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Obesity Is Not New—Addressing It in Counseling Is

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Abstract

Counselors can no longer ignore the obesity crisis which affects 35% of adults and 17% of children/adolescents in the U. S. (Centers for Disease Control and Prevention [CDC], 2012a, 2012c). One of the most significant issues affecting clients with obesity is weight discrimination, as well as behavior change, isolation, depression, low self-esteem, body dissatisfaction, education and job discrimination, family interventions, bullying, and medical illnesses that accompany obesity. To empower clients to make sustained lifestyle changes, counselors must first recognize and acknowledge their own biases and countertransference issues regarding obesity. Assessment, goals, and interventions are discussed.

The topic of obesity in counseling is quite broad and encompasses the expertise of multiple disciplines. The focus of this article is on mental health issues related to obesity that can and should be addressed in counseling. The emotional and behavioral effects of obesity and obesity discrimination on children/adolescents and adults will be discussed, as well as the covert bias that the counselors themselves might be experiencing. Culturally competent cognitive and behavioral counseling interventions for the treatment of issues related to discrimination and obesity will also be explored.

Obesity affects 35% of adults and 17% of children and adolescents (CDC, 2012a, 2012b). Individuals are considered obese when their weight is 20% or more above normal weight (CDC, 2012a), as measured by the Body Mass Index score (BMI). Obesity-related

health conditions are well documented in the medical literature and include heart disease, stroke, type 2 diabetes, and certain types of cancer (CDC, 2012a). Studies have also examined the differences in obesity rates between urban and rural settings (Filbert, Chesser, Hawley, & St. Romain, 2009; McKee, Maher, Deen, & Blank, 2010), obesity rates in the workplace (Heinen & Darling, 2009), obesity rates among college students (Gieck & Olsen, 2007), and healthy dietary offerings in schools (Story, Nanney, & Schwartz, 2009). Some efforts have also been directed toward the promotion of public health laws to impact the eating habits of individuals in an effort to control obesity rates (Dietz, Benken, & Hunter, 2009).

Although much of the focus in obesity literature is on the detrimental physical effects of obesity, the emotional effects are less well understood. Research indicates that about 25% of individuals who are overweight or obese experience mental health issues that warrant treatment (Simon et al., 2006). Counselors should not assume that simply because an individual is overweight or obese, he/she will automatically have mental health issues.

Obesity Discrimination

For the 25% of overweight and obese individuals who do develop a mental health diagnosis, a major contributing factor to the depression and anxiety experienced is the societal discrimination they experience daily. Recent research on the bias and discrimination associated with obesity has identified it as the last acceptable form of discrimination in society today (Puhl & Brownell, 2001). Common misconceptions about obese individuals are that they are lazy, unmotivated, lonely, unintelligent, immoral, dishonest, inactive, less successful, and less self-disciplined (Harris, Harris & Bochner, 1982; Polinko & Popovich, 2001; Puhl & Brownell, 2001; Tiggemann & Rothblum, 1988). These stereotypes lead to prejudices and discrimination affecting wages and employment, admissions to college and other educational opportunities, and access to quality medical care and appropriate mental health treatment. The obese participants in a study by Puhl and Brownell (2006) identified the most common sources of discrimination as family members, doctors, classmates, friends, coworkers, teachers, and nurses.

Obese children and adolescents have been found to be the targets of early and systematic social discrimination (Dietz, 1998), with it beginning in children as early as age three (Cramer & Steinwert, 1998). Peer rejection, hurtful comments, social isolation, bullying, weight related teasing, and jokes are common with serious long-term consequences that manifest in adulthood as negative self-perceptions, loneliness, anxiety, poor adjustment, and greater body dissatisfaction (Robinson, 2006; Storch & Masis-Warner, 2004). For overweight and obese children, the psychological stress of social stigmatization can have the immediate effect of causing low self-esteem and poor body image which, in turn, can hinder academic and social functioning, and persist into adulthood (Swartz & Puhl, 2003). Obese children miss more days of school than normal or underweight children (Geier et al., 2007). A recent study by Halfon (2013) revealed that obese children have higher rates of activity restrictions, repeating grades, missing school, internalizing problems, behavioral conditions such as attention deficit disorder with hyperactivity (ADHD) or conduct disorder, and learning disabilities. Obese girls reported higher rates of relational victimization, suggesting higher rates of exclusion from

social activities (Pearce, Boergers, & Prinstein, 2002). Parents are less likely to invest in the college education of overweight children, with the effect being most pronounced for obese women (Crandall, 1994, 1995). There is also evidence to suggest that the acceptance rate to college is lower for obese applicants (Canning & Mayer, 1966). The bias against obese children extends to teachers who reported that most people don't want to associate with the obese and that obese persons are untidy, more emotional, less likely to succeed and have more family problems (Neumark-Sztainer, Story, & Harrris, 1999).

Adolescents who suffer from depression are at a greater risk of becoming obese and staying obese, with the greater risk for adolescent females (Blaine, 2008).Thus in adolescents, especially adolescent girls, depression can lead to obesity. Studies are mixed on the effects of obesity on depression, however, with some adolescents, particularly males, exhibiting resiliency against depression despite overt stigmatization (Wardle, Williamson, Johnson, & Edwards, 2006). Clearly more research needs to be done on the effects of depression on obesity and obesity on depression in the adolescent population.

Employment discrimination may be subtle but research indicates that obese employees earn less for the same position, are not hired into executive positions, and are denied promotions (Puhl & Brownell, 2001). Obese women earn 12% less than non-obese women (Loh, 1993). In regards to heath care, physicians have been found to spend less face-to-face time with obese patients (Hebl & Xu, 2001) and 24% of nurses reported they were "repulsed" by obese persons (Bagley, Conklin, Isherwood, Pechiulis, & Watson, 1989).

Adults who were overweight as children have fewer and less effective coping skills (Puhl & Brownell, 2006). Women who are obese report greater impairments in quality of life, weight related stigmatization, body image disturbance, risk for depression and suicide, and discrimination in education and the work force (O'Brien, Latner, Ebneter, & Hunter, 2012). In U.S. women, obesity increases the risk of being diagnosed with major depression by 37% (Haslam & James, 2005). Recent studies indicate that the discrimination may also extend to the courtroom. Schivey, Puhl, Levandoski, and Brownell (2013) found that obese female defendants were judged more harshly than non-obese defendants by male jurors. Heo, Pietrobelli, Fontaine, Sirey, and Faith (2006) found that the association between depression and obesity was dependent on gender, age, and race. Young overweight and obese women, Hispanics in particular, experienced depressive moods more often and of longer duration than non-overweight and non-obese women. Research is consistently confirming that obese females experience more weight-related discrimination than obese males. The reasons for greater impairment in women who are obese are complex but involve both cultural and psychosocial issues. Chronic stressors from daily life issues, cultural standards of beauty and body image criteria, societal roles that place women in the caregiver positions, caring for others before themselves, classism and poverty related stress, and their membership in low status groups which could include both race and gender are all contributing factors (Talleyrand, 2006).

Men seem to experience the effects of obesity discrimination to a lesser degree than women. Men who are obese seem to have a buffer against depression and suicide with obese men having a 37% lower risk of depression than men of normal weight (Haslam & James, 2005). However, men who experience perceived discrimination of any kind are more likely to see an increase in abdominal fat thought to be related to stress

hormones (Hunte, 2011). While obese men may not feel the effects of bias as acutely as women, a recent study revealed that the perceptions of others are equally negative for obese men and women, with obese Chief Executive Officers perceived to be less competent (Kwoh, 2013). Carr and Friedman (2005) found that obese upper white-collar workers (executives) were more likely to report work-related discrimination than their thinner peers, indicating that obese individuals in high status positions are perceived more negatively.

Counseling and Obesity Discrimination

Although the health care field has led the way in researching the effects of obesity discrimination in medical treatment, few studies have examined obesity bias/discrimination by mental health professionals. Young and Powell (1985) found that mental health diagnoses were affected by the weight of the client, with obese clients being assigned more negative symptoms than overweight or normal weight clients. The researchers also found interactions with the gender, age, and weight of the counselors, with men, older counselors, and overweight counselors assigning less negative symptoms (Young & Powell, 1985). Schwartz, O'Neal Chambliss, Brownell, Blair, and Billington (2003) found implicit anti-fat bias in a study of researchers, clinicians, psychologists, and other health professionals. Like Young, and Powell (1985), they also found lower levels of implicit anti-fat bias in males, older participants, and overweight participants. Other researchers have found that mental health professionals assign more negative and more severe psychological symptoms, lower functioning levels, more negative attributes, and more pathology to obese clients (Hassel, Amici, Thurston, & Gorsuch, 2001; Hassel & Lynn, 2002). This bias against obese clients does not seem to be addressed in counselor training programs to the same extent that bias against race, age, and ethnicity are discussed. In a study of mental health professionals in training, Pascal, Kurpiu, and Robinson (2012) found mental health trainees ascribed more negative personal characteristics to obese clients than normal-weight clients. Trainees rated obese clients as lacking in self-control, more unattractive, and having low self-esteem (Pascal et al., 2012).

The implicit bias counselors may harbor toward overweight and obese clients has significant implications for the treatment of these clients (Pascal & Robinson Kurpius, 2012). Assigning more negative symptoms and more severe pathology can result in more serious diagnoses which may in turn affect the client's self-perceptions and motivation for treatment. A counselor who believes that a client is lacking in self-control may be less likely to suggest the most appropriate interventions, inadvertently predisposing the client to failure without real evidence of any lack of self-control. It would be difficult, if not impossible, to assist a client who is facing discrimination in activities of daily life if the therapist harbors hidden feelings of disgust toward the client.

Obesity Related Issues in Counseling

Once it has been determined that the client is one of the 25% of obese/overweight individuals experiencing mental health issues related to their weight, counselors must examine their personal attitudes and beliefs about working with this client. To facilitate

this self-analysis, counselors can take self-assessment instruments such as the Universal Measure of Bias-Fat Subscale (Latner, O'Brien, Durso, Brinkman, & MacDonald, 2008). Once this self-evaluation reveals no underlying biases, the focus should shift to an examination of the specific issues causing concern.

Obese/overweight clients often bring both physiological and psychological concerns to the counseling sessions. Some clients will face the frustration of postponing necessary surgeries, such as knee and hip replacements, until weight loss is achieved, thus being forced to endure increased joint pain and decreased mobility. Some will also report sexual dysfunction or avoid going to see a doctor for a serious medical condition because of embarrassment of being weighed.

Clients might also reveal the emotional pain they feel from being rejected by family, friends, and peers and share experiences of being bullied or subjected to physical or verbal victimization. Some will report a lack of self-confidence and self-efficacy which in turn affects their employment opportunities. Others might report that they tend to isolate and refuse requests to engage in family activities, parties, and vacations because they fear the embarrassment of chairs not big enough to accommodate them, seat belts not large enough to fit them, and airlines that have been hostile to obese fliers (Doll, Peterson, & Stewart-Brown, 2000). Clients have reported the desire to accompany their families to amusement parks and other social activities, but fear not being able to get into the rides, being subjected to hurtful comments by waitstaff and other patrons at restaurants, and expressing a reluctance to engage in conversations because "people don't listen to fat people."

Assessment

Historically, professional counselors have responded to emerging societal mental health trends in assessment and treatment. Substance abuse and eating disorders (bulimia, anorexia nervosa) are prime examples of evolving mental health problems considered so pervasive as to warrant specific attention in general mental health screening efforts. Data continues to reveal the prevalence of obesity in society (CDC, 2012a, 2012c) and provides the impetus for professional counselors to expand and research current assessment and treatment efforts to include a specific focus on obesity-related issues.

A comprehensive psychosocial assessment provides the greatest foundation for the development and application of effective therapeutic interventions. Such an assessment should include gathering historical and current data to better understand the physiological, social/family, cultural, behavioral, psychological (emotional) development, and stressors related to bias/discrimination experienced by the client. One assessment tool that may be helpful is the Weight and Lifestyle Inventory (WALI) (Wadden & Foster, 2006). Once the assessment is completed, appropriate referrals to other professionals may be in order.

Physiological Data

Counselors should collect historical information regarding the presence of obesity during the lifespan of the client (child, adolescent, adult), early memories of weight issues, and individuals involved in those memories (parents, physicians, relatives, friends, classmates, sports team members, etc.). A BMI history should be developed along with a

history of diet/weight loss efforts including those under the supervision of a physician or nutritionist and those that were done independently.

Social/Family Assessment

The assessment should also include a family weight history. This history should include parents, grandparents, siblings, and other known relatives. Caution should be made to collect such information regarding natural family members rather than information about adopted or step-family members.

Cultural/Spiritual Assessment

Professional counselors should include an assessment of cultural/spiritual factors when assessing obese clients. Of primary concern might be an assessment of the availability of culturally competent counselors and social and spiritual leaders.

Efforts should be made to examine a client's "health beliefs" with regard to their perceptions of a healthy child or a healthy adult as they relate to the cultural and social environment. Such a discussion could lead to a better understanding of cultural standards related to beauty and body image as well as any social status associated with being overweight.

Additional information should be gathered regarding level of acculturation and the effects of racism, sexism, or classism on access to healthy food choices. Such data collection might also include the identification of the person responsible for the preparation of the family meals, and the location where food is purchased. Efforts should also be made to ascertain if healthy food choices are available where food is purchased.

Behavioral Assessment

Counselors should gather data regarding a client's eating habits. Such information should include a review of typical daily meals, snacking habits, and family holiday/celebration food history. Additional information should be gathered regarding the frequency and nature of eating out at restaurants or consuming "fast foods."

A behavioral assessment should also include a review of emotional eating. In particular, clients should be asked to identify how often eating occurs to satisfy emotional discomfort, whether this behavior can be classified as binge eating, and if purging behaviors are involved.

Clients should also be asked to identify their work and exercise habits as well as identify their level of involvement in typical leisure time activities. In particular, the counselor should be looking for the degree to which the client maintains a sedentary lifestyle. Leisure time activity should also include time spent watching television, time spent at the computer, and time spent playing video games.

Psychological Assessment

Attention should be paid toward an assessment of the client's preferred coping mechanisms and the degree to which these skills can be applied to daily stressors. In particular, counselors should be looking for the use of both positive and negative coping mechanisms. Puhl and Brownell (2006) identified positive coping mechanisms such as positive self-talk, heading off negative comments, coping through faith, seeking social support from others, humor, viewing the situation as the other person's problem, ignoring

the situation, and satisfaction with one's weight. These authors identified negative coping mechanisms as negative self-talk, avoidance, negative responses, eating more, dieting, and crying.

Stressors Related to Bias/Discrimination

Professional counselors should seek to determine the degree to which their obese clients have been exposed to weight-related bias/discrimination in various areas of their lives. Related educational stressors might include discrimination during college admission procedures, negative peer comments, bullying, or lack of support from parents. Related workplace stressors might include discrimination in hiring, promotions, or work performance ratings.

Clients might also experience stressors related to professional services they receive. Such stressors might include physician/nurse bias and inadequate accommodations in the waiting room or in hospital rooms. Stressors related to mental health services might include inadequate waiting room or therapy office accommodations or therapist bias.

Referral Assessment

Professional counselors working with obese clients should be sensitive to the need for referrals to other professionals in their communities. A referral to a physician or dietician/nutritionist might be in order as well as a referral to an exercise professional. Counselors should seek feedback from clients referred to other professionals to help develop a network of professionals who will not discriminate, either intentionally or unintentionally, against their clients.

Counseling Goals

Professional counselors should collaborate with their obese clients in developing a treatment plan that best meets the client's individual needs. Appropriate global counseling goals might include the following:

- Promote health and wellness
- Increase positive coping skills
- Set manageable goals that promote change in diet, exercise, or both
- Educate about discrimination and mental health risks
- Acquire the skills, motivations, and support to change diet and exercise patterns
- Improve social relationships
- Increase self confidence in social relationships
- Social skills groups focused on peer acceptance
- Referrals to physicians/dieticians/exercise specialists

Interventions

The Centers for Disease Control publishes numerous guidelines and recommendations for promoting healthy living and weight control (CDC, 2012b). These guidelines include innovation practices for school and workplaces and information for

children, adolescents, parents, adults and health professionals. The Council on Size and Weight Discrimination and the Healthy at Every Size movement provide information on health, counselors, and support groups (http://www.cswd.org/docs/links.html). In an interview with Warchal, Kennedy (2008) writes that both behavior and environment can be points of intervention for obesity prevention and treatment for both children and adults (p. 36). It is important to note that while the above mentioned goals for counseling individuals who are overweight or obese are generally accepted practice for dealing with issues related to discrimination and health concerns in general, there are few studies that support specific interventions for obesity discrimination. In one study, an intervention that aimed at eliminating a client's internalized weight bias by teaching acceptance and mindfulness showed promise and improvements in quality of life, distress tolerance, and psychological flexibility (Lillis, Hayes, Bunting, & Masuda, 2009). Much of the literature to date is focused on increasing public awareness of obesity discrimination, not on testing specific interventions to eliminate it in clients, professionals, or the public at large.

Professional counselors should consider utilizing fundamental elements of engagement when working with obese clients who meet assessment criteria for counseling services. Initially, clients should be assessed for readiness for change (Prochaska & DiClemente, 1983) using motivational interviewing and applying the Transtheoretical Model of Change (TTM). This model includes the core constructs of change processes, decisional balance, self-efficacy, and temptation (Prochaska & DiClemente, 1983). Use of the TTM coupled with unconditional acceptance and positive reinforcement provides the foundation for maximizing the counseling experience for clients.

Research has identified several buffering factors that can be developed and strengthened through counseling. Some of these include positive coping skills, support groups, positive reinforcement and motivation, and satisfaction with one's weight. It is also important to note that counselors need to be aware of when a referral to a physician, psychiatrist, dietician, nutritionist, or exercise specialist is appropriate so the counselor is not subject to a charge of practicing outside their area of competence. Murphy (2013) quotes Clark as advising "we need to be sure not to overstep our boundaries [as counselors] and stick to the general guidelines of what we know is healthy" (p. 44).

Summary

Counselors have an ethical responsibility to examine their own feelings about obesity and increase their awareness of any covert bias they may harbor toward clients who are obese. First and foremost, counselors should "Do No Harm." The American Counseling Association's *Code of Ethics* (2005), section A.4.b states, "Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that are inconsistent with counseling goals." Counselors also have a responsibility to develop skills appropriate to the needs of their clients, as stated in C.2.a., Boundaries of Competence: "Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client." The Council for Accreditation of Counseling and Related Educational Programs (CACREP)

2009 Standards also stress the responsibility of counselor training programs to address "counselor's roles in eliminating biases, prejudices, and processes of intentional and unintentional oppression and discrimination" (Section II. G.2.f; CACREP, 2009).

Shallcross (2012) quotes Perryman as suggesting that counselors who focus on a holistic approach to treatment are in a unique position to help clients overcome the effects of bias and discrimination and live a more complete and fulfilled life. Counselor education programs must include obesity discrimination, the last acceptable form of discrimination in today's society, in the multicultural/diversity training of future counselors.

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