, who was neither objectively fat nor told she was fat as a child and Rita, who cannot remember an age at which she was not told she was fat, offered their observations on how fat women are viewed in the
African American communities with which they are familiar. Louise reflects on generational and socioeconomic considerations. Rita offers her observations on geographic and cultural differences.

I feel that traditionally, African American women have had a greater acceptance of size. I don't think that's true of younger women, especially college students, today -- absolutely not -- they're right down the mainstream with everybody else. In my generation not only did we accept it but it was maybe even good that grandma was fat. I've heard this from a lot of people, not just black people. I think there was a lot greater acceptance. And I really think among black women my age and SES there is a lot greater acceptance than among white women my age. Even though we are in the world and we would like to be seen as attractive, which also means thin, like everyone else, still I feel we are a little less agonized about it. More used to it somehow.

We tend to have more obesity and more obesity related diseases, diabetes being a major one. So our consciousness is being raised about it, the need to watch your diet and exercise but on the other side we're kind of used to it. If you walk into social gatherings of women like ourselves, middle class women, you're likely to see proportionately more heavy women who are black than heavy women who are white. I'm not saying that anybody likes that especially but it seems a bit more the norm. It's not quite so jarring. (Louise)

We moved from an all-black environment to an all-white environment when I was 10 and we moved from Boston to Maine. I stayed in Maine until I was 25... I just recently spent two years in the south and I just felt like a queen there. I could buy my clothing in a regular store and not have to pay an extreme amount (more than) smaller sizes and I really felt bombarded by men wanting dates and wanting my company. For the first time in my life I felt, "Oh, this is what it's like to be blond."... My car broke down on the highway one day and three cars stopped right away. Three guys stopped to help me, give me a lift home, and get my phone number. Whereas I really feel like here, if my car broke down on the highway, I could stand out there all day.

In communities of color, larger women are not necessarily seen as the pariahs they are in white culture. There's this whole notion I found in black culture where a large woman is seen
more as being loving and gentle and a caretaker and a mother figure -- and embraced because of that -- as opposed to being ostracized and ridiculed. That’s a lot to live up to as well, especially if you don’t want to be a caretaker or a mother figure. (Rita)

Chloe cites her studies in divinity school and her work, which focuses on political and cultural analysis and action, as contributing factors in her decision to accept and embrace her size. She sees a parallel between the dream of being thin and the fantasy of becoming wealthy and asserts that fat women need to grieve the dream of becoming thin and move forward. She notes a significant difference in the evolution of fat liberation and the origins of identity politics surrounding race and sexual orientation.

I think there's an interesting parallel between fat liberation movement and class and economic change movements. In fights for progressive taxation, for example, you get a lot of low-income and middle-income voting for tax benefits for wealthy people that won't benefit them. But they're holding onto a pipe dream that they're going to be rich someday, even though there's no possibility they're going to be rich someday. I think there's a parallel with the pipe dream of weight loss.

What does it mean to let go of the possibility that you're going to be that thin happy girl one day? There's a sense of loss in that, and I think a lot of people still hold out that possibility that that's going to be true for them and it really is all their fault . . . that they haven't lost weight and that they're the size they are. It requires letting go of the possibility that that's going to happen.

We need to grieve this one and move it along. The grief work in (realizing) how much time is lost being ashamed of your size. The grief work in how ugly you’ve felt all those years, when you weren't ugly the whole damn time. There's a lot of pain there.

Also there's not as identifiable a community like (in the beginning of) the gay/lesbian movement where there were gay bars where people could develop some kind of community consciousness. Or the black church where the African American
community can come together and generate some kind of consciousness. The only place that fat people get together is Weight Watchers, and there they hate each other so much that nothing positive can come of it.

These findings confirm Erdman's (1991) finding that an identification with "something outside themselves" fostered women's progress along what she terms the spiral of size acceptance. Engaging in activities that facilitate the task of reconnecting mind and body was essential to many women's success at being able to see their work on acceptance as worthy and not as a form of denial. The single factor that most often influenced a woman's decision to work toward acceptance was a personal connection -- with a physician, teacher, other fat women, members of ones minority community -- that provided encouragement and support.

Meanings Given to Working Toward Acceptance

Several participants were able to offer reflections on the meaning that working toward acceptance of their size and weight holds for them.

It wasn't like I was working to accept my size -- it's more like my size is a given. I was unaccepting of it for so long and finally had enough self-worth to say, I can't be perfect and that's okay. I think I was working to self-acceptance period. A lot of that had to do with getting rid of all those senses of being bad and inadequate because of the critical nature of the surroundings I was brought up in. (Ruth)

I love my work and I'm a good teacher. I used to think that I shouldn't do this work (as a fitness instructor) until I lose a certain amount of weight. Now I know that me and my work can go together. This is my body and this is my work and they go together. (Mariah)

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It means claiming my power, claiming my beauty, claiming myself. It means having the courage to stand in the body that I’m in, even if the whole society regards it as the symbol of all that is evil... Some of it is about accepting what God offers us in terms of who we are and what the spirit calls us to. I feel that spirit calls us to be as big as we possibly can -- big of spirit, big of heart, and in my case, big of body. (Chloe)

Meaning-making about the process of acceptance is as personal and individual as meaning-making can be concerning any area of human endeavor. What is clear from participants' comments is that their own journey toward acceptance of their size and weight has brought with it the benefits of a renewed sense of agency in their own lives. Interviewees reported, variously, a reuniting of mind and body, freedom from dieting compulsions, an emphasis on exercise and healthful eating, a renewed sense of spirituality and a commitment to living in the present instead of putting off activities until they lost weight.

The previous three sections have focused on participants' recollections as expressed in individual interviews and at the group focus interview. Participant experiences were organized into four areas of inquiry: childhood and family of origin, adulthood and independence, and working toward acceptance of size and weight. The final section of the chapter will focus on participants' experiences in psychotherapy.

**Participants' Reflections on Psychotherapy**

This section presents participants' reflections on their experience as clients in psychotherapy. One of the study criteria was that participants have
been clients in therapy at some point; six were engaged in therapy at the time of the study.

One of the most significant findings of the study is the difficulty participants reported in bringing to therapy issues they faced as fat women. Several of the women in the study, both those who were never able to talk about size issues in therapy, and those who had seen a number of therapists before they found someone with whom they could share these concerns, expressed the fear that they would lose what they had built in terms of trust and shared information or that they would be made to feel further shame about their bodies or their nascent attempts to come to terms with their size. Some felt that their weight and size were just too painful to discuss with anyone. Others feared a repetition of the prejudice they had experienced with doctors and other healthcare professionals.

None of the ten participants reported having gone to therapy with weight loss as a goal although some did experience having a therapist suggest they lose weight. None reported having had working toward acceptance of size and weight as a goal for therapy although several reported wishing they had felt comfortable enough to broach these issues. Many participants reported that their participation in the study had brought new realizations and reflections about their experience in therapy.
Therapy as a Factor in Participants' Acceptance of Size and Weight

Each of the ten participants in the study reported that their experience with at least one therapist had advanced their process of working toward acceptance of size and weight. For most participants, however, the help they found in therapy came in indirect ways. Only four reported discussing issues relating to coming to terms with their size and weight directly with a therapist. Of these four, only one, Rita, reported having worked with a therapist directly on these issues since she was a teenager. She has maintained "fat-positive" as a criterion for any therapist she considered working with since that time.

Chloe reported realizing well into her ten-year (and continuing at the time of the study) therapy that her therapist was indeed "fat-positive" and described the substantial gains toward size acceptance she was able to make in that relationship. Leigh had seen a number of therapists before she was able to share her seventeen-year struggle with bulimia and only recently found two therapists in succession (one succeeded the other in a managed care environment) who successfully helped her with drug addiction, eating disorders and working toward size acceptance.

Emma, a size activist for more than twenty years, reported having been in therapy with a number of clinicians during that time. She shared what she terms her "politics" regarding size acceptance and fat liberation with each of them but never felt she could fully share what it means to live as a fat
woman until the therapist she was seeing at the time of the study. Emma reported having realized, as a result of the first interview, the extent to which she refrained from talking about size issues in therapy, out of fear that she would lose the foundation of trust and shared information she and her therapist had built, and out of concern that her therapist would dismiss or denigrate her views as had many previous therapists. At the group interview, she reported having shared those concerns with her therapist and found that, and consequently being able to talk more about the issues she faces as a fat woman and that these interactions had significantly strengthened their therapeutic relationship.

Some participants described utilizing tools for improving self-esteem they had learned at some point in therapy, in their quest for size acceptance. They found themselves employing these tools, self-help style and absent discussion in therapy, even if they were engaged in therapy at the time of this exploration. These tools included learning problem-solving methods; ways to gain distance from issues via diffusing the emotional charge and cognitive reframing; ways to bring intellect and emotion, mind and body together; and techniques for interrupting automatic response to triggers for shame and powerlessness.

Prior to the time of the study, Emma had not brought size issues to therapy for some time, because of negative reactions she had previously encountered. She describes the many activities she engaged in, concurrent with but separate from her engagement in therapy, that advanced her process
of size acceptance. Interestingly, Emma credits the integrating nature of therapy as making body acceptance possible, even though she did not address size issues directly in therapy.

I never really felt safe in the past talking about my weight (in therapy) because the last thing I wanted to hear was someone suggest I lose weight or hand me a diet . . . So it was weekend workshops, meditation and healing groups, fat women's support groups, writing and lecturing (about size issues) that empowered me and reinforced my self-acceptance . . . I had tools to do healing work with myself . . . but it was therapy that helped me get past a lot of things and have the self-esteem to accept myself, my body, really my entirety.

Emma's experience is emblematic of the great complexity many of the women described. Overall, they learned a great deal from therapy. They learned tools for coping and for making change. They learned to extrapolate from what they learned about other topics and areas of concern and apply it to issues of acceptance of size and weight. What they found difficult was addressing these issues directly, even with therapists they liked and found helpful in other areas.

Each of the women in the study regarded therapy, whether or not they had been able to share issues concerning being fat in any of their therapies, as having advanced their process of working toward acceptance of size and weight. The women who had not been able to share size issues in therapy remarked on the importance of the many ways therapists had helped them through insight and practical tools. These women emphasized that they regarded their progress on size issues as an integral and essential part of accepting themselves in general.
Many participants remarked that at one time they had considered size issues relatively unimportant, in comparison to more pressing issues that had brought them to therapy. In retrospect, however, from a perspective informed by the benefit of enhanced self-knowledge and an improved appreciation of their physical selves, these women saw the role of size in a new light.

Mariah was not able to talk about size or weight issues in her several times in therapy with various therapists. “The fat issue seemed like the least of things that I was handling (in therapy). And yet it wasn't, because it's so core to my identity, who I am . . .” (Mariah)

Chloe was suicidal and agoraphobic when she first sought therapy and only fairly recently has she been able to discuss size issues in therapy.

When I left home, I went through a pretty major depression and part of it was around self-hatred around size, body-hatred, not wanting to be in a body.

I'm really lucky to have found a size-accepting therapist before I even knew what size acceptance was. It's been really helpful although... it's one of the later issues that I've brought up in the therapy process because of my shame around it . . . (Chloe)

For many women, the benefit of hindsight brought an appreciation of the centrality of accumulated negative experiences regarding size -- dynamics of family of origin concerning food and eating; negative attitudes and behaviors of family of origin and sometimes, adult partners; repeated instances of prejudice and discrimination; the totality of cultural opprobrium surrounding fatness -- to the issues they brought to therapy, issues including
depression, anxiety, agoraphobia and feelings of being disassociated, body from mind and body from emotions.

Participants' Descriptions of Helpful and Unhelpful Interactions with Therapists

Study participants recalled interactions with therapists that were particularly helpful or unhelpful in regard to their working toward acceptance of size and weight. These interactions included both direct statements of support or lack of support for the process of working toward acceptance and statements that participants perceived as failing to establish or diminishing a requisite level of trust.

Rita and Leigh relate stories about therapists failing to establish a trusting environment.

She tried to tell me that any problem I had I should just give it to God and by not giving it to God I was keeping the problem and perpetuating it. When I brought the issue about my family history and the abuse around food and eating, she told me I should have trusted in God.

I let her know it was not going to work and she said she wanted me to know her opinions didn't matter. I told her her opinions may not matter but her facial expressions do. That was really difficult to do but I was thinking about the next fat person who walks through that door and how strong they might be. (Rita)

I was trying to express my feelings of frustration about being a food addict and hating my body and hating myself. She looked disgusted and said how really unhealthy my weight was. She made me feel so small, so ashamed, and I didn't want to be there anymore. I really didn't trust her -- there was no connection there. That's what's come up all my life is shame, because of other people's expectations. I hadn't even gotten to the bulimia. I didn't talk to anybody else about it until (a recent therapist). (Leigh)
Emma tells of a trust destroyed by a therapist's suggestion that she lose weight.

I was in therapy with a woman who had a very positive approach and I felt like a lot of issues in my life were getting resolved with her. I had given her things to read (about issues facing fat women) and she had even showed me an article in a counseling newsletter about fat liberation. We had reached a strong trust level. One day out of the blue, she said, "Don't you think it's time you wake up and go on a diet?" It was like a thud, like a wall had gone up, a door had clanked shut. I never was able to trust her again. (Emma)

Several of the women described interactions with different therapists that proved helpful. Some recalled specific incidents; others described a style or an approach; others, the felt sense of being with that therapist.

Emma describes how she feels being with her current therapist.

When I sit with her, I don't feel like I'm Emma that fat woman sitting in therapy. I feel like Emma. So, there's a sense of wholeness and normalcy. (Emma)

Lilly relates her therapist's lack of anticipated reaction when Lilly lost weight and what she as a therapist learned from this experience.

There was a time with my current therapist when I lost an enormous amount of weight and I felt disappointed that she didn't mention it at all. She seemed not to notice it. But once I gained all that weight back, I was awfully glad she hadn't made a big deal of my having lost it. It was a very good decision for her. Since then, as a therapist, I've had that same experience where clients are losing weight and they want me to make a big deal of it, but I don't. (Lilly)
Chloe comments on the relief she felt at realizing her therapist does not equate weight loss with mental health and about the mistaken notion that many therapists have that once fat people work through emotional issues, they will naturally lose weight.

I think the most helpful thing was to have her just go where I was going with this and not see me as ridiculous or stupid or mentally unhealthy to go towards size acceptance, not to assume that it’s some kind of denial.

The conventional alternative mind-set is that once you become aligned in your mind and body and spirit, the weight will magically disappear . . . sometimes I get the image that fat is like some cosmic drain clog and if you pour in the right psychotherapeutic Drano™, it’ll just drain out in ten minutes or . . . there’s some major secret that you’re keeping from yourself and you’re in denial . . . and when you shed some light there, (your weight) is gonna disappear. Lo and behold, it doesn’t work that way . . . My eating has cleared up and my weight hasn’t changed and my exercise is way up and my weight hasn’t changed.

I have a friend who is (now) thin and (used to be) a fat man. There was one year when I had gained a lot of weight and he said, isn’t it interesting, when I started to love myself, I lost all this weight and when you started to love yourself, you gained all this weight . . . This man just made an observation. It was a big step for me to just see it as interesting and just an observation.

Rita’s experience with a therapist she found helpful demonstrates the complexity of interactions between fat women and their therapists. The very encouragement Rita found most helpful generally, felt difficult when considered in the context of finding a partner.

The most helpful thing she said was, you’re a queen, respect yourself the way you are and just go out there and be who you are. It seemed kind of radical at the time and it took me a long time to get what she was saying, not the meaning but to actually feel it.
Around dating issues, though, "go out there and get what you want" is pretty difficult. To tell someone who's spent most of her life traumatized about size and weight -- just go out there, just be in the world, just let people see you -- when you're someone who's a larger size, you can't just go out and get what you want.

Participants' recollection of helpful and helpful interactions with therapists suggest some necessary elements for supporting fat women in their journey toward acceptance: maintaining an atmosphere of trust and exploration; decoupling the resolution of mental health issues from weight loss; regarding a woman's work toward acceptance as positive and healthy rather than as an indicator of denial; and being able to honor the subtleties and complexities of fat women's experience as they navigate the larger culture.

The Meaning of Therapists' Size and Weight

The issue of therapists' size and weight was the subject of much conjecture, but only occasionally, actual discussion in therapy. More than any other topic considered in the study, the issue of therapists' physical presence called upon participants' transferential processes. Participants described how they thought their therapists regarded their own size and weight, what they as clients perceived to be their therapists' attitudes toward people who are large, how the therapist's size encouraged or inhibited talking about size issues during therapy and whether or not they might consider a therapist's size when choosing a potential therapist.
Half the participants commented on how they thought their therapist regarded his or her physical self. Only two, however, reported that a therapist had actually talked about her own size during therapy.

Mariah described an interchange with a female therapist as having a normalizing effect and expressed curiosity about a male therapist's relationship with a very fat wife.

[Her talking about being fat] was helpful, in that it made it just a regular thing, like we women deal with this . . . we don't have to make a big deal about it -- it's just a part of life.

I would like to have (the male therapist) talk about his wife. I could see [how he interacted with her] but I would have liked him to talk about it, even if it was his own confusion about well, geez, if my wife is this (very) fat and she's fine and she's healthy, then what's your problem, because you're only this fat.

Clare described having seen a female therapist who seemed very comfortable in her own body but who was prejudiced toward fat people and having seen a male therapist who did not seem comfortable in his body but was open and encouraging of her size acceptance issues.

Chloe attributes her initial difficulty in talking about size issues in part to her current therapist being "very conventionally beautiful" and Chloe's belief that her therapist wanted her to look the same.

In the beginning . . . I thought that she thought that if I would just lose some weight I would be happier. . . I had a lot of assumptions about what she thought, which never turned out to be true.

Eight participants offered an opinion about whether they might choose a therapist based on that person's size. Of the eight, two felt that size would
not be a consideration in their potential choice of a therapist. Two others felt that seeing a fat therapist would be helpful at the beginning of the journey toward size acceptance.

I think back when I was seeing that Indian woman (who was large), her size made me feel more comfortable with myself because I was so unsure of myself. I think a thinner person would have intimidated me more back then. Now, when I have more of a foundation for myself and I have more self-esteem, it doesn’t matter. (Leigh)

If I was just picking a therapist for the first time, I could see a really big benefit going to a fat, self-affirming therapist. . . when I was back on the journey a bit, there would have been a good learning in that. Now I think my question would probably be about where they were about fat acceptance as a psychological option and a psychological preference. Because I imagine there are fat therapists who are fat hating . . . and there are thin therapists who aren’t. (Chloe)

All other factors being equal, Emma and Clare would choose a fat therapist with the expectation that a fat therapist would have more of a shared understanding about the issues that fat people face.

If I had a choice between a skinny woman (or man) or a fat woman or man, I would probably choose the fat one because . . . my assumption would be they’d be more understanding of any fat issues that would come up for me. (Clare)

I want someone who has strong self-esteem and accepts their body. I like it if they’re large . . . because at least they know what it’s like. . . (Emma)

Rita and Louise, who are African American, include the role of race in their considerations. Rita feels more comfortable with fat therapists and, because she has had to explain issues concerning race to white therapists
many times, she would choose a fat therapist so as not to have to explain
issues regarding fatness to a thin or average-size therapist.

I think it would be very hard for me to have a thin therapist. I
don't feel comfortable. Also, I've had so many problems
explaining to white therapists what it's like being black in this
society, that I don't want to have a thin therapist and have to
explain what it's like being black and fat, so I always seek fat
women as therapists . . . I don't like always having to start at
square one . . . I instantly feel comfortable with larger people.
Right away I feel, okay good, we're buddies. (Rita)

Louise is a therapist who has not talked about size and weight issues in
her own therapy with thin white therapists. She speaks in retrospect about
what it might have been like to have a fat person or a black woman as her
therapist. Louise comments on her proclivity to ask questions of therapists
and conjectures that she would ask a fat therapist about his or her size.

If I had a heavy therapist, particularly if it was a white person, . . .
that would have made it harder to bring up the topic (of size).
But with a black woman of almost any size, I think it would feel
more comfortable because a black woman would have made it
easier. We have a lot of heaviness as a group of people . . . and I
would have felt like she would probably understand, that she
would . . . know what race and gender is like and . . . I wouldn't
have had to explain.

If I were seeing a fat therapist, I would be very curious about
(that person's size). I would have to bring (the issue of size) up
around myself and at some point I would say how is it for you. I
generally do that kind of thing . . . I'm cautious . . . but I ask my
questions and they can answer them or not depending on how
they feel about it. (Louise)

Each of the participants, whether or not they had brought issues of size
and weight to therapy, expressed curiosity about how therapists regarded their
own size and weight, whether the therapist was fat, thin or average-size.
Some participants expressed a preference for a fat therapist, especially at the beginning of their journey toward acceptance. Most considered therapists' knowledge of issues facing fat women as the most salient factor in their consideration of a possible future therapist.

**Issues Participants were Unable to Bring to Therapy**

Participants named size, sexuality and eating concerns as the issues they found most difficult to bring to therapy. The themes of feeling shamed, not wanting to be stereotyped; not wanting to jeopardize the therapeutic relationship; and feeling the topic was unworthy emerged as the foremost reasons women were unable to speak about these issues to their therapists.

Emma, who was recently diagnosed with diabetes, is clear that she does not eat compulsively. She is finding the restrictions placed on her dietary habits by diabetes difficult and an issue she would like to raise with her therapist.

I need help with eating for diabetes. But there's that barrier, that boundary... I'm afraid... my trust will be betrayed. Also, if she has the perception that I'm another fat person with an eating disorder, or compulsive eating, then I'm not seen as Emma. I'm not seen in my wholeness, I'm seen as a compulsive eater, and I'm not.

When I can't talk about these things, there's dissonance in the session, something's missing, it's almost like a lie. There are things (that are) not being discussed and... a big piece is missing. Still, I'm not feeling like I want to rock the boat. There is a part of me that is afraid to go further because things are so good with her.
Emma’s experience of not wanting to "rock the boat" typifies that of other participants who felt they had built a solid basis of trust but worried they might lose the relationship if they brought up issues of size or weight. Some women described being able to speak to their therapists about very difficult and complex issues including the trauma of sexual and physical abuse, issues that carry enormous emotional charge and transferential fear of betrayal. These same women were unable to speak about their size and weight for fear that their therapist would characterize their journey toward acceptance as wrongheaded and the result of denial, and that the sense of betrayal that would engender might undermine both the work they had accomplished as well as the future of the therapeutic relationship.

Several participants mentioned feeling too shameful about their bodies and too wounded by the hurtful behaviors of others, to broach issues about size in therapy.

There were some years when talking about my body caused me to shut down, absolutely, because of all the shame I felt around it. (Lilly)

Unless (therapists) showed me that they were capable, then I wasn't going to go there with them... I needed to keep that piece close to my heart because there was so much tenderness around it and I (didn't) need any more judgment than I already got in the world. (Mariah)

I'd have some food and eating issues and I had so much shame about them that I never brought them to the therapy table... A lot of issues with my mother were about shame and size, how she would shame me about my size and shame me about my wants and desires. As the years have gone on (in therapy) I've really had to work through the shame about bringing up shame. (Chloe)
Lilly's shame prevented her from being able to ask for clarification from her therapist about a comment Lilly took to refer to her size.

When I was talking to her about the fact that I was starving to death inside my mother's body essentially because of the placenta having torn away ... she said, "Ah, ha! That makes a lot of things make sense to me." I think she was referring to my size but I was too embarrassed and too triggered in shame to be able to ask her. ... I always wondered what she meant by it and I never asked her.

Chloe's fear of discussing sex and sexuality reflects both her concern about being stereotyped and her concern not to "invalidate" the work she had accomplished in therapy. Her continuing difficulty exemplifies the non-linear aspect of what Erdman (1990) terms the spiral of acceptance.

It's hard to bring up sexuality. I think one of the ways sex ties into being fat is because it's about desire and I think claiming desire is something that's really hard for me as a fat person ... Also the old voices saying you are fundamentally asexual and anybody would laugh at you if you talked about your sexuality and your desire -- everybody knows you don't have a sex life ... that you're never going to be happy sexually because look at you! I was afraid I would just affirm all the stereotypes and I felt so fragile about affirming something else about fat people. ... I was also scared that bringing that in would invalidate all the work I had done.

Sometimes it's so big and scary that I can't bring words to it ... it's still a fuzzy line between feeling the pain and having the pain have to mean that the answer is to lose weight. ... That's an old, old voice but it's there.

Mariah, who experienced significant and repeated job discrimination based on her size, never considered discussing these incidents in therapy.

I never thought to talk about it in therapy. It's just what I've lived with all my life -- you just learn to live with it. That's what comes with the territory, so you deserve it. If you're fat
and you don't (lose weight) you deserve this kind of treatment. It's another way we get blamed and then feel shame about it.

Eating issues and sexuality concerns are often difficult issues for clients to discuss in psychotherapy. For these women, the shame they felt about their size made it particularly difficult to bring issues of size and weight to therapy and seemed to potentiate the difficulty of discussing food and eating issues and sexuality concerns.

Participants' Suggestions For Therapists Who Work with Fat Women

As a group, participants were particularly enthusiastic about offering ideas, information and recommendations regarding what it takes for a therapist to engage in effective psychotherapy with fat women. These suggestions range from the importance of therapists' having furniture that can accommodate large women to recommendations that hold implications for therapist self-knowledge, clinician training, continuing education and the process of conducting good therapy.

All participants listed comfortable furniture as a basic requirement for successful therapy. Leigh reported seeing a therapist she regarded highly and sitting on the floor because there were simply no other chairs available in that managed care setting. Mariah recalled only one therapist "who had a chair worthy of sitting in."

Emma relates a story about asking a therapist to locate another chair.

I said, "I'm sitting in pain because (this chair) is so small and uncomfortable. I wonder if you could maybe switch with a
waiting room chair or find a different chair. There must be other large size clients who come to see you." Her response was, "I can't do it. This is the chair I have." I told her I was terminating and why -- the chair was an important part of it. It was terrible because I had an issue that was so pressing at that time.

In addition to being physically uncomfortable, furniture that is too small has the potential to recapitulate experiences of being made to feel discounted or negated, experiences shared by many participants in their families of origin and in the culture at large.

Some participants listed as desirable attributes the manner in which a therapist carried herself and the comfort she expressed about her own body. Leigh's experience in the late 1980s with a fat woman who was clearly comfortable with herself and more recently with a thin, size-affirming therapist exemplify these behaviors that often serve as correctives to clients' earlier experience. Leigh has struggled with bulimia for 17 years.

I had this wonderful Indian woman who was very comfortable in her own skin. . . . all the roles models in my family, all the large women were so uncomfortable and always trying to change what they looked like. . . . and here is this large woman sitting there in her flowing skirts and her turban . . . and accepting and wise and wonderful . . . and I knew that she had something that I wanted.

The same with (the recent therapist). I saw her one time eating dessert and I said, "You eat dessert?" She said, "Everyday." And I realized you don't have to punish yourself. That's not what life is about. Life is about enjoying yourself.

So I just see them as being comfortable in their own skin . . . and that's where I want to be -- whatever size that is.
The theme of therapist-as-role model recurs when women speak about the necessity for therapists to have an understanding of issues faced by fat women including being blamed for their size by those who don’t understand the role of genetics, the exacerbating effects of dieting, or the psychological sequelae in adult life resulting from being shamed repeatedly as children for something that was not within their control. Participants voiced their concern that therapists educate themselves about these issues, examine their own biases and hopefully, once educated, take a stand on issues of size as so many psychologists and social workers have on other social justice concerns including race, gender and sexual orientation.

Clare and Ruth emphasize the need for therapists not to make assumptions about size being within ones control and about fat women necessarily wanting to lose weight.

I want therapists to be educated about the fact that being fat isn't something you can control necessarily... And it doesn't mean I necessarily want to lose weight, either. (Clare)

The first thing is not to make any assumptions. There's as big a range among fat women and their comfort with self as there is in the range of any other body type, ethnic group, whatever... we live in a culture that assumes fat people are miserable, and there's certainly a lot that could make one miserable, but I think we need to be careful about putting templates on people. (Ruth)

Several of the participants stressed the importance of therapists not make assumptions in either direction about fat women as compulsive eaters or survivors of sexual abuse. Fear of being stereotyped as "just another fat
woman who" prevented some women from discussing food or eating issues in therapy.

Participants including Celia mentioned the necessity of therapists engaging in self-examination of their own prejudices and biases, the possibility of their having an eating disorder themselves and how they regard their physical selves.

They really need to be educated and learn what is going on . . . if they're going to be a good therapist they have to know what they're dealing with and they have to face their own issues, to be able to recognize if they themselves have an eating disorder. Or (if they) are fat and not feeling good about themselves, they need to work through that and get help in dealing with it. (Celia)

Emma mentions an important transferential dynamic and the possibility of childhood issues being unintentionally reenacted by an unaware therapist. She makes a connection to the implication this holds for therapist education.

They need to know that diets don't work, that it's better to focus on health than on losing weight . . . Fat women already think of themselves as children who are bad because they ate something that was bad, so (therapists) learning about that guilt is important . . . The therapist needs to examine his or her attitude about food, about their own body image and about their comfort level in talking about this. I want someone who accepts their own body and themselves and can work with me on all levels.

I wish that therapists would educate themselves. If I were an alcoholic or manic depressive, my therapist would have had training (about those issues). Instead, with the fat population, all these assumptions and perceptions, all these stereotypes and collective beliefs are terrible -- that they would think it's a psychological rather than a physiological or genetic issue.
Ruth and Chloe remark on what they feel to be the importance of therapists regarding size as a social justice concern. Chloe makes the link between a therapist's "politics" and an examination of his or her own size.

I think that just as therapists have begun to take a stand around social issues, that somewhere we have to start dealing with the craziness in this culture about size and diet. Perfectly healthy people can be made crazy and I'm especially thinking of the young girls I see. (Ruth)

A therapist needs some kind of politics around (size issues) . . . I can't imagine going to a therapist who didn't have some social justice concern . . . I think therapy is dangerous without that. There's so much the matter with body in this culture. I think a lot of the fear of fat is that fat women have so much body . . . So it's important that a therapist is someone who is comfortable with her own body and someone who is comfortable with mine. It takes a real sense of self to see a fat woman's beauty in a fat-hating culture . . . and it takes an acceptance of self so that my size doesn't threaten . . . it takes an understanding of the psychological process that makes our society put people in certain categories and certain roles. (Chloe)

Taken together, participants comments and suggestion point to the importance of therapists asking questions rather than making assumptions about the origins of a particular person's size or about a fat person necessarily wishing to lose weight; educating themselves on issues of the physiology of fatness and the exacerbating effects of dieting; engaging in work to challenge cultural stereotypes and personal biases; and working to come to an understanding of how to best conduct therapy with fat clients.
Reflections on Interviewing Potential Therapists

Emma and Rita emphasized the importance of interviewing potential therapists. In the first conversation, Emma let potential therapists know that she was comfortable with being a fat woman and proceeded to inquire about that person's level of understanding and willingness to learn more. Emma explained that while she does not like having to take part of the therapy hour to educate, she felt she could learn a good deal from a potential therapist's reaction to her offer to bring simple readable literature on issues relating to fat women.

Rita describes her experience interviewing potential therapists.

I believe in interviewing, going there and asking questions. . . If I'm going to get anything out of the therapy, other than more trauma, I need to be aware of how they stand on certain issues. I'll let them know my history with abuse, because I consider that whole dieting thing when I was a kid, abuse. . . and I listen to how they react to it. Now, if they feel, maybe you should have lost the weight and you and your mom would have gotten along a lot better, I'm heading for the door.

It is important to note that the option of interviewing is often available only with therapists in private practice. Increasingly, in mental health centers operating under the restrictions of managed care, therapists are assigned to clients on a waiting list on a first-come, first-served basis with little opportunity to match client's stated preference regarding a potential therapist's gender, race or sexual orientation.
Participant Therapists On Therapy

The three therapists in the study each offered insights about fatness and therapy. They related colleagues' prejudicial comments about fat clients, instances in which as fat clinicians they were paradoxically rendered invisible, and examples of ways in which they attempt to be helpful to their own clients who are fat.

Lilly and Louise describe instances that demonstrate fellow clinicians' internalized fat phobia and unexplored personal issues concerning body size.

There's tremendous potential . . . for therapists to be very judgmental, to say very harsh things and to be insensitive and callous to the feelings of fat women. . . In clinical meeting, somebody will be described as obese and their weight will be used as a descriptor that's intended to convey slovenliness or a lack of care about how one presents to the world. (Lilly)

I remember being at (a college) health service, starting to work with anorectics and having all of my colleagues go on and on about how they wished they were just a little bit anorectic and thinking, "What a thought -- these people are really crazy." (Louise)

Ruth relates a story about fellow clinicians speaking as if she weren't present or weren't fat, in a supervisory meeting.

I was in this meeting with people that I really like who really like me, who've known me for a long time. Two women therapists who are model thin and clothes conscious were talking about a client . . . one said something to the other about (she) didn't know what (her) client was going to do about her weight. Her doctor had basically told her to stop dieting but the therapist put it in terms of "she's got some story about" meaning the client wasn't being honest with herself. And the other therapist was saying, "It's more what goes by your lips than any other thing."
And, meanwhile, they’re sitting next to me! I realized they didn’t have a clue that they were essentially saying that this woman was absolutely to blame because she was overweight, and yet, they wouldn’t think of saying that to me. They were making a moral judgment on her. I was so stunned by it I didn’t even have a response, which I felt bad about the next day. But I was just absolutely flabbergasted by the duality of how they were talking about the client, the fact that they were sitting next to me, and the fact that I knew both of these people to be extraordinarily kind, good people who were working hard.

Lilly describes her role as advocate for disenfranchised clients and how she plans to respond to colleagues’ fat prejudice at the next opportunity.

I take seriously my role as an advocate for any group that’s being treated badly . . . I’m always the one to speak up about gay and lesbian issues or refugee issues or gender issues and it seems to me that it’s an important piece to also be willing to speak up about issues of body size . . . I don’t like the implications that size or physical attributes make or break anybody or necessarily constitute some sort of pathology.

As a person who works with disenfranchised people all the time, I just really can’t continue to pretend that fat women aren’t also a disenfranchised group . . . the next time anybody says anything in a clinical meeting, I’m going to say something. And that’s new . . . before I would feel that I should keep my mouth shut, that I shouldn’t call attention . . . my worry had been that if I opened my mouth and said something that everyone would look at me and say, well, it’s obvious why she has an issue with this.

Each of the three therapists talked about the ways in which they attempt to be helpful to clients who are fat women.

Ruth recalls that the grandmother she described earlier as "soft" and "round" was her emotional savior and how as a therapist she stays attuned to the possibility a client may have such a role model. Ruth also shares what
she feels to be the importance of viewing each therapy experience as a cross-cultural encounter.

I do see my grandmother as my emotional savior, that it was through her love and concern and model of a different way to be that I had some sort of beacon to hold onto. And to this day, when a client walks in the door and describes a horrific childhood and yet somehow looks like there's a core that's well-wrapped and sound, I always go looking for the grandma... or a best friend's mother, or an aunt or a teacher... and I almost always find her... there's almost always somebody else who offered an alternative.

Every single therapeutic encounter is to me a cross-cultural experience. And I work very hard (not to) make assumptions about anything, including a fat person's experience. I don't know the particular meaning someone has put on something, or the particular spin their life experience (means in terms) of their physical reality.

Ruth and Louise speak about the importance of asking, rather than assuming, that a fat woman wants to talk about issues relating to size.

I ask the questions. Just as I ask questions about alcohol, and I ask questions about sexual abuse, I also ask people, is (size) a problem for you? (Ruth)

Mainly, I ask about it... Even though I was trained more or less psychoanalytically... I like questions better than interpretation. If somebody says (they're overweight), I might ask questions like: What makes you think so? How can you tell if you're overweight? Why is it a concern for you?... How does it matter?... [What] are the messages that you got about it?... Who do you know of different sizes?... All of those questions that help people to clarify for themselves where they stand and take (the therapist) out of the position of a rush to judgment in any way. (Louise)

Lilly and Ruth describe how they bring the issue of their own size into the therapy room. Lilly reflects on the stance she now takes with clients who
bring issues regarding size or weight and what she would now expect of a fat therapist if she were to seek therapy from such a person. Ruth emphasizes the importance of normalizing size as a topic and inquiring if a client in a mental health clinic setting feels comfortable with a fat therapist.

I tend to be pretty open... I feel like I just can't sit there as a woman of my size with any client if they bring up something about weight or dieting or exercising... and not say I've got some issues about this stuff myself... It would be stupid and it would be blatantly dishonest.

If I were having therapy right now with a fat man or woman, and I started talking about issues around food and my issues around wondering what it all meant, I would think it strange if they didn't say, those are really complicated issues and I have to say that I've thought a lot about them in regard to my own size. (Lilly)

One of the first things I say is are you comfortable dealing with a fat therapist? ... I want to make it an open conversation. I don't want them to feel they can't talk about fat with me because I am (fat). I'll (say) it's a lifelong issue... we all have our own journeys and is this something you want to talk about with me? Because... (clients don't know) when they call up for an intake who they're getting. (Ruth)

Participants who are also therapists were in a unique position to offer

a) the perspective of having been a fat woman in therapy, b) the perspective of being a fat therapist with women of all sizes. These women’s dual perspectives could contribute important insights for education programs designed for therapists, both initial therapist training and ongoing continuing education workshops.

This section presented findings from the second individual interview, which focused entirely on therapy, and from those parts of the group.
interview where participants discussed their experiences as clients in psychotherapy.

Chapter Summary

This chapter presented findings gleaned from in-depth phenomenological interviews with fat women who are engaged in the process of working toward acceptance of their size and weight, and who had been clients in psychotherapy as a fat woman either previous to or concurrent with the study. The findings were presented in four sections: childhood and family of origin; adulthood and independence; working toward acceptance; and experiences in psychotherapy.

The following chapter will present conclusions based on these findings, a discussion of relevant literature, and recommendations for further research.
CHAPTER V
CONCLUSIONS, DISCUSSION OF RELEVANT LITERATURE AND RECOMMENDATIONS FOR FURTHER RESEARCH

This first section of this chapter offers conclusions that arise from the results of the study as presented in Chapter IV. The second section is a discussion of the points at which these findings are consistent with relevant literature. The final section of the chapter focuses on possible implications these findings hold for educators, psychotherapists and researchers and recommendations for further research.

Conclusions
Family of Origin, Adulthood and Independence, Working Toward Acceptance of Size and Weight

The nine participants who were either fat or told they were fat as children reported that repeated negative actions and attitudes on the part of family members significantly affected their self esteem, their sense of agency, and their perception of the physical self as integrated with the intellectual and emotional aspects of their personalities. As children, many participants experienced severe control and regulation of their food by caregivers and, in some cases, were denied food when hungry. Variously, they were told that they were unattractive, lazy, incapable of being athletic and unworthy of treats (food and otherwise) given to other children. Many were cautioned from an
early age that because of their size they would be undesirable as potential partners and employees.

Some participants described feeling unable to fully inhabit their bodies and experiencing a sense of disconnection of mind from body. Mariah recalls feeling that she was "living from the neck up." Ruth describes experiencing a "functional dissociation," the feeling that "the body exists to carry the head around" that persists into the present. She considers her need to excel in academics, from childhood through graduate school, not as primarily an expression of intellectual gifts but rather as an attempt to compensate for a body she considered shameful and inadequate.

Seven of ten women thought of themselves as fat when they were children because caregivers told them they were fat. When as adults they viewed photographs taken of them as children, they saw that they were not fat by their own definition of fatness or that of friends, partners or other adults. In some cases, participants' caregivers projected onto their children the fear that they, the adults, would become fat. In other instances, caregivers pointed to a genetically fat relative as the example of what they did not want their children to become.

In addition to having many aspects of their lives controlled and regulated, participants were told as children that their size was something that was within their control. Some participants experienced their parents' undue emphasis on the size of their children, whether they were actually fat or told they were fat, as an expression of their parents' need to control. It may
be that children who were actually fat served as a constant visual affront to parents whose own ego demands required that the child be thin.

Participants described feeling terrible shame as a result of being told they were fat, whether or not they were actually fat, because of the negative connotations placed on fatness by their families and by the culture at large. Being told that their size was something over which they had control intensified feelings of shame and made them feel blamed for their size and shape and for the fact of their physical presence. For many participants, feeling blamed for who and what they were resulted in a profound sense of hopelessness and inadequacy and contributed to their developing a negative fat identity.

Children's fatness reflects negatively upon parents' child-rearing. This sentiment was voiced by participants regarding their parents' raising them, parents commenting on participants raising a child who is fat, and, in the case of one participant, her own reflections on having a fat child. Participants commented that the dynamic of their own size acting as a reflection of their parents' ability to parent fostered the notion of failure. Their parents feared being seen as failures and often treated their children as failures, thus reinforcing the notion that their children's size was within the children's control.

Some participants characterized relentless regulation and control as abusive. Some described bitterly strained relationships and lengthy periods of
estrangement from family members resulting from this abusive treatment that continued well into adulthood.

Puberty, a difficult time under the best of circumstances, was experienced by several study participants as particularly painful. These women cited internalized shame resulting from relentless negative messages regarding their bodies as having an exacerbating effect on their experience of the normal biological changes associated with puberty.

For fat children, the presence of a positive adult role model can serve as an important counterbalance and corrective to familial and cultural prejudice concerning large size. The three women in the study who named an adult other than a parent who was kind and positive regarding size (for these participants, they were aunts and grandmothers), described that relationship as very supportive and, in some cases, life-changing.

Several women in the study, whether or not they have children of their own, spoke about the importance of interrupting the transmission of harmful and prejudicial attitudes to the next generation. These women variously described the importance of normalizing food and eating with their own children, supporting a positive image of fat children and adults for all children, and developing educational programs for all age groups to combat size prejudice.

As adults, many participants experienced instances of prejudice and discrimination based on their size, particularly in the arenas of healthcare and employment. Prior to reaching some level of acceptance regarding their size
and weight, these participants experienced prejudice and discrimination as simply what they deserved as fat women. Mariah described experiencing job discrimination as "just desserts" and "what comes with the territory" of being fat. Rita experienced being told she would not be hired as a nurse's aide because of her weight as "the period at the end of a sentence" that began in childhood, the beginning of the sentence being that no one would hire her if she was fat.

Participants named several factors that influenced their initial decision to work toward acceptance of their size and weight and that continue to support them on that journey. Those influences include learning about genetic predisposition toward fatness and the exacerbating effects of repeated dieting; meeting other fat women who lead full and active lives and inhabit their bodies with comfort and ease; interacting with a size-positive physician, therapist or other healthcare provider; learning as part of a women's studies course about the connections among class, race, gender, sexual orientation and size; and being able to see large women on television and in films portrayed in strong, positive roles.

Participants typically characterized their journey toward acceptance of size and weight as lifelong and non-linear, and as integral to and interactive with all the ways in which they are working to realize their potential and lead full, active and meaningful lives. The decision to work toward acceptance of their size and weight enabled many participants to make significant and lasting positive changes with respect to healthful eating, exercise,
relationships, careers, learning to live in the present, developing a spiritual practice and perhaps most important, adopting a substantially different mental and emotional perspective about themselves and who they are in the world.

Three participants cited their involvement in Twelve Step groups as having been a helpful complement to their working toward acceptance of size and weight. Many named some form of exercise including dance as promoting a sense of integration and wholeness. Others mentioned their practice of meditation or martial arts as expressions of spirituality and methods to achieve balance and groundedness.

Psychotherapy

One of the criteria for participation in the study was that women have the experience of being a client in therapy. With few exceptions, however, participants found it very difficult to bring issues of size and weight to therapy, either experiences from their families of origin or experiences concerning what it is like to live as a fat woman. Some women reported that they had been able to discuss physical and sexual abuse in therapy but could not talk about size and weight issues. The instances when women were able to talk about size issues in therapy were primarily with a current therapist, and sometimes following a number of other therapists with whom the participant did not discuss size.
Participants attributed their inability to discuss size and weight in therapy to a number of factors. For some, having been shamed repeatedly about their bodies and being blamed for their size as children and adults made it impossible to discuss any subject having to do with size or weight. Some feared losing the relationship they presently enjoyed with their therapist and all that had gone into building it, including a significant level of trust and substantial shared information about personal issues.

These participants felt that if they broached any issues having to do with size or weight -- issues from family of origin, present eating habits, instances of prejudice or discrimination or simply the difficulty of finding clothing as a large size woman -- in the context of acceptance, they could be in jeopardy of undermining the relationship they had worked so hard to build with a therapist they liked and found competent to help them on many other issues. They feared that their therapist would regard work toward self acceptance of size and weight as a manifestation of denial, possibly suggest weight loss as a remedy, and thus undermine both the work they had done in therapy and the work they had accomplished on acceptance issues on their own.

Overall, participants found therapy helpful although few were able to address size issues directly. Some participants spoke of using tools they learned in therapy in the service of furthering their acceptance of size and weight. These tools included problem-solving methods, ways to bring
intellect and emotion together, and techniques for interrupting automatic response to triggers for shame and powerlessness.

Those participants who were able to address issues of size, weight and acceptance in therapy stated their delight and relief at being able to do so. Some of these women felt they had had to educate their therapists regarding such issues. One participant felt fortunate to have started in therapy with a fat-positive therapist before she herself could give meaning to the notion of fat-positive.

Some participants described having once regarded size issues as relatively unimportant compared to other issues they had brought to therapy (including adult relationship issues, employment concerns, abuse issues, anxiety, phobias and many manifestations of depression including suicidality) but in retrospect saw a connection between their internalized shame about size, the recapitulating effects of experiences involving prejudice and discrimination based on their size, and the difficult life issues they had discussed in therapy.

Some participants stated a clear preference for a fat woman as therapist, if that choice were available, because of the comfort level they feel with other fat women. Some voiced the opinion that a fat therapist, male or female, who was fat-positive and at a high level of acceptance would be ideal. Some felt strongly that a therapist's size did not matter as much as an understanding of issues that fat women face. Still others felt that, while at their present level of acceptance, the size of their therapist was not so
important, having had a fat therapist in early stages of their journey toward acceptance would have made it easier to talk to about issues of size and weight.

Participants uniformly expressed a preference for a therapist who is cognizant of the biological determinants of size, knowledgeable about issues facing fat women, and, whatever the therapist's own size and weight, comfortable with his or her physical presence.

Participants were of mixed opinion about whether having a therapist speak about his or her own size and weight might be helpful. Some thought it would be extremely helpful, others were neutral, and still others felt such conversation might somehow violate boundary issues between client and therapist. All participants described experiencing significant curiosity about how their therapist regarded his or her own size and weight, whether the therapist was fat or thin.

Those participants who had experienced having a therapist suggest they lose weight, or suggest that they were in denial if they spoke in terms of accepting rather than changing, their bodies, reported that such suggestions had a negative impact on the therapeutic relationship.

Participants who are also therapists described clinical meetings in which fat clients were spoken of in disparaging terms. One therapist participant recalled fellow clinicians expressing the wish that they could be "just a little bit anorectic." These participants variously emphasized the need for this behavior to be interrupted; underscored the need for therapists be
educated about issues relating to fatness; and proposed that psychology as a profession needed to "get political" about size issues much the way it had regarding gender, race, ethnicity and sexual orientation.

The interactive design of this study allowed participants to comment on the effects of having been interviewed for the study. One participant reported to the group that as a result of her participation in the study, she had been able to speak to her therapist about size issues and that the outcome had been very positive. Another participant, who is a therapist, made the realization while she was being interviewed that she was ready to intervene the next time a fellow therapist made a disparaging remark about a client in a clinical meeting. Several participants included notes in their return copy of their interview transcripts saying how much they had learned about their own process of acceptance and their experiences as clients in therapy as a result of participating in the study.

All participants, whether or not they had been able to discuss issues of size and weight in therapy, offered suggestions concerning what therapists need to do in order to be helpful to clients who are fat women. Those suggestions included the following:

- Educating oneself about the biological determinants of size and the exacerbating effects of dieting, and issues that affect fat women as children and as adults.
• Engaging in significant personal self-exploration regarding one's own size, weight, eating habits and level of prejudice toward fat people.

• Remaining aware of the difficulty some fat women experience bringing issues of size and weight to therapy, even if they are able to discuss other difficult personal issues.

• Refraining from making assumptions about clients who are fat women including assumptions about whether a particular woman does or does not have an eating disorder, was or was not fat as a child, is or is not a survivor of sexual abuse, is or is not working toward acceptance of her size and weight.

• While not assuming that a fat woman has an eating disorder, asking about eating behaviors in the same way one might ask thin or average-size women.

• Understanding that problems a fat woman faces are not always a result of, but are often made worse by, the fact that she is fat. Additionally, understanding that therapy does not bring thinness and that the resolution of difficult life issues does not result in weight loss. This last point was aptly illustrated by Chloe when she described therapists' tendency to mistakenly conceptualize the therapy process as employing "psychotherapeutic Drano™" -- with the intention of suddenly thinning a fat woman through insight.
• Making the office size-friendly, that is, including furniture that accommodates large bodies, prints that reflect a range of body types and magazines geared toward large people.
• Developing an understanding of the "politics" of fatness including an understanding of the determinants of the social and cultural opprobrium regarding fatness; the political economy of the United States' 40 billion dollar per year diet industry; and the propensity of the dominant culture to sometimes view women, people of color, poor and working class people, fat people, and gay and bisexual people as negatively "different from," "other than," "not fitting into," and needing to change in order to be accepted.

Section Summary

Women who have chosen to embark on a journey toward acceptance of their size and weight represent an exceedingly small minority of women in this country. At any given time, 50 percent of women and 85 percent of high school girls in this country are dieting to lose weight. A culture of extreme diet and weight consciousness supports a diet industry whose profits exceed 40 billion dollars annually.

With the exception of the one study participant who was neither fat nor told she was fat as a child, these women experienced significant, some would say overwhelming, criticism and disapproval as a result of their actual size or caregivers' fear that they could become fat. Particularly difficult were
experiences that led to shame based on being told they were unattractive, and blame as a result of being told that they could control their size. As adults, experiences involving prejudice and discrimination based on size served to confirm and intensify feelings of shame, worthlessness and inadequacy.

Despite significant obstacles -- familial, social and cultural -- these women succeeded in transcending what they had at one time regarded as immutable givens, the "just desserts" or "what comes with the territory" of being a fat woman: that they would forever conceive of themselves as somehow inferior, unable to control their bodies, and incapable of fulfilling their potential in several life arenas until they achieved permanent weight loss.

These women have chosen to leave behind the assumptive world of their caregivers and the culture at large and adopt instead a different set of assumptions that has allowed them to live more fully. That these women have been able to find and remain on a different path, the path of acceptance, is testimony to the triumph of knowledge, will and spirit that allows them to live very different lives than the ones to which they once felt destined.

Taken together, participants' experiences in therapy (whether or not they were able to discuss issues relating to size and weight), and their recommendations for therapists who wish to be helpful to fat women, suggest that they want therapists to adopt a different world view, another paradigm regarding fatness and the issues that fat women face, than the one that is offered by the prevailing culture. Medicine, psychology, academia, sports,
media, entertainment and most particularly, the fashion and advertising industries -- all have adopted and actively promote a world view that denigrates size and severely proscribes the lives of fat people.

A paradigm of size acceptance begins from the premise that fat people do not need to change their size or shape in order to be acceptable and that large size can be enjoyed and even celebrated. A paradigm of size acceptance includes but is not predicated upon information regarding the biological determinants of size and the iatrogenic effects of dieting -- fat people deserve respect and equal treatment regardless of how and under what conditions they became fat.

The experiences of the fat women in this study demonstrate that the decision to work toward acceptance of size and weight can bring beneficial results in terms of improved physical and mental health. The realization that one can be fat and fit led some to enjoy exercise for the first time. Many reported learning to eat healthfully without regard for weight loss, beginning or deepening a spiritual practice, changing the tenor of personal relationships and being able, finally, to live in the present instead of waiting until the day they lost weight to do what they dreamed of doing with their lives. The majority expressed the desire to be able to share their journey toward acceptance, its triumphs and its continuing challenges, with a therapist they respect and trust without fear that early negative experiences be recapitulated as a result of the therapist's adherence to an outdated and harmful set of assumptions about fatness.
Table 5.1 illustrates the elements of contrasting paradigms. The outmoded but prevailing paradigm outlined in the left-hand column describes the values and beliefs most participants grew up with and subscribed to before they decided to work toward accepting their size and weight. The emerging paradigm outlined in the right-hand column represents values and beliefs that support and sustain fat women's, and by extension, all women's, choice to live full and active lives unrestrained by size and weight prejudice.
<table>
<thead>
<tr>
<th>Prevailing Paradigm</th>
<th>Emerging Paradigm</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Childhood and Family of Origin</strong></td>
<td><strong>Emerging Paradigm</strong></td>
</tr>
<tr>
<td>• Fat children eat too much and cannot control their food intake; therefore, food should be regulated and sometimes denied.</td>
<td>• When food and eating are normalized, most fat, thin and average-sized children eat similarly.</td>
</tr>
<tr>
<td>• If the eating patterns of fat children are regulated and controlled, they would not be fat.</td>
<td>• Fatness is a matter of biological diversity.</td>
</tr>
<tr>
<td>• Fat children are seen as the result of a parenting failure; parents should be able to control their children's behaviors.</td>
<td>• Fat children are fat because it is in their genetic makeup to be so.</td>
</tr>
<tr>
<td>• Fat children are targets for caregivers' control issues.</td>
<td>• Fatness is no longer a target for parents, teachers and other caregivers.</td>
</tr>
<tr>
<td><strong>Adulthood and Independence</strong></td>
<td><strong>Adulthood and Independence</strong></td>
</tr>
<tr>
<td>• Fat women are unattractive and challenge the current notion of beauty.</td>
<td>• Fatness is seen as no more or less attractive than other body shapes and sizes.</td>
</tr>
<tr>
<td>• Fat women should diet to lose weight.</td>
<td>• Repeated dieting resets the body's setpoint, resulting in weight gain.</td>
</tr>
<tr>
<td>• Fatness represents the absence of physical and mental health.</td>
<td>• Fat women's physical fitness and mental health is not associated with their size.</td>
</tr>
<tr>
<td>• Fat women are the object of ridicule.</td>
<td>• &quot;Making fun&quot; of fat women is a transgression of societal norms.</td>
</tr>
</tbody>
</table>
• Fatness is the result of out-of-control behaviors that should be mastered.

• Fat bodies reflect biological diversity. Some women are fatter than they might have been had they not dieted repeatedly.

• Fat women are not hired or promoted because they are perceived as incompetent, unattractive and poor representatives of the organization; they are discriminated against based on their size.

• All women are considered by employers and potential employers on the basis of their talents, skills and experience.

• Fatness is reviled and feared.

• Fatness is a neutral state of being; "fat" is a descriptive term.

• It is shameful to be fat. Fatness represents a lack of willpower and moral fiber.

• Fatness is neither a moral issue nor an issue of lack of self-control.

• Fat women are unattractive and non-sexual and therefore undesirable partners.

• Fat women are attractive, sexual and desirable as partners.

• Fat women should dress simply, in dark colors and vertical stripes.

• Styles for fat, thin and average-sized women are not determined by body size but by individual taste and expression.

• Women are valued based on what they look like.

• Women are valued based on who they are, not on how they look.

Therapy

• Many therapists regard insight or the resolution of issues as resulting in weight loss.

• Many fat women reach resolution of difficult life issues and do not lose weight.

• Many therapists see fatness as the source or manifestation of unresolved issues.

• Therapists understand that fatness is biologically determined.
• Therapists’ unexamined and unresolved issues about size and weight (regardless of therapists’ actual size) prevent them from effectively discussing these issues with their fat clients.

• Fat women are reluctant to talk about issues of size in therapy for fear of rejection by therapist or suggestions regarding weight loss as an antidote to emotional pain.

• All fat women have eating disorders. All fat women have experienced sexual assault.

• Therapist training and education programs do not include information on issues of size, the biological and physiological origins of fatness, and possible transferential and counter-transferential dynamics.

• Therapists operate from opposing erroneous assumptions 1) that fat women’s problems result from their being fat and 2) it is because women are fat they have difficult life problems.

• For fat women to accept their body size is to be in denial of the health consequences and social stigmatization and therefore self-destructive.

• Therapists are free of internalized shame and false assumptions about fatness.

• Therapy is a safe arena for fat women to bring any and all issues.

• Some fat women have eating disorders. Some fat women have experienced sexual assault.

• All therapists are trained and educated regarding issues of size, the origins of fatness and dynamic considerations.

• Therapists understand that many fat women’s lives are made more difficult by their size but that size is not a manifestation of unresolved issues.

• Fat acceptance represents self-affirmation, belonging and a sense of greater possibilities, resulting in women leading fuller, more active lives.
Discussion of Relevant Literature

This section will offer a discussion of the ways in which the results of the present study are consistent with relevant literature as well as the points at which they diverge.

Many participants described being "dieted" as children and their many successive attempts at weight loss as adolescents and adults. Two women in the study each reported losing one hundred pounds during a single episode of dieting. All participants described gaining back the weight they lost on any particular weight loss plan most often with additional pounds added to their starting weight. These women's experience is consistent with literature on setpoint and the body's tendency to return to a certain weight range after a period of what it perceives to be deprivation (Keys, 1950; Bennett and Gurin, 1982; Stunkard, 1974; Gaesser, 1996).

Many women came to believe that dieting was futile as a result of their own, sometimes expert-level, experience with dieting well before they learned about research on setpoint and the deleterious effects of repeated weight loss. Also, with the exception of one participant who had been a size activist for 20 years and another who as a divinity student had explored the cultural implications of size, women in the study were largely unaware of the significant subset of material that might be described as popular or self-help within the body of literature on the psychological and cultural aspects of size.

Without direct benefit of reading titles from authors in this group such as Kano (1985), Freedman (1985), Ornstein and Sobel (1989), Lyons and Miller
(1999) and Erdman (1995), some participants described deciding on their own to engage in many of valuable and sometimes life-changing activities contained in these books. Recommendations made by these authors include ceasing dieting for weight loss, eating for health and increased energy, interviewing and educating healthcare professionals about size issues, and learning to live in the present rather than putting off living until they lost weight.

Several of the women in the study discovered that it is possible to be fat and fit and that the benefits of exercise pertain in the absence of weight loss, thus confirming the findings of both physiological researchers (Ernsberger and Haskew, 1985; Gaesser, 1996) and proponents of fitness and exercise geared toward large people (Lyons and Burgard, 1990); (Lyons and Miller, 1999).

Nearly all study participants commented on feeling shamed because of their size and the intensifying effects on that shame of being blamed for their size as something that was within their control. Many also described feeling that their size made them entirely too visible to people who regarded them as unattractive. Erikson, in his pioneering work on identity (1968), speaks of shame and visibility. “Shame supposes that one is completely exposed and conscious of being looked at -- in a word, self-conscious. One is visible and not ready to be visible...” (p.110).

Paradoxically, when these women began to access information about the role of successive dieting in their weight gain and came to terms with the
notion that they had been blamed for something not within their control, they began to take control of their lives in ways not previously possible. They came into their own in terms of finding their sense of agency and becoming the locus of control (Strickland, 1989; Bandura, 1997) for positive change rather than the object of blame for their inability to lose weight. Participants began to eat healthfully without having weight loss as a goal, to engage in exercise to become fit regardless of weight, and to participate in activities they had been putting off until they lost weight.

It is instructive to compare the experiences of the women in the present study coming to terms with their identity as fat women to the literature on identity development for other marginalized groups. Here it is important to distinguish between the process of acceptance that has taken place in adulthood and the identity as fat people these women developed (with the exception of Louise who was neither fat nor told she was fat), as children and adolescents.

The processes by which individual fat people work toward acceptance of their size and weight lend themselves to analysis under the rubric of stage theory of development. Erdman (1991) asserted that these processes more properly describe a spiral rather than discreet stages in so far as the process is fluid, dynamic and not linear. Her observations are consistent with Tatum's (1997) analysis of theories of racial identity development. Tatum employs the image of the spiral staircase in pointing out that an individual may move up or down a spiral staircase and view a spot above or below that she has already
seen. The new vantage point, together with the individual’s accumulated experiences since the last time that spot was viewed, lend a unique perspective to the current viewing and the individual’s understanding of it.

Many of the participants in the present study were quick to point out how often assumptions had been made about them, based solely on their size. During childhood and in their adult lives, these women were assumed to be depressed, have low self-esteem and not care about how they appeared to others. Some participants recalled therapists making the assumption that they had an eating disorder or were survivors of sexual abuse.

The process by which an individual comes to accept and celebrate her physical self needs to be distinguished from the makings of a social movement. Most of the women in the present study reported that they had no knowledge of organizations such as the National Organization to Advance Fat Acceptance, the American Help Large People or Council on Size and Weight Discrimination. These women reported being unaware of either autobiographical works by fat women or the literature on the physiological and cultural aspects of size.

For these participants, the notion that they could begin to accept rather than change their bodies developed from personal experience with repeated unsuccessful dieting, an awareness of a personal genetic tendency toward fatness and a sense of justice and self-determination. These women’s lack of awareness of a fat acceptance movement or a nascent fat culture speaks to extraordinary strength of spirit and of intellect. Not only was there no
catalyzing experience such as the Black power movement for American Americans or the Stonewall Riots and their aftermath for gay people. These women had the support of neither their families nor a fat positive reference group.

Crandall (1994) and Wann (1998) assert that there is as yet no positive fat culture with which fat people who are resisting cultural stigma and stereotypes can affiliate and identify. Crandall suggests that fat people might benefit from membership in such a group culture in order to counter self-rejection and the tendency for marginalized groups to take on the negative values of the dominant culture. She suggests that a look at Fanon’s (1968) work on the effects of colonization on the colonized might be instructive for the formation of fat people’s identity as a group.

Wann (1998) contends that at present there is a fat community of sorts in that there are now more services and activities available to fat people. In order for there to be a true fat culture, however, there needs to be a critical mass of fat people willing to resist fat hatred. Only then can a common language evolve by which fat people can refuse oppression and celebrate shared understandings and experiences as do members of Jewish culture, black culture, queer culture and deaf culture.

In looking at the development of a fat identity in childhood, the experiences of the women in the present study diverge significantly from those of children from other marginalized populations. With the possible exception of children of color who were adopted by white families, children
who are members of populations marginalized by race or ethnicity generally live with caretakers who look like them in terms of target characteristics. Hearing parents of deaf children often take great pains to introduce their children to others who are deaf and to deaf culture at large. The notion that skin color or physical difference or disability could be under one's control is simply not a consideration much less an enduring topic of discussion in these households. Additionally, these caretakers are generally supportive of their children's identity and development regardless of the caretakers' own stage of development on the targeted characteristic or level of assimilation into dominant culture. In situations where the larger culture is regarded as hostile concerning target characteristics, home and family can serve as safe haven.

In some aspects, the childhood experiences of participants in the present study is probably more analogous to that of children whose caretakers perceive signals that a child's sexual orientation might be other than heterosexual, regardless of what the child's orientation turns out to be, and do all they can to discourage behavior that might support or confirm such an identity. For women in the present study who were fat or told they were fat as children, the attitude toward fatness on the part of caretakers was uniformly negative, regardless of their caretakers' own weight and size.

Whether or not fat was an accurate descriptor for a particular child, fatness carried only negative connotations. Whether these women were fat as children or told that they were fat when in fact they were not, they
developed a negative fat identity, an identity forged primarily by caretakers and confirmed by the culture at large. For many, their weight and what they were perceived as doing or not doing to lose weight were persistent topics of discussion for the entire time they lived with their families. At home they experienced no sense of safety from the dominant culture. There was, in fact, complete congruency between home and prevailing cultural prejudice and discrimination concerning size.

Study participants described their reaction to repeated negative actions on the part of their families of origin as sometimes resulting in distanced family relationships or emotional cut-offs similar to dynamics described by Kerr and Bowen (1988) and Alymer (1989).

Three participants described the presence of a positive adult role model who acted as an emotional savior, a concept prevalent both in family therapy literature and in the literature on child abuse, most particularly childhood sexual abuse (Featherman, 1989; Herman, 1992; Miller, 1994). In the present study, the women who served as a positive adult role model were relatives but not primary caregivers. These women who in Miller’s terminology constituted a "protective presence" treated study participants with kindness regarding their size, were nurturing of their dreams and aspirations, and encouraged them to participate in activities with age peers even when the participants as girls had internalized the notion that they were too fat to do so.

Participants’ descriptions of their process of working toward acceptance of size and weight as non-linear and life-long are consistent with Erdman’s
(1991) concept of the spiral of acceptance. Erdman comments that for the women in her study on fat acceptance "the process appears to be slow and gradual, circular and fluid" often without a stated goal or sense of what the process would look like at the outset (pp. 211-212).

Without attempting to place the totality of any one participant's experiences along a continuum of acceptance, it became clear that some participants in the present society had evolved further on some issues than others, an observation also consistent with Erdman's findings. Erdman discarded the metaphor of journey to describe the process of acceptance because of what she perceived to be its implication of consistent forward movement. In the present study, the word journey was employed purposefully to describe women's process toward acceptance because of its ability to connote a deepening of understanding and the possibility of transformation, as in a spiritual journey.

**Implications and Recommendations for Research**

A question that both overarches and undergirds each of the implications and recommendations that follow is: how might study participants' lives have been different (and what might be done to insure that the lives of children are different) had their families and the culture at large been operating on a set of assumptions regarding fatness that regarded diversity of size and shape as normative, supported a positive fat identity,
fostered physical and mental well-being, and emphasized living in the present in order to realize ones potential?

Continued Research with Fat People as Participants

The conclusions drawn from this study's findings presented important new information about these participants' experience in therapy, the difficulty many of them experienced in bringing issues of size and weight to therapy, and suggestions each of them offered to therapists who work with fat women as clients. A longitudinal study involving these same women would enable the researcher to study participants' process of acceptance as it continues to unfold. A continuing study would have benefit in at least two major aspects: the stage-setting and information-gathering purposes of the first interview, which focused on issues other than therapy, would not need to be repeated and the interactive effects of women having participated in the first study could be assessed in terms of furthering their process of working toward acceptance of size and weight.

Two study participants who are African American postulated that there is greater acceptance of large size in African American communities. They suggested that this broader range of preferred body sizes, together with ideals of beauty that are differently constructed than those of the dominant culture, has been a source of support, solace and positive identity for women who have been largely marginalized by the dominant culture. One of these women, a therapist, contends that this latitude is eroding because of the
increased influence of nationalized media and greater assimilation of many members of communities of color into mainstream culture, with the result that the experiences of younger generations concerning size and weight differ significantly from those of older generations.

Research with fat women from various communities of color could determine a) if there is, or ever was, greater acceptance of large size in these communities, b) if so, if this range is narrowing and to what that effect might be attributable, and c) if the experiences and attitudes of younger women regarding size and weight differ significantly from those of their elders.

If it is true that parameters of body size acceptability are narrowing, it might mean that young women of color are caught between assumptive worlds concerning size and weight at this point in history. If that were the case, it would be helpful for women who are members of these communities of color, and educators and counselors who work with them, to know that a change in cultural trends does not need to signal that women need to change their bodies.

Similarly, some lesbians maintain that there is greater latitude of size acceptance in some lesbian communities and that many women have found there a refuge from the narrowly defined standards of beauty, including size, espoused by the dominant culture. Some theorize, however, that this greater acceptance is being challenged by the countervailing effects of the significant emphasis currently placed on fitness and athleticism.
Studies with only lesbians as participants could explore the question of a) whether there is, or ever was, greater latitude of acceptance of body size in lesbian communities, b) if so, if an emphasis on athleticism and fitness has countered or tempered this effect and c) how fat lesbians of various ages make sense of their experiences regarding size and weight.

If it turned out to be true that such a cultural shift were in process, it would be helpful for fat lesbians, and for educators and counselors who work with them, to be able to name it as such. Again, a change in cultural ideals does not need to signal that women need to change their bodies.

Fat men have routinely been excluded from some activities traditionally regarded as the male sphere. For example, fat boys are often not chosen as competitors in sports activities and fat men are excluded from the description of "athletic" or "fit" even though they may be both. When advertisers seek to portray masculinity, for example, in the image of the successful businessman, accomplished artist or rugged outdoors man, they do not seek fat men as models. Fat men are sometimes rendered ineffectual or invisible by prevailing cultural standards.

Research with men as participants could lend valuable information about issues that fat men face as a result of their size and weight. It would be important not to assume that men’s experiences are similar to fat women’s experience. Important information might be gleaned from this research about how best to assist individual men along the path of acceptance, if that is what they choose and if that is how they might conceptualize such a process.
If men bring these issues to therapy, it would be important to learn how they present such issues and which therapeutic activities and interventions might be most helpful.

Studies with only therapists as participants might inquire as to therapists' attitudes toward fat women as clients, therapists' attitudes toward their own size and weight and if and how they might bring issues of size and weight into therapy with fat women. One possible design might be a two-part study in which therapist participants are first given a quantitative questionnaire assessing their level of knowledge about issues influencing the lives of fat women followed by a qualitative interview examining 1) therapists' attitudes toward their own body size and 2) how they interact in therapy with clients who are fat women.

Research with fat women who are therapists might inquire about these women's perceptions of themselves as fat woman and as therapists, their stated and tacit positions when conducting therapy, and how a) their level of knowledge and b) their manner of self-presentation as fat women affect how they conduct therapy.

Finally, research with members of a culture less identified with or influenced mainstream U.S. values concerning size and weight including possibly some of the more isolated Micronesian islands or domestically, various American Indian nations, could offer valuable insights into the lives of fat people who grew up in a culture that constructs the notions of size and shape differently. Identifying the elements that contributed to building a
positive fat identity as children that continue to sustain them as adults, particularly if theirs is a culture undergoing a shift toward mainstream or Western values. This information could contribute to programs that might help maintain traditional values in their culture and possibly shed light on similar programs to be developed for children growing up in fat-phobic cultures.

**Continued Research with and for Educators**

Educators at all levels need to create and adapt curriculum for classrooms, parenting programs, sports activities and health education settings that teach acceptance and affirmation of diversity in regard to body shape and size. Aronson (1997) indicates that size prejudice is a significant problem in both elementary and secondary schools. He cites a National Education Association report that describes fat children as being subjected to "almost constant harassment, discouragement and . . . discrimination at school." During the mid-1990s, 12-year-old Florida boy, a 15 year-old boy in Georgia and a 13 year-old girl in England all committed suicide after being teased about their weight at school. The deaths of these young people brought into focus the importance of size diversity education for teachers who learned about these incidents.

Participants in the current study reported that the negative messages they received at home were confirmed and replicated in all other venues they visited as a child and as a teenager: the classroom, the playground, summer
camp, the school nurse, gym class, health education class. Each of these can become an arena in which size and weight are included under the umbrella of diversity. Key to the success of any curricular effort is the degree of attention and emphasis it receives as part of an education program for educators, either as initial training, as inservice, or as part of other continuing education initiatives.

An effective program for classroom teachers and other caregivers on the topic of children and size diversity would include information concerning the genetic foundations of fatness, the concept of setpoint, and the exacerbating effects of dieting (or, in the case of young children, being "dieted") on a biological tendency to gain weight. This information might enable teachers and other educators to regard fatness in children as an expression of biological diversity rather than the result of overeating.

An effective program would also include information about normalizing eating for all children so that they can find the natural pattern of eating that supports their normal growth and development. With this information, teachers could assess how food is managed in the school setting and assist parents in learning that food does not need to be regulated and controlled at home. Teachers would be able to help parents, and visa versa, understand that fatness is neither within children's control nor the result of bad parenting. The overarching goal of such a program would be the elimination of teasing and ostracism based on size and the development of a supportive environment for fat children to participate fully.
Adams, Bell and Griffin (1997) present the theoretical foundations of diversity and social justice education and offer curriculum designs tailored to teaching about race, gender, class, sexual orientation and disability. The work of Adams, Bell and Griffin and their contributors can serve as a blueprint for developing curricula for teaching about size diversity.

Evans and Wall's (1991) volume on the experiences of gay, lesbian and bisexual students on college campuses offers many helpful suggestions for college faculty and administrators concerning how the college campus might move from mere tolerance to a deeper understanding and appreciation of sexual orientation. Many of the ideas cited in this work could be adapted for use in educating college students, staff and faculty about fat prejudice and size discrimination.

Elements of Hardiman's (1982) work on the development of white identity might be successfully adapted to teaching about issues of size. Thin and average-size people might be helped to learn a positive appreciation of their own body size, how a dominant cultural standard of body size emerges and becomes normative, the relative and transitory nature of such standards, and the cultural and social privilege that accompanies membership the dominant group.

The model employed by Weise, Wilson, Jones and Neises (1992) to educate first-year medical students about size prejudice might be adapted for a variety of target groups and audiences. In a pre-intervention assessment, Weise et al. found that medical students had accurate knowledge of the
genetic bases of obesity but still blamed fat people for their size and described them as lazy, sloppy and lacking in self-control. Following an educational intervention, students were less likely than the control group to blame fat people for their size or to engage in negative stereotypes.

The few curricula on size diversity directed at children need to be evaluated with the seriousness and attention paid to violence education programs, peer mediation programs and other diversity education curricula. The Council on Size and Weight Discrimination, the National Association to Advance Fat Acceptance and Radiance magazine currently offer such programs. The elements of each of these teaching units evaluated as most effective need to be made available to classroom teachers and other caregivers at all levels.

Particular attention must be paid to the needs of fat children themselves. The initiatives described above are aimed at educating a child’s peers, parents, teachers, nurses, coaches and other professionals about the topic of size diversity and the issues facing fat children. These efforts are intended to make the fat child’s environment a safe and welcoming one. The most important consideration, however, is ensuring that the fat child feels confident and competent in each of these settings. The development of a positive fat identity among fat children needs to be supported in all possible venues.
Continued Research with and for Psychologists and Psychotherapists

Participants in this study identified ways in which the actions of parents, teachers and other caretakers fostered the development of a negative fat identity. Psychologists can play a key role investigating the ways in which a positive fat identity might be fostered by a child’s caretakers and formulate programs based on careful research and well-grounded theory. Practicing psychotherapists might introduce these programs to parents, teachers, exercise instructors, coaches, camp counselors and other caregivers. A fundamental research question might be posed as follows: How can well-informed and well-intentioned caregivers who operate in the context of a largely fat-phobic culture not only teach acceptance and affirmation of diversity in regards to body shape and size but also engender a positive fat identity in children whose body size appears larger than average?

Therapist education remains an area of crucial importance. Sue, Ivey and Pedersen (1996) maintain that current theories of counseling and psychotherapy inadequately account for cultural diversity and that at present therapists are inadequately prepared, by education and experience, to successfully engage in multicultural counseling. Brown (1985, 1989) urges psychotherapists to educate themselves about issues facing fat women before seeing these women as clients and posits that it is unethical to do otherwise. Sue, Ivey and Pedersen’s metatheory of multicultural counseling holds promise for being adapted as a tool for inquiry into fat women’s issues, fat
culture and the possible dynamics involved when conducting therapy with this population.

The following are fundamental areas of inquiry and exploration regarding size issues to be addressed by therapist education programs, both initial therapist training and continuing education for practicing therapists:

An effective therapist education program would include information about the genetic basis of fatness and the intensifying effects of repeated dieting on a tendency to gain weight. This information would allow therapists to regard fatness as an expression of biological diversity and to understand the connection between dieting and repeated weight gain. A possible outcome is that therapists might no longer a) suggest weight loss as a solution or b) continue to view fatness as a manifestation of unresolved problems.

Lyons and Miller (1999) offer a useful paradigm in their approach to working with large women in medical settings. In their transition from weight-focused therapies to health-focused therapies, Lyons and Miller witnessed many large patients begin to eat healthier and exercise more regularly, with the benefits of lowered cardiovascular risk, increased functional capacity, reduced fear of seeking medical care and decreased incidence of depression. Lyons' Great Shape Program is a dance and exercise class designed especially for large women. Each session ends with a 20 minute discussion designed to encourage social support and lessen shame and embarrassment about weight. Psychotherapists might make use of a
similar paradigm shift in their clinical practices by focusing on positive and effective changes in activity and body image regardless of actual weight status. Therapists can also refuse to support the "thin-at-any-cost" mindset and instead encourage clients to engage in food and exercise choices that promote health.

An effective therapist education program would include information about issues that fat girls and fat women face as a result of living in a culture that regards fatness in wholly negative terms. For example, women in the present study who were fat as children or whose caregivers feared they would become fat, had their food controlled or denied, and were told they were lazy, unattractive and failures because they were unable to control their weight. The routine teasing and exclusion from activities they experienced was largely uninterrupted by parents, teachers and other caregivers. Only three mentioned an adult who acted as a protective presence.

It is important for therapists to learn about the impact of size discrimination. Many participants carried compromised self-esteem from childhood into adulthood. Adult experiences of prejudice and discrimination, by health care providers, employers and others, only served to further confirm feelings of worthlessness and inadequacy. Some women employed a form of functional dissociation, separating body from mind. They did so in order to distance themselves from bodies that continued to carry shame and represent a fundamental lack of control and as a coping strategy in response to the paradox of being physically large and
simultaneously being regarded as invisible. Developing an awareness of experiences such as these could assist therapists in understanding possible effects on fat women’s social and emotional development.

Access to information concerning on-going discrimination against fat women in the areas of employment (Rothblum, 1992) and healthcare (Olson et al., 1994; McAfee, 1996) would give therapists and would-be therapists a grounding in the political and economic realities facing fat women. Rothblum found that whereas it was previously thought that poverty causes obesity, that in reality fat people are often poor because of the effects of employment discrimination. Olson et al. and McAfee found that many fat women do not seek medical care because they have a history of significantly negative interactions with health care providers. McAfee found that some fat women do not receive the care they need because providers do not know how to perform certain procedures on fat patients.

Programs for therapists and therapists-in-training might look at how cultural prejudice regarding fatness enters into the therapeutic relationship, both in terms of the client’s internalized fat phobia and in terms of unexamined assumptions about fatness on the part of the therapist. Also, an examination of transferential considerations could lend important insight into possible dynamic aspects of doing therapy with fat women. These considerations include the decision by each party concerning whether or not weight or size will be discussed, the relative sizes of client and therapist, assumptions the therapist might carry about whether the client has an eating
disorder and the meaning of weight loss, the client's conjecture about how the therapist regards the client's size and how the therapist regards his or her own size.

Stiver's (1997) remarks on the role of transference in the relational model of therapy espoused by The Stone Center for Women could provide important guidance concerning conducting therapy with fat women who previously have been unable to discuss issues of size and weight.

Contrary to the traditional notion that it is the "blank screen" of the therapist that allows the transference to be "worked through," we believe that a genuine relational context provides the safety and conducive setting to attend to representations of old relational images in the transference, in a way that can be most helpful. (1997, emphasis is Stiver's)

A model of therapy that is interactive and relational could serve as a necessary corrective measure for women whose experience of their physical selves was sometimes overwhelmingly negative. Such a model could prove helpful for women whose early experiences concerning size lacked adequate protective measures on the part of adults.

In order for therapists to work effectively with fat clients, it is important for them to examine how prevailing cultural standards of beauty influence the therapeutic relationship. An effective therapist education program would also include self-examination and self-discovery aspects designed to foster an identification of how the therapist's own attitudes toward size and shape either support or help to dismantle size discrimination and fat prejudice. A possible learning unit could focus on the ways in which
psychologists, social workers, and other psychotherapists have begun to engage in political activity regarding other social justice issues and how anti-fat prejudice work might be included. Therapists who completed such learning activities would be better positioned to act as resources for fat clients who choose to work toward acceptance of their size and weight.

**Chapter Summary**

This chapter focused on conclusions drawn from the analysis of the data presented in Chapter IV. The conclusions were presented in two major categories: participants' experiences as children, adolescents and adults and the process of working toward acceptance of size and weight; and participants' experiences as clients in psychotherapy. These conclusions were followed by a review of relevant literature and recommendations for further research.

**Final Summary**

Information gleaned from the researcher's experience as a member of a fat women's support group and from pilot activities conducted prior to embarking on the present study indicated that the lives of fat children, adolescents and women are often made more difficult as a result of size prejudice, that a small number of fat women have made a decision to work toward accepting rather than changing their bodies, and that many fat women found it difficult to speak about issues of size and weight in therapy.

An examination of the literature indicated an increasing but still limited understanding of the biological bases of fitness and the exacerbating
effects of dieting. It showed an increase in the number of volumes written from a psychological or cultural perspective that emphasize the notion of socially constructed standards of beauty and body size. Another area of research indicates that there is significant social prejudice toward fat people in nearly every arena. Only one study, however, focused on fat women's process of acceptance of size and weight. There were no known studies focusing on fat women's experiences as clients in psychotherapy.

Four criteria formed the basis for participation in the present study. Participants needed to have been at least 30 years of age; have a body mass index of at least 34; self-describe as working toward a positive acceptance of their size and weight; and have been a client in psychotherapy, either previous to or concurrent with participation in the study. The study was exploratory and descriptive. Using in-depth phenomenological interviewing (Seidman, 1991 and 1998), ten women from New England were interviewed twice individually and were invited to a focus group interview that followed the individual interviews. Prior to the individual interviews, participants were asked to complete two worksheets: one regarding their attempts at weight loss and factors that influenced their decision to work toward acceptance of their size and weight, the other on experiences in psychotherapy.

The first individual interview focused on issues they faced as a result of their size, as children, as adolescents and as adult women. The second individual interview focused on participants' experiences in psychotherapy.
Prior to the group focus interview, participants received a copy of the transcripts of their individual interviews and an executive summary of themes, without attribution to individuals, that had emerged from all individual interviews. The focus group interview provided an opportunity for participants to reflect upon issues most salient to them, in the context of the group, and to reflect further upon the meaning they attached to working toward their size and weight and the role of psychotherapy.

The data were analyzed for themes and experiences common to several participants and for those unique to an individual. Only one participant was neither actually fat nor told she was fat as a child. The childhood experiences of the other nine participants concerning size and weight were largely negative. These experiences included having food regulated and sometimes denied, being told they were unattractive and lazy, being blamed for being unable to control their size, and being cautioned that, as adults, they would be unacceptable as partners and employees.

As a result of relentless negative messages concerning their bodies as children, participants found puberty a particularly difficult time. Three participants described the protective presence of an adult other than parents who treated them with kindness regarding their size and encouraged them to participate in activities with their peers rather than waiting to lose weight. As adults, experiences of prejudice and discrimination were experienced as recapitulating of childhood messages concerning their unacceptability as partners or employees. Most participants expressed that until they made the
decision to work toward acceptance of their size and weight, they continued to experience feelings of worthlessness, inadequacy and failure.

Factors that influenced participants’ decision and process of acceptance were many and varied. They included a personal connection such as a size-positive physician, therapist, or other healthcare provider; having a strong, self-affirming fat woman as a teacher or other role model; seeing large women portrayed positively in film and on television; and being able to make connections between race, class, gender, sexual orientation and size as part of a women’s studies course. Two participants who are African American cited the legacy of greater size acceptance in the communities of color in which they grew up. One participant pointed to her work on cultural analysis and political activism. Three women mentioned participation in Twelve-Step programs as a helpful complement to their work on size acceptance.

Most participants found it difficult to discuss issues of size and weight in therapy. Some participants cited fearing losing the relationship they had built with a therapist they had found helpful with other issues. Others feared that if they brought up size or weight issues in the context of acceptance, their therapist would see their working toward acceptance as a manifestation of denial and recommend weight loss as a remedy. These women feared that broaching issues of size meant the possibility of undermining the work they had already accomplished in therapy. Participants who are therapists recalled
harmful assumptions and disparaging remarks made about fat clients by fellow clinicians.

Participants who were able to discuss size and weight in therapy were typically able to do so with a current or recent therapist. One woman reported seeing a fat-positive therapist before she could articulate the meaning of fat-positive. Participants were of mixed opinion about whether or not it is important for a therapist to self-disclose concerning their size or weight. Participants felt it was important for therapists to know about the biological bases of fatness, to be aware of issues that face fat girls and women, to refrain from making assumptions about fat women having or not having eating disorders or being survivors of sexual abuse, and most important, to examine their own biases concerning size and weight. Participants described the ideal therapist as fat-positive and as having achieved a high level of self-acceptance concerning size.

The lives of fat women have only recently become the subject of serious research. This recent interest stems at least partly from a growing societal understanding of the biological basis of fatness and the compounding effects of repeated dieting on a tendency to gain weight. Additionally, fat women have begun to speak about the prejudice and discrimination they faced as children and adolescents and continue to face as adults. Participants in the present study who were fat or told they were fat as children spoke to the ways in which negative familial and cultural messages contributed to their developing largely negative identities as fat children. All described
incidents involving fat prejudice as adults, some with employers and healthcare providers including therapists, others with life partners or work colleagues.

Conclusions regarding these participants' experiences as children, adolescents, and adults; the decision and process of working toward accepting their size and weight; and their experiences as clients in psychotherapy can form the basis for further research. Further research might focus on various populations of fat people including men, women from various communities of color, lesbians, people who grew up in cultures less identified with prevailing U.S. cultural standards of beauty. Another possibility might involve the women interviewed for the present study in longitudinal research concerning their continued process of working toward acceptance and their possible further experiences in therapy.

Conclusions from the present study can also form the basis for creating and adapting curriculum for use with children and with adults. Curriculum for elementary, secondary and college students would focus on size as a diversity issue in schools, with a dual emphasis on lessening size prejudice and on creating supportive environments for fat children and adults to learn and thrive. Curriculum for adults would have the same goals and be tailored specifically to teachers at each level, social justice educators, parents, after school programs, camp staff, sports instructors, nutritionists, school nurses and all other professionals whose job it is to educate and create a supportive environment for all learners.
Finally, these conclusions can serve as the basis for effective therapist education programs, both initial therapist training and on-going continuing education. Therapists who are able to educate themselves about the biological bases of fatness and the issues that face fat girls and fat women; engage in self-examination of their own biases concerning size and weight; learn about what it means for women to work toward acceptance of size and weight; and learn about possible dynamic considerations involved in conducting therapy with fat women, will have positioned themselves well to be effective partners in assisting these women to live fully, in the present, with enhanced self appreciation. Ideally, therapists who are already aware of connections between race, gender, class and sexual orientation will be inspired to include information on size in their work as agents of possibility and change.
# APPENDIX A

**DEMOGRAPHIC SUMMARY OF PARTICIPANTS**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Sexual Orientation</th>
<th>Class Background</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emma</td>
<td>57</td>
<td>White, Jewish</td>
<td>Heterosexual</td>
<td>Middle Class</td>
<td>Masters Degree</td>
</tr>
<tr>
<td>Celia</td>
<td>46</td>
<td>White, Irish</td>
<td>Heterosexual</td>
<td>Working Class</td>
<td>Bachelors Degree</td>
</tr>
<tr>
<td>Chloe</td>
<td>29+</td>
<td>White, Jewish</td>
<td>Bisexual</td>
<td>Upper Middle</td>
<td>Masters of Divinity</td>
</tr>
<tr>
<td>Rita</td>
<td>34</td>
<td>African American</td>
<td>&quot;Mostly Straight&quot;/ Bisexual</td>
<td>Working Class</td>
<td>Working Toward Bachelor's Degree</td>
</tr>
<tr>
<td>Clare</td>
<td>39</td>
<td>Biological Parents: Irish/ French/American Indian Adoptive Parents: White English Protestant</td>
<td>Heterosexual</td>
<td>Lower Middle/Middle Class</td>
<td>Working toward Associates Degree</td>
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<tr>
<td>Leigh</td>
<td>38</td>
<td>White, French Canadian</td>
<td>Lesbian</td>
<td>Poor, Working Class</td>
<td>Working toward Associates Degree</td>
</tr>
<tr>
<td>Mariah</td>
<td>43</td>
<td>White, French Canadian and Seneca Iroquois</td>
<td>Lesbian (was married to a man)</td>
<td>Working Class</td>
<td>Bachelors Degree</td>
</tr>
<tr>
<td>*Ruth</td>
<td>50</td>
<td>White and Abanaki Indian</td>
<td>Heterosexual</td>
<td>&quot;Blue collar with white collar aspirations&quot;</td>
<td>Doctoral Degree</td>
</tr>
<tr>
<td>*Lilly</td>
<td>47</td>
<td>White, English and Irish</td>
<td>Lesbian (was married twice to men)</td>
<td>Both Working and Middle Class</td>
<td>Doctoral Candidate</td>
</tr>
<tr>
<td>*Louise</td>
<td>53</td>
<td>African American, West Indian</td>
<td>Heterosexual</td>
<td>Working Class</td>
<td>Doctoral Degree</td>
</tr>
</tbody>
</table>

*indicates participant who is a therapist
FAT WOMEN AND THERAPY

I am conducting a study of the process by which fat women work toward an acceptance of size and weight and of fat women's experiences as clients in psychotherapy. Following an initial telephone interview, participants will be asked about their experiences as fat women during two individual interviews and one group interview.

Potential participants need to be at least 30 years old; have a Body Mass Index of at least 34 (chart printed on reverse); and have experience in psychotherapy. I am interested in interviewing women in a wide range of sizes (large and supersize); ages; sexual orientations; dieting/non dieting histories; racial, ethnic and cultural identities; and class backgrounds.

All information contained in participant questionnaires and interviews will be kept confidential. Interviews will be recorded on audio tape. Pseudonyms will be used in the written dissertation. Participants may discontinue participation for any reason. Participants will have an opportunity to ask questions about the study and will receive a copy of a summary of the results.

I am a fat woman and a doctoral student in counseling psychology in the School of Education at the University of Massachusetts, Amherst. I have a long-standing interest in the process of self-acceptance and in fat women's experiences in therapy.

If you are someone who meets the above criteria and would like to be considered as a potential participant, or if you would like more information, please give me a call.

Anne Downes
Dear (Participant Name):

Thank you for your time and for your interest in participating in this study on your process of working toward acceptance of size and weight and on your experiences in psychotherapy.

I am including in this mailing three items that I am asking you to review carefully before we interview on day at time. The three items are: a letter concerning informed consent regarding being a participant in the study; a worksheet history of dieting/weight control and significant events that affected your decision and process of working toward acceptance of size and weight; and the interview guide which contains questions that will form the basis of our first interview.

* **Informed Consent Letter** Please read this letter carefully and be sure to ask for clarification of anything that is not clear. You may call me for more information (phone) or we can discuss your concerns when I see you on . I will ask you to sign the informed consent letter, which I will keep, before we begin our first interview. You will have a copy of the letter to keep.

* **Worksheet** On the left side, please record any attempts you may have made at dieting, weight loss or weight control. On the right half, please record significant people or events that affected your decision to work toward
acceptance of your size and weight and your current process of working toward that goal.

* Interview Guide These questions will guide the process of our first interview. We will focus on those issues that hold the most meaning for you. The questions are meant to stimulate recollection but not intended to be exclusive by any means. You do not need to write responses but please feel free to do so if you find it helpful. Note that there is a question that asks you to comment on experiences you have had that may not be mentioned in the guide.

Please call me (phone) if you have questions about any of these materials. I look forward to seeing you on date.

Sincerely,

Anne Downes
APPENDIX D
WRITTEN CONSENT FORM

Dear Participant,

I am a doctoral student in the School of Education at the University of Massachusetts at Amherst. For my dissertation research I am conducting a study that focuses on fat women's process in coming to terms with size and weight and their experiences in psychotherapy. You are one of 8 - 12 participants from around New England.

As a participant in this study, you are being asked to take part in three in-depth interviews: the first two will be with you alone and last between ninety minutes and two hours. The third will be a focus group interview of all participants and last approximately two hours. The goal of each of the interviews will be to allow me to understand your experiences as expressed in your own words. The first and second interviews will focus on your experiences as an individual. The focus group session will allow for interaction between participants.

Prior to the first interview, I will mail to you a worksheet asking about possible dieting history and list of potential questions about your process of coming to a positive acceptance of your size and weight. Prior to the second interview, I will mail to you a worksheet on which I will ask you to simply record any engagement in psychotherapy and a list of potential questions.
about your experiences as a client in psychotherapy. Prior to the third interview, I will mail to you a group summary of themes that have emerged from the interviews thus far. This information will form the basis of our third interview, the focus group interview.

Each interview will be recorded on audio and the tapes will be transcribed. On the transcripts, a pseudonym will be used in place of your name. Any identifying information and the audio tapes will be kept in a locked location. After the first two interviews, you will be given two copies of the transcript. If you wished to delete any portion of the transcript you, you would be able to do so simply by indicating those deletions on one copy of the transcript and returning it to me. Following the third interview, the focus group interview, each participant will be asked if there is anything she wishes not to have included in the transcript. For reasons of continued privacy for individuals, transcripts of the group interview will not be made available to participants.

Very little has been written about fat women's process of coming to terms with size and weight or about fat women's experiences in psychotherapy. During the course of this study, I will be looking for themes and significant issues in each woman's experience. I will want to know which factors influenced your decision to adapt a fat identity, rather than that of a person continually struggling to be thin. I will want to know what the experience of psychotherapy has been like for you and the ways in which you may or may not have used therapy to explore issues of size, weight and
eating. Your story (under a pseudonym) will be represented in the written dissertation, using quotes or profiles of your experience. This material may at a future time be incorporated into other writing such as a book or journal article or used to further classroom instruction. Again, at no time would I make available identifying information about you or about others you choose to speak about.

Prior to the interviews, you will be asked to complete brief worksheets as described above, and this consent form. You may withdraw from participation at any point during the study. If you withdrew from the study, all audio tapes and transcriptions would be destroyed.

In signing this form, you are authorizing me to use the material collected as described above. In addition, you are acknowledging that all documents, including audio tapes and transcripts, will become my property.

I, ____________, have read the above information and I agree to participate in this study under the conditions stated above. I have had the opportunity to ask questions and Anne Downes has answered any questions I might have had to my satisfaction.

_________________________  __________
Signature of Participant            Date

_________________________
Signature of Interviewer             Date
WORKSHEET ON ATTEMPTS AT WEIGHT LOSS

<table>
<thead>
<tr>
<th>AGE</th>
<th>Please describe any attempts at dieting or weight control.</th>
<th>Please describe significant people or events that influenced your decision/process of working toward acceptance of your size and weight.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-15</td>
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<td>16-20</td>
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<td>21-29</td>
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<td>30-39</td>
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<td>40-49</td>
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<td></td>
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<td>50-59</td>
<td></td>
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<td>60-69</td>
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</tr>
<tr>
<td>70-79</td>
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<td></td>
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</tbody>
</table>
## APPENDIX F

### EXPERIENCE IN THERAPY

<table>
<thead>
<tr>
<th>Approximate Dates/Duration</th>
<th>Issues That Brought You To Therapy</th>
<th>Satisfaction With Process Of That Therapy</th>
<th>Other Comments</th>
</tr>
</thead>
</table>
Being Fat

People have all sorts of ideas about why people are fat. What do you think has contributed to your size and shape?

Have you always been fat? At what age did you first think of yourself as being fat? At what age did someone else first call you fat?

What is the best thing about being fat? What is most difficult about being fat?

What were/are the attitudes of the members of your family of origin toward your size and shape?

Were any of your primary caregivers fat? If so, how did they regard their size and shape?

What were the meanings given to food and eating by the members of your family of origin? What are the meanings given to food and eating by the people with whom you currently live or have primary relationships?

Describe your eating habits. In what areas are you more satisfied or less satisfied now with how you eat than you have been in the past?

Have you ever experienced prejudice or discrimination because you are fat?

If so, please give examples. What meaning do these experiences hold for you?

Before you started to feel that you could accept, rather than change your body, how did you think of yourself as a large woman?
Working Toward Acceptance of Size and Weight

When did you start to embrace the idea of choosing to accept, rather than change, your body?

Can you describe how you got to the point where you decided to work toward accepting your size and weight?

What does it mean to you to work toward acceptance of your size and weight?

How would you characterize where you were in the process of working toward acceptance of your size and weight two years, five years, ten or more years ago?

What are continuing challenges for you personally in reaching acceptance of your size and weight?

Social and Political Activity

Do you consider yourself socially identified with or politically active around issues of size acceptance or fat liberation? If so, please describe your involvement and say how it is meaningful to you.

* * * * * * * * * * * * * * * * * * * * * *

If there are important issues pertaining to: your experiences as a fat woman prior to deciding to work toward acceptance of your size and weight; your process of working toward that goal; or your involvement in social and
political activity concerning size acceptance or fat liberation that were not inquired about so far, please describe them.

Thank you for considering these questions carefully. I look forward to our interview time so I might hear your in-depth responses to the issues that resonate with your experience.

Therapy

If therapy has played a role in your process of working toward acceptance of your size and weight, has it advanced, deterred or been neutral in that process?

Using the worksheet on your experience(s) in therapy as a guide, please comment on the extent to which you felt supported in your goals for that therapy by your therapist in regard to the issues of dieting, weight loss, eating disorders and size acceptance. [You may or may not have entered therapy with these as stated issues. If you did not enter with these as issues please say how and by whom they were introduced into the therapy if that was the case.]

What is the most helpful thing a therapist has said or done in regard to your coming to terms with size and weight issues? What is the least helpful thing a therapist has said or done in regard to your coming to terms with size and weight issues?
In terms of your therapist educating you or you educating your therapist regarding issues of fat acceptance, what did you learn and what did you teach?

How do you think your therapist regards her or his own body in regard to size and shape?

How important is/was it for your therapist to have an understanding of the issues faced by fat women?

If you have had concerns or questions about your therapist's knowledge or attitudes about size and weight issues or about the process of therapy, have you been able to ask questions or state your concerns? If you have had concerns or questions, are there some issues about which you have been able to remark and other issues about which you have not? Please give examples.

What do you think therapists need to know and do in order to be helpful and appropriate toward clients who are fat women?

If you were looking for a therapist now, what attributes or experience would you look for?

If there are important issues about your experience of being a fat woman in therapy that were not mentioned here, please describe them.

Again, thank you for giving thoughtful consideration to these questions. I look forward to our next interview.
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