# TESTING A MODEL OF COUNSELOR BIAS IN THE ASSESSMENT OF AND PLANNING TREATMENT FOR OVERWEIGHT CLIENTS

By

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To all those who have nurtured my growth, creativity, and curiosity and have encouraged me to go after my dreams

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Health professionals, such as physicians, nurses, and nutrition specialists, have endorsed having a preference to not care for obese patients, according to published reports (Puhl & Brownell, 2001). Three previous studies document that *mental* health professionals showed negative bias in their clinical judgments of overweight clients (Agell & Rothblum, 1991; Young & Powell, 1985; & Davis-Coelho, et al, 2000). This study tests a model for understanding the causes of these clinical biases. Specifically, this study evaluated three hypotheses within the context of a model. The model predicted clinicians' to view overweight clients as less attractive than average weight clients. Together endorsement of anti-fat attitudes and perception of overweight clients as unattractive are hypothesized to represent bias against and/or relative less liking of overweight clients. Mental health professionals' bias against or relative less liking is predicted to be related to engaging in biased clinical judgments and potentially discriminatory treatment of overweight clients. Mental health professionals were provided a pseudo client with a provisional diagnosis, assessed the pseudo client's psychological functioning, chose one or more areas of treatment focus, assessed the pseudo client's perceived level of motivation for change, and disclosed their own level of interest in working with the pseudo client. Participants evaluated three pseudo clients all in the same format. After completing the pseudo client evaluations,

participants completed three short measures. The measures included in the study are the Negative Attitudes Toward Overweight Individuals Scale (AFAS), the Body Image Avoidance Questionnaire (BIAQ), and the Goldfarb Fear of Fat Scale (GFFS). A total of 149 mental health professionals participated in the study (women = 115, men = 31, transgender = 3). Analyses found support for a relationship between pseudo client weight and perceived pseudo client attractiveness. Further, mental health professionals endorsement of anti-fat attitudes is inversely related to ratings of attractiveness. Finally, attractiveness and anti-fat attitudes predicted differential treatment considerations. However, pseudo client weight did not significantly predict differential treatment considerations. Implications and limitations are further explored in the context of improving the field's understanding of anti-fat biases in clinical judgment and treatment.

# CHAPTER 1
# INTRODUCTION

The prevalence of overweight and obesity has risen in the United States for the last few decades despite interventions aimed at decline (NCHS, 2006). According to the National Center for Health Statistics, approximately 67% of adults between the ages of 20-74 years old meet criteria to be classified as overweight, 34% meet criteria for the classification of obesity. Demonstrations of bias against overweight or obese persons have increased through research during this same time. Many researchers investigating these negative biases have used the term "anti-fat attitudes" to describe the prejudicial beliefs regarding overweight individuals (Crandall & Biernat, 1990, p. 227). However, terms such as obesity stigma, weight prejudice, sizism, weightism, have also been used in previous research. A review article by Puhl & Brownell (2001) documented perceptible weight-related discrimination across many domains of everyday life such as education, employment, and health care.

In the current political and social climate, many prejudices, stereotypes, and biases are not openly expressed. Since the Civil Rights movement, researchers have begun to focus more on covert or disguised expressions of racism, sexism, heterosexism, monoculturalism, and various other forms of discrimination. Additionally, the expression of stereotypes, prejudices, and biases through discrimination is generally regarded as socially unacceptable. Though these biases still exist, they are often conceptualized as occurring through covert actions, such as microaggressions (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Esquilin, 2007). However, according to Crandall & Biernat (1990), the expression of anti-fat attitudes is differs from other discriminatory attitudes, beliefs, and behaviors, in that the expression of anti-fat attitudes is commonly an accepted form of social prejudice.

Crandall (1994) asserts the stigma of being fat differs from stigmatization of other marginalized groups in that both fat and non-fat people report similar levels of dislike of overweight persons, whereas members of most marginalized groups like members of their group more than people outside their group do. "One primary reason for identifying with a group is that association with other members in the group can enhance self-esteem (Tajfel & Turner, 1985), and overweight people may see few opportunities to bask in self-reflected glory" (Crandall, 1994, p. 891). Additionally, Crandall suggested that, unlike members of many other marginalized groups, overweight individuals may feel they will be able to leave the group, through diet, exercise, and/or surgery, thus they have less motivation to identify with other overweight individuals. Crandall's research suggests that overweight individuals do not appear to hold the protective in-group biases documented in other marginalized groups.

As the study of therapists' racial biases and prejudices are important in determining areas of intervention, improving quality of care for all potential clients, and increasing personal awareness, a similar argument can be made regarding the importance of studying anti-fat attitudes of therapists and other mental health professionals. As succinctly articulated by Sue and fellow authors (2007)

> . . . White therapists are members of the larger society and are not immune from inheriting the racial biases of their forebears (Burhard & Knox, 2004; D.W. Sue, 2005) they may become victims of the cultural conditioning process that imbues within them biases and prejudices (Abelson, Dasgupta, Park & Banaji, 1998; Banaji, Hardin, & Rothman, 1993) that discriminate against clients of color (Sue et al, 2007).

Therapists and other mental health professionals, regardless of weight, are members of a larger society in which negativity towards overweight and obese individuals is normative. Recent research even indicates obesity stigma is more intense today than 40 years ago even though rates of obesity and overweight are also increasing (Latner & Stunkard, 2003). As reviewed in Chapter 2, the few studies that have examined differential treatment of overweight and obese clients in

therapy have yet to explicitly measure anti-fat attitudes. The existing studies find support for differential expectations for treatment and impressions based on client weight. However, one study of health professionals specializing in obesity treatment found an absence of explicit negative attitudes towards overweight persons while the participants demonstrated a strong *implicit* bias (Teachman & Brownell, 2001).

Research has found relationships between weight stigma and several adverse psychological consequences for victims, including increased vulnerability to depression, body image disturbances, psychiatric symptoms (Friedman et al, 2005; Myers & Rosen, 1999).and decreased self-acceptance (Carr & Friedman, 2005). The increase of literature on weight stigma and anti-fat attitudes can be seen as a representation of the growing need to address anti-fat attitudes in mental health settings and potentially acknowledge and amplify the role mental health care providers' play in the social justice issues relating to weight.

# CHAPTER 2
# REVIEW OF LITERATURE

A review of research revealed that across different specialties in health care, there are consistently more negative attitudes held against overweight patients than patients with various other characteristics (Puhl & Brownell, 2001). Physicians reported that obesity was among their least preferable patient conditions, preferred *less* than alcoholism, drug addiction, and mental illness. Physicians associated obesity with poor hygiene, noncompliance, hostility, and dishonesty (Klein, Najman, Kohrman & Munro, 1982). In a survey of nutrition specialists, researchers found that 88% of those surveyed believed obesity was the manifestation of the need for love or attention, 87% believed that obese persons are indulgent, 74% believed that obese persons have family problems, 70% attributed obesity to emotional disturbances, and 32% believed that obese people lack willpower (Maiman, Wang, Becker, Finlay, & Simonson, 1979). This pattern of findings suggests the possibility that nutrition specialists linked obesity with low psychological functioning. Nurses have been shown to hold similar beliefs about obese patients, with nearly half (48%) of the nurses surveyed indicating that they felt uncomfortable caring for obese patients and about a third (31%) expressed the preference not to care for obese patients.

Young and Powell (1985) demonstrated that mental health professionals (including family therapists, mental health counselors, psychiatric aides, psychiatric social workers, psychiatrists, psychologists, rehabilitation counselors, and substance abuse counselors) evaluated clients who were 40% or more above their ideal weight as lower in psychological functioning than other clients. In the same study, mental health professionals reported that they viewed these overweight clients as possessing more agitation, egocentrism, emotional behavior, hypochondriasis, impaired judgment, inadequate hygiene, inappropriate behavior, intolerance of change, obsessive-compulsive behavior, self-injurious behavior, stereotyped behavior, and

suspiciousness than other clients. However, the authors did not find that mental health professionals were less willing to work with obese clients and did not have differing treatment expectations for clients of different weights. Young and Powell did find that younger mental health professionals rated obese clients' symptoms more negativity than did older mental health professionals. To explain this finding the authors first considered the idea that experience may have mediated the effect of bias. However, years of reported experience did not account for the age effect. They also found that female mental health professionals evaluated obese clients more negatively on eight of 20 symptoms than male mental health professionals. The authors proposed that having been more harshly judged by society regarding their physical appearance, female mental health professionals are more aware of client's weight than male mental health professionals. These finding highlight the presence of significant bias against obese clients by mental health professionals. How these initial negative biases affect subsequent therapy sessions is unclear and should be further considered.

Agell and Rothblum (1991) specifically looked at gender and obesity effects on therapists' judgments. The authors found that respondents from the American Psychological Association's Psychotherapy Division rated obese targets more negatively than non-obese targets on appearance and how embarrassed the clients were to be in therapy. The authors also found a difference in perceived motivation between obese and non-obese targets. An older and obese target client with anxiety regarding job performance was viewed as less motivated than a college-student target client with difficulty concentrating in class and who had failed two courses. The authors contended that psychologists are apt to follow a "jolly fat stereotype" (Agell & Rothblum, 1991, p. 228) when evaluating clients without seeing them. This finding

suggests that other factors that remain unexplained may bias mental health professionals' expectations about motivation for obese clients.

More recently, Davis-Coelho, Waltz & Davis-Coelho (2000) attempted to measure anti-fat biases in practicing psychologists from the American Psychological Association's Divisions of Clinical Psychology, Counseling Psychology, Psychotherapy, and Psychologists in Private Practice. The authors found that psychologists younger than 40 years old were significantly more likely to expect less effort from obese targets than their older counterparts. Female psychologists gave obese targets more negative provisional diagnoses. Younger psychologists gave obese targets significantly poorer prognoses than they gave non-obese targets. Obese and non-obese targets did not significantly differ in psychologists' assignment of Global Assessment of Functioning, although the difference approached significance in the direction of more obese clients receiving lower global functioning scores, consistent with stereotypes. The psychologists were more likely to suggest a provisional diagnosis of eating disorder for obese targets than non-obese targets. Psychologists were significantly more likely assigned the treatment goal of "improving body image" to obese than non-obese targets. Psychologists also indicated that 'increasing sexual satisfaction' was more often a treatment goal for obese targets than non-obese targets, even though sexual difficulties were not mentioned in the client's case history provided to the psychologists.

A clear pattern of bias has begun to emerge from these reviewed studies. The three studies just reviewed show a pattern of younger and female psychologists and mental health professionals demonstrating more bias than older or male counterparts. However, these previous studies only explored biases towards white clients. Only the study by Agell and Rothblum (1991) included male targets and younger targets (21 years old and 28 years old). Young and Powell and

Davis-Coehlo et al. both used middle-aged, white women as targets. None of the reviewed studies have incorporated other client variables, such as race, ethnicity, socioeconomic status, sexual orientation, religion, or ability.

Published research on obesity does not appear to mirror prejudice research in general (Perez-Lopez et al, 2001). If their behavior followed the pattern of other prejudice research, male mental health professionals *would* rate obese targets more negatively than female mental health professionals, but that is not the case. Some researchers have hypothesized that, because women are more harshly judged by society regarding their physical appearance, a type of projection is occurring wherein women mental health professionals are evaluating obese clients more negatively because they feel *they* would be evaluated more negatively if they were obese. However, it remains unknown whether this or any other process is responsible for the male-female differences between biased clinical judgment regarding obesity and prejudice research, generally. Lewis et al. (1997) did find support for women-judged-more-harshly hypothesis. Initially women judged obese targets more harshly. However, after statistically controlling for the effect of participants' attitudes regarding their *own* weight, men once again held more negative attitudes than did women towards overweight individuals.

The proposed study attempts to advance the current literature in several ways. First, the author has developed a model to explain why mental health professionals have consistently evaluated overweight clients more negatively than average weight clients (Figure 2-1). The proposed study is the first of which the author is aware that tests a causal model of mental health professionals' biased reactions to overweight clients. This study evaluates three hypotheses testing the proposed model. The model describes how mental health professionals' anti-fat attitudes and perceptions of lower attractiveness of overweight clients may lead them to be bias

against overweight clients and in turn to have more negative therapeutic expectations and evaluations. First, mental health professionals are predicted to evaluate the overweight pseudo clients as less attractive than non-overweight pseudo clients. Second, the evaluation of the overweight pseudo client as less attractive will be related to the endorsement of anti-fat attitudes. This relationship is hypothesized to represent bias against overweight pseudo clients. Third, bias against (the combination of perceived attractiveness and endorsement of anti-fat attitudes) the overweight pseudo client is hypothesized to lead to differential clinical judgments. These will include lower rated psychological functioning, more negative clinical diagnoses, lower interest in working with the overweight pseudo clients, shorter preferred length of treatment, less ambitious treatment goals, and a greater chance of an identified treatment focus on body image in the absence of the pseudo client identifying this issue as problematic.

The test of this model will add to the research literature by helping to understand the role of mental health professionals' anti-fat attitudes and whether they are implicated in biases of clinical judgments. Additionally, this study will add to the research literature by conceptually replicating previous studies, using differing pseudo clients. Other studies have looked only at white targets, whereas this study will vary the race of target pseudo clients. The inclusion of non-whites as targets is intended to provide support regarding the generalizability of the model across racial and ethnic groups.

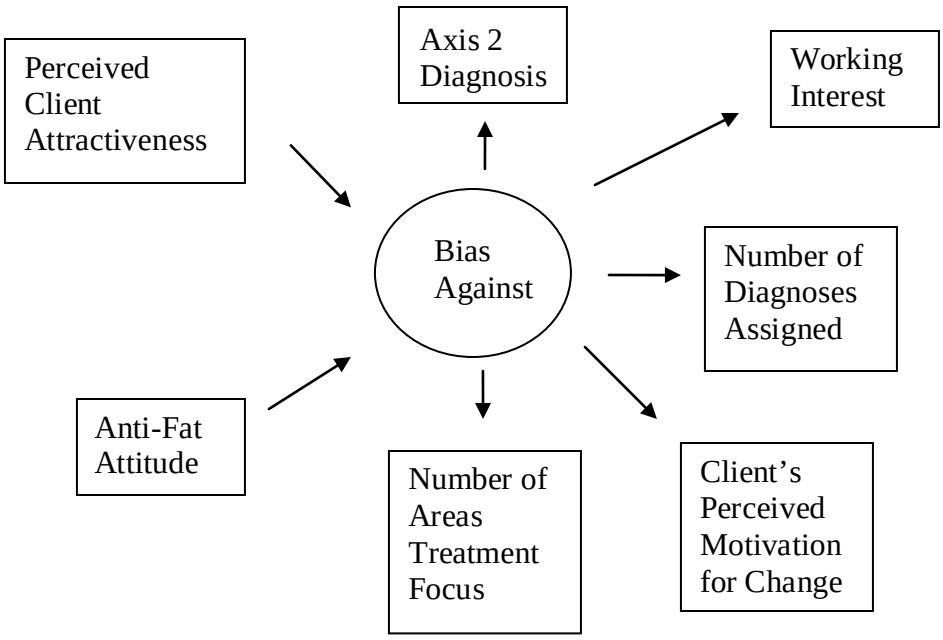


Figure 2-1. The hypothesized model of counselor bias

# CHAPTER 3
# MATERIALS AND METHODS

## Participants

Participants were contacted through email to participate in an internet survey. The participants selected for contact came from several professional listserv resources. Requests for participation were made through the American Psychological Association's Counseling Psychology Division 17 listserv, yahoogroups Counseling listserv, SPSSI listserv, yahoogroups Feminist Psychologists Moms listserv, American Counseling Association listservs on Diversity Issues and the listserv for graduate students, mental health professional groups on facebook.com (social networking site) and through listserv networking (e.g. asking individuals to post participation requests on listservs to which they are a member but the author is not).

A total of 149 participants completed the survey. The majority of sample, 115 participants, identified as women, 31 identified as men and 3 participants identified as transgender. Racial/ethnic composition of the sample broke down as the following: 75.8% (113) of the sample identified as white/European origin, 6.3% (10) as Black/African origin, 9.4% (15) as Hispanic/Latin(o/a) origin, 3.8% (6) as Asian origin, 2.5% (4) as Multiracial/Multiethnic, and 0.6% (1) as "other". The participants ranged in age from 20 to 70 years old ($M$ = 39.36, $SD$ = 11.58). Participants were recruited across the United States with 20.8% (33) reporting be in the Northeast, 5.4% (8) in the Northwest, 27.7% (44) in the Midwest, 20.8 (33) in the Southeast, 12.6 (20) in the Southwest, 2.5% (4) in the West coast or Hawaii, 0.6% (1) in the Mountain states, 0.6% (1) in the Mid-Atlantic states, and 3.1% (5) in other locations.

Further, information specific to clinical work was also gathered. Participants reported working on average 18.37 hours a week (SD = 10.99) with clients. Additionally, participants had on average 7.26 years of experience as mental health professionals ($SD$ = 7.36 years).

## Procedure

Participants clicked on the survey hyperlink which brought them to the survey page and one of 12 versions of the survey was administered. After reading the consent form and agreeing to consent to participation, an image of one pseudo client and a clinically descriptive vignette was presented. Participants were instructed to make initial clinical evaluations of the pseudo client, including level of attractiveness, psychological functioning, provisional diagnosis(ses), and treatment foci, interest in working with the client, and perceived client motivation for change based on the image and clinically descriptive vignette. Once the participant has evaluated the first pseudo client, a second pseudo client's clinically descriptive vignette and image appeared for evaluation. The participants were instructed to make initial clinical evaluations on this pseudo client on the same domains as the first pseudo client. This format was repeated one final time with a third pseudo client, to total three different pseudo clients receiving evaluation. After finishing the clinical evaluation portion of the survey, the participants were directed to complete three measures reflecting their personal beliefs and opinions. These measures are the Negative Attitudes Toward Overweight Individuals Scale (AFAS), the Body Image Avoidance Questionnaire (BIAQ), and the Goldfarb Fear of Fat Scale (GFFS). Following completion of those measures, the participants provided demographic information and information regarding the mental health professionals' clinical experiences including gender, age, race/ethnicity, geographic location, hours weekly working with clients, years practicing, practice setting, endorsement of various multicultural and diversity training experiences, and height and weight.

## Materials

### Client Images

Twelve images were created to represent the pseudo clients participants would evaluate. The race, gender, and weight of the pseudo clients were completed crossed, meaning that in each

race condition both genders and weights were represented, in each gender conditions both weights and all races were represented, and in each weight condition all races and both genders were represented. Appearance of pseudo clients varied by racial/ethnic background, appearing Black/African origin, white/European origin and Hispanic/Latino(a). Appearance of the pseudo clients also varied by gender (man or woman) and weight (average/ideal weight and overweight). The images were created by the use of weight-loss simulator software available free of charge at virtualmodel.com. The use of this program allowed the author to maintain attractiveness across weight conditions and maintained relative consistency across race conditions. Images used in the study are available in Figure 3-1 and Figure 3-2.

**Vignettes**

Three vignettes were created for the use of this study. The vignettes were modeled after clinical case notes and previous vignettes used by past researchers, specifically the studies reviewed in Chapter 2 were informative to the style and content of this study's vignette style, (Agell & Rothblum, 1991; Young & Powell, 1985; and Davis-Coelho, et al, 2000). All vignettes were written so they may be paired interchangeability with any one of the 12 images created for the study. Specifically, no identifying information regarding sex, race, age, sexual orientation, ability, or other characteristics was written in the vignettes. Further, in order to stay consistent with the previous research reviewed and to facilitate hypothesis testing, vignettes were written without mention of body image or disordered eating concerns. All three vignettes are in the Appendix

**Psychological Functioning**

Participants evaluated the pseudo clients on psychological functioning by providing a Global Assessment of Functioning Score (between 1 – 100) for each client to whom they are exposed (American Psychiatric Association, DSM-IV-TR, 2000, pp. 32-34).

### Clinical Diagnosis

Participants were prompted to provide a provisional diagnosis for each client. Participants were given a short list of diagnostic options to select up to three diagnoses, including adjustment problems, adjustment disorder, depression, self-esteem problems, eating disorder, body image problems, anxiety disorder, personality disorder, and other (please specify).

### Treatment Considerations

Participants were prompted with questions regarding treatment attitudes. Specifically, participants were asked to indicate working interest with pseudo client, perceived pseudo client motivation and treatment focus. In evaluations of working interest, perceived motivation, and ratings of attractiveness, participants were asked to choose a value written in Likert format (1-5). When choosing treatment focus, participants were asked to choose up to three foci from a list of 21 available options, including Emotional Behaviors, Impaired Judgment & Decision Making, Self-care & Hygiene, Tolerance to Change, Obsessive-compulsive Behaviors, Suspiciousness and/or Paranoia, Stereotyped Behaviors, Self-injurious Behaviors, Inappropriate Behaviors, Egocentric Thoughts/Behaviors, Agitation, Addiction, Hypochondriasis, Impulsive Behaviors, Incoherent Speech, Disorientation, Reminiscence, Sexual Dysfunction/Problems, Thought disorder, Body Image, and Antisocial Behaviors.

## Measures

### Anti-fat Attitudes

The first measure participants completed was the Negative Attitudes Toward Overweight Individuals Scale (AFAS) developed by Morrison and O'Conner (1999). This is a 5-item instrument. An example item is: "Fat people only have themselves to blame for their weight." The instrument uses a 5–point, Likert scale, with higher scores indicating stronger anti-fat attitudes. Items on this instrument have demonstrated Cronbach's alphas ranging between .72 in

a convenience sample of college students and .80 in a sample of individuals in a university cafeteria. Construct validity has been established by its correlation with the conceptually-related constructs of homonegativity, authoritarianism, and political conservatism, as well as the Dislike of Fat People Subscale a 7-item scale that measures pejorative beliefs about overweight persons. The Negative Attitudes Toward Overweight Individuals Scale was also chosen because of its low correlation with social desirability and fear-of-fat measures.

**Body Image Avoidance Questionnaire**

The second measure completed by participants was the Body Image Avoidance Questionnaire (BIAQ) developed by Rosen, Srebnik, Saltzberg, & Wendt (1991). This nineteen-item, Likert scale was designed to address personal levels of concern over physical appearance. An example item would be "I wear a special set of clothing, e.g. my 'fat clothes'". Higher scores indicate lower levels of concern over appearance. This instrument has produced a Cronbach alpha of .89 and test-retest reliability of .87, across a 2-week interval. The BIAQ and the Body Shape Questionnaire are highly correlated, $r = .78$, $p < .0001$, which Rosen, Srebnik, Saltzberg, and Wendt (1991, p. 34) describe as "…indicat[ing] that self-reported behavioral avoidance was strongly associated with more negative attitudes toward weight and shape".

**Personal Fear of Fat**

The third measure completed by participants was the Goldfarb Fear of Fat Scale (GFFS) developed by Goldfarb, Dykens & Gerrard (1985), which is a ten item questionnaire on a 4-point Likert scale with higher scores indicating higher levels of fear of fat. This instrument distinguishes between clinical fear of fat in individuals with anorexia and/or bulimia and the normative fear of fat in the general population. An example of an item from this scale is: "If I stopped concentrating on controlling my weight, chances are I would become very fat." This measure will be used to control for the effects of personal fear of fat so that those effects are not

confounded with participants' anti-fat attitudes regarding others. This scale produced high test-retest reliability in a sample of high school girls ($r$ = .88) and high internal reliability (Cronbach's Alpha = 0.85) in a sample of psychiatric patients. Construct validity has been established by its correlation with the conceptually-related but different scales measuring depression by Beck Depression Inventory (Beck, 1976), family environment by the Family Environment Scale (Moos, 1974), anxiety by State-Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1974), and self concept by Tennessee Self-Concept Scale (Fitts, 1965).

**Demographic Information**

Participants were asked to provide demographic information. The information requested included participants' age, gender, race/ethnicity, and geographic location. Additionally, participants were asked to provide information regarding their professional experiences including years of psychotherapy practice, amount of multicultural competency education, weekly hours of working with clients, and practice setting. Finally participants were asked to report their weights and heights in order to calculate a Body Mass Index (BMI) score.

Figure 3-1. Images of the female pseudo clients as seen by the participants

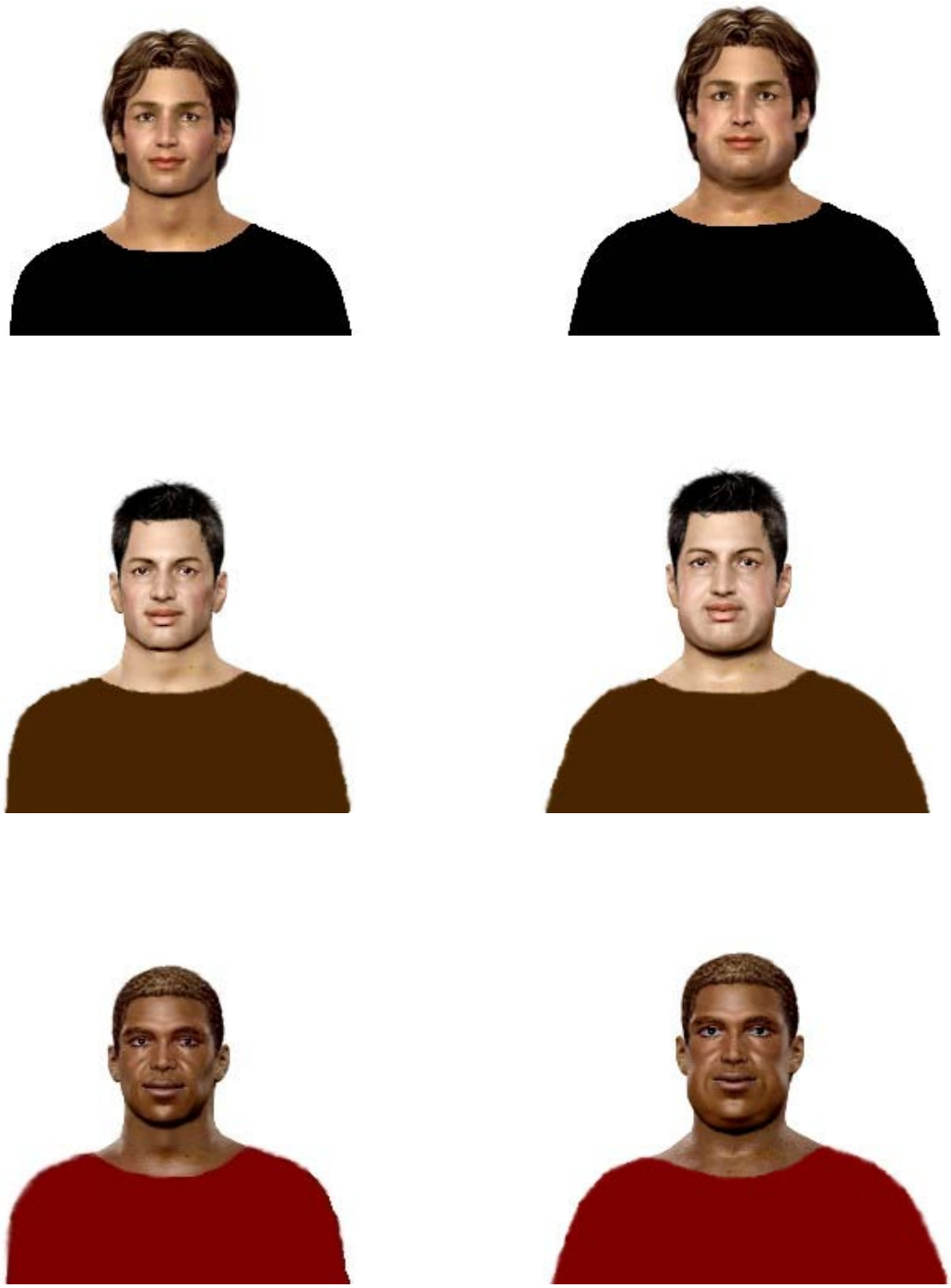

Figure 3-2. Images of the male pseudo clients as seen by the participants

# CHAPTER 4
# RESULTS

## Preliminary Data Inspection

An inspection of the data was conducted before proceeding with hypothesis testing. All participants were exposed to three pseudo clients and through random assignment there were equivalent cell sizes for each of the three pseudo client characteristic. A similar number of overweight and average weight pseudo clients were seen by participants, 231 and 246 respectively. Additionally, a similar number of men and women pseudo clients were seen by participants (240 and 237). Pseudo clients from each racial/ethnic group, white/European, Black/African, and Latino/a, were seen 149 times each. Further, the variables were inspected for normality. With the exception of Global Assessment of Functioning scores, there were no variables with high levels of skewness or kurtosis, that is with levels over +/- 2.0 (Weston & Gore, 2006). Means, standard deviations, skewness, and kurtosis values of the dependent variables are in Table 4-1. Further, because each participant evaluated pseudo clients in three different vignettes, a MANOVA was conducted to determine if there were interactions with vignettes that would suggest analyzing each vignette separately. Although the omnibus MANOVA showed statistically significant main effects for pseudo client gender, weight, race, and vignette; there were no statistically significant interactions with vignette. Because each participant saw three pseudo clients representing at least one of each gender, all three racial/ethnic groups, and both weight groups it was appropriate to collapse across vignette and conduct all further analyses collapsed across vignette.

## Hypothesis Testing

To test the overall model of bias proposed by the author, the model has been broken down into three hypotheses. First, it was predicted that mental health professionals would rate

overweight pseudo clients as less attractive than average weight pseudo clients. To test this hypothesis a one-way ANOVA was conducted. Levene's test supported adequate error variance normality and the *F* statistic is interpretable, $F(1,464) = .28$, $p = .60$. Pseudo client weight was found to be a significant predictor of the attractiveness rating by the mental health professionals in the expected direction, $F(1,466) = 51.27$, $p < .001$, overweight pseudo client = *M* 3.34 (*SD* .67), average weight pseudo client = 3.79 (*SD* .68). Cohen's *d* was computed from the means and standard deviations, and yielded a moderate effect size, $d = .67$ (Cohen, 1992).

Second, it was hypothesized the evaluation of the overweight pseudo client as less attractive will be related to the endorsement of anti-fat attitudes. This relationship is hypothesized to represent bias against overweight pseudo clients. The overall relationship between anti-fat attitudes and ratings of attractiveness across all pseudo clients is significant, $r = -.20$, $p < .001$. Because attractiveness ratings and endorsement of anti-fat attitudes are correlated with each other, a composite variable to represent bias against was computed. The composite variable was calculated by transforming attractiveness ratings and anti-fat attitudes into *z*-scores. Once the variables were on the same metric, adding them together produced the standardized composite variable of bias against that will be used in Hypothesis 3.

Third, it was hypothesized that bias against (the combination of perceived attractiveness and endorsement of anti-fat attitudes) the overweight pseudo client will lead to differential clinical judgments. These differential clinical judgments are hypothesized to include lower rating of psychological functioning, more severe clinical diagnoses, more clinical diagnoses assigned, lower interest in working with the overweight pseudo clients, more areas chosen for treatment focus and a greater chance of an identified treatment focus on body image in the absence of the pseudo client identifying this issue as problematic. In order to evaluate this hypothesis, a

MANOVA was conducted with the composite bias against score as predictor variables and clinical judgments as dependent variables. Box's M = 378.43, $F(294, 10059.5) = .961$, $p = .671$ which indicates adequate variance-covariance equality. The MANOVA produced one significant main effect on the set of dependent variables. Main effect of bias against $F(312, 2178) = 1.8$, $p < .001$, $\eta^2 = .21$. Weight of pseudo client did not produce a significant main effect or interaction with bias against.

Because of the significant main effect of bias against, follow up on each dependent variable through individual ANOVAs was conducted. Bias against served as a significant predictor of four of the six treatment variables. Specifically, bias against predicted client's perceived motivation for change, $F(52, 363) = 1.94$, $p < .001$, $\eta^2 = .22$, working interest, $F(52, 363) = 2.28$, $p < .001$, $\eta^2 = .25$, Global Assessment of Functioning score, $F(52, 363) = 2.99$, $p < .001$, $\eta^2 = .30$, and number of provisional diagnoses, $F(52, 363) = 1.76$, $p = .002$, $\eta^2 = .20$.

To test the hypothesis that there would be a greater chance of an identified treatment focus on body image in the absence of the pseudo client identifying these issues as problematic, the data were reviewed to determine how many times 'body image' was chosen as treatment focus. Body image was rarely chosen as a treatment focus. Out of the 830 treatment foci chosen by participants, only six times (>1%) did body image become a treatment focus. Interestingly, five out of the six times it was chosen as a treatment focus for overweight pseudo clients, whereas it was split evenly across racial/ethnic groups and men and women. Though six is not a large enough sample to conduct an analysis, inspection of the pattern suggests that weight of pseudo clients was strongly linked to the selection.

In summary, Hypotheses 1 and 2 have clear support. However, Hypothesis 3 garnered markedly less support. Though it was predicted and supported that client attractiveness and

mental health professionals' endorsement of anti-fat attitudes would together as a measure of bias against predict differential clinical judgments, the absence of a significant main effect or interactions of pseudo client weight implies mental health professionals in this sample were not making clinical judgments solely on weight of client.

## Ancillary Analyses

The relationship between anti-fat attitudes and ratings of attractiveness across all pseudo clients was $r = -.20$, $p < .001$, meaning as the personal endorsement of anti-fat attitudes increases, ratings of the pseudo client's attractiveness decreased. Additional exploration of the relationship between anti-fat attitudes and perceived attractiveness was conducted. When examining the relationship between anti-fat attitudes and ratings of attractiveness only in overweight pseudo clients, the magnitude of this relationship increases to $r = -.38$, $p < .001$. The relationship between anti-fat attitudes and ratings of attractiveness of average weight pseudo clients is $r = -.05$, $p = ns$, indicating there is no relationship between personal endorsement of anti-fat attitudes and ratings of attractiveness for the average weight pseudo clients. The difference in the strength of relationship across pseudo client weight conditions appears to provide support that participants' endorsement of anti-fat attitudes impacted how attractive they evaluated the pseudo clients to be.

Although other studies have used white individuals as pseudo clients, this study incorporated white/European, black/African, and Hispanic/Latino(a) appearing (term appearing used because no labels were given to the participants regarding race or ethnicity) pseudo clients. The inclusion of non-whites as pseudo clients was an attempt to establish the generalizability of effects. First, a MANOVA with race as the predictor and clinical diagnosis severity, total diagnoses, total treatment foci, Global Assessment of Functioning score, perceived client motivation, working interest, and attractiveness rating served as dependent variables was

conducted to determine if mental health professionals gave differential evaluations based on perceived racial or ethnic differences in the pseudo clients. Race of pseudo client did not produce a significant result in an omnibus test. However, one dependent variable was significant in the MANOVA break down and will be followed up with a univariate test. An ANOVA found a significant effect of race on predicting participants ratings of working interest, $F(2, 463) = 3.88$, $p < .05$. A Tukey's HSD post hoc test showed a significant difference between race condition 1 (appearing white/European origin) and race condition 3 (appearing black/African origin), $p = .019$. Reviewing the means revealed that the lowest level of interest was towards pseudo clients who appeared white/European origin ($M = 4.18$, $SD = .83$) whereas the highest level of interest was toward pseudo client who appeared black/African origin ($M = 4.42$, $SD = .68$), with those appearing Hispanic/Latino(a) fall in between ($M = 4.25$, $SD = .75$), whose interest score did not significantly differ from those of the other conditions. While no predictors were made regarding differences among treatment outcomes, an analysis was conducted to garner support for the generalizability of the relationships to not only white clients but to members of other racial or ethnic groups as well.

Table 4-1. Means and standard deviations

| | | GAF | Total Dx | Total Treatment Focus | Axis 2 Dx | Motivation | Working Interest | Attractiveness |
|---|---|---|---|---|---|---|---|---|
| N | Valid | 466 | 465 | 465 | 465 | 466 | 466 | 466 |
| | Missing | 11 | 12 | 12 | 12 | 11 | 11 | 11 |
| Mean | | 69.29 | 1.42 | 1.78 | .48 | 3.91 | 4.29 | 3.6 |
| Std. Deviation | | 11.58 | .70 | .78 | .50 | .66 | .76 | .71 |
| Skewness | | -1.41 | 1.08 | .36 | .10 | -.58 | -.91 | .11 |
| Std. Error of Skewness | | .11 | .11 | .11 | .11 | .11 | .11 | .11 |
| Kurtosis | | 6.88 | .290 | -1.12 | -2.00 | 1.00 | .66 | -.07 |
| Std. Error of Kurtosis | | .23 | .230 | .23 | .23 | .23 | .23 | .23 |

Table 4-2. Correlation matrix of dependent variables

| | | GAF | Total Dx | Axis 2 Dx | Treatment Focus | Motivation | Working Interest |
|---|---|---|---|---|---|---|---|
| Correlation | GAF | 1.0 | | | | | |
| | Total Dx | -.16 | 1.0 | | | | |
| | Axis 2 Dx Total | -.44 | .30 | 1.0 | | | |
| | Treatment Focus | -.21 | .28 | .13 | 1.0 | | |
| | Motivation | .25 | -.18 | -.22 | -.23 | 1.0 | |
| | Working Interest | .01 | .04 | -.09 | -.04 | .25 | 1.0 |

# CHAPTER 5
# DISCUSSION

The overall purpose of this study was to expand the literature regarding bias against overweight individuals seeking mental health treatment by mental health professionals. Further, the key aim was to test a novel model linking empirically and theoretically related constructs as a means to understand better this previously identified bias. As laid out through Hypothesis 1 through 3, the relationships within the model have varying support.

There is clearly a relationship between the mental health professionals' ratings of attractiveness and pseudo client's weight. The relationship between mental health professionals' endorsement of anti-fat attitudes and ratings of attractiveness of the pseudo client is small in magnitude but significant, implying there are potentially other factors implicated in the differences in attractiveness ratings. The relationship between client attractiveness and therapeutic outcomes has been a topic of interest in the field for many years and most famously discussed in the context of a YAVIS client (Schofield, 1964). Among the findings that have linked client attractiveness as perceived by the mental health professionals to therapeutic outcomes is Tryon's (1992). Tryon found a significant relationship between how attractive counselors rated clients and an increase likelihood of setting a follow up appointment and attending the appointment. This relationship highlights a potentially important aspect in acknowledging differences in perceived client attractiveness by mental health professionals. Increased likelihood of attendance in the second session may ultimately be predictive of longer treatment length when mental health professionals perceive clients as attractive (Tryon, 1992).

Further, the main effect of bias against on treatment considerations may be reflective of a general negativity from the participant, independent of the pseudo client weight. Though the author did not measure general negativity in participants, the possibly of this personality aspect

cannot be dismissed in light of current of outcomes that do not support a main effect of pseudo client weight on any of the treatment considerations (Watson & Clark, 1984).

Another aim of the study was to conceptually replicate previous studies through using differing pseudo clients. In some ways the findings mirrored previous research but in other ways there was divergence. Specifically, unlike Young and Powell (1985) this study did not find a significant difference between GAF scores of overweight and average weight pseudo clients. Further, in Young & Powell's study, a wider variety and clearer pattern of bias was demonstrated in areas of treatment focus. In the current study there were no differences in treatment focus except for "body image" being identified in overweight pseudo clients five times and identified once for an average weight pseudo client. The present study did replicate a main effect of perceived client attractiveness based on client weight. One possible explanation in explaining non-replication may lie in the differences of methodology between the current study and Young and Powell's design. The present study asked for endorsement of up to three areas of treatment focus while Young and Powell asked participants to score importance of many areas of treatment focus on a Likert scale.

Similarly, Agell and Rothblum (1991) found therapists rated obese clients more negatively than non-obese clients on appearance and reduced perception of motivation of obese clients. The current study replicated difference in appearance ratings but failed to find support for a direct relationship between perceived motivation and client weight.

Finally, the current study did replicate some of the findings from Davis-Coelho, Waltz & Davis-Coelho (2000). In both studies, mental health professionals were significantly more likely assigned the treatment goal of "improving body image" to overweight clients. Additionally, neither study found support for the hypothesis that client weight would predict differences in

Global Assessment of Functioning scores. The current study did not focus on mental health professionals' gender on treatment variables due to the imbalance in gender sample sizes.

The absence of client weight as a significant predictor of differential treatment considerations should be considered an optimistic finding. It implies that even though mental health professionals endorse anti-fat attitudes and perceive overweight clients as less attractiveness, a client being overweight in itself does not appear to directly influence treatment considerations. Although, further exploration of how these relationships can coexist is warranted to better understand the complexities between holding anti-fat attitudes, perceiving overweight individuals as less attractive but managing to avoid observable differences in the treatment considerations measured in this study.

This research represented an attempt to clarify possible pathways by which perception of a client as overweight may lead to clinical bias. Though the model hypothesized by the author did garner full support, it did highlight the role perceived attraction and anti-fat attitudes may play in impacting treatment considerations in a hypothetical situation. Further, because the role of anti-fat attitudes on the interaction between overweight clients and their therapists has yet to be explored in non-hypothetical ways, the possibly of bias reduction as a means to improve quality of care for overweight clients cannot be dismissed.

It is imperative to also review the limitations of the study. First, social desirability may remain an issue even with anonymity. In the development of the AFAS there was not a significant relationship with social desirability; however those in the mental health field may be especially unlikely to reveal personal biases even under the anonymity of the internet.

Second, because the sample is relatively young and restricted to those who use internet listservs, it is difficult to general the results in this study broadly to all mental health

professionals. Though attempts were made to broaden those contacted and hence broaden the spectrum of ages, genders, races, ethnicities, fields, and other demographic characteristics, internet recruitment was slow and often times sporadic. Further, due to the wide range of training and occupational titles, the author was unable to succinctly group participants into occupational groups or clearly identity they background training they had received. This poses difficulty in making recommendations about which occupations may be at particular need for training in overweight bias or whether there is even a difference between occupations. Additionally, because recruitment for the study was particularly challenging, less than ideal numbers of mental health professionals were recruited. Specifically, a greater prevalence of men and members of underrepresented racial/ethnic minorities in the sample would have been beneficial to examine any potential relationships between mental health professionals' personal characteristics and their treatment recommendations.

Third, due to the relatively limited research in this topic, specific treatment considerations, measures, and materials chosen in the study have varying levels of support for use. Specifically, the previous studies measuring bias in clinical judgments have all used different designs and do not overlap a great deal in what treatment considerations have been explored. Further, to the author's knowledge the use of the measures in the study have not been tested in a sample of mental health professionals. Additionally, the images used have been created specifically for use in this study and lack testing within other samples.

In conclusion, the current study tested a model of bias that did not receive full support. The failure of the model to capture the full picture of bias is seen as informative to future work and will be used a building block in future research. Further, though the model did not receive full support, it did find a significant relationship between a composite measure of bias against an

array of treatment considerations. This relationship may serve as a reminder to mental health professionals that our own worldviews are implicated in our work with clients and to strive for quality in our work by allowing for self-care and personal growth.

# APPENDIX
# VIGNETTES

Vignette 1:

Read the following as information gathered in an initial session with a new client:

The client has recently moved from one state to another and expresses feelings of loneliness and sadness. Client indicates feeling guilty by taking a new job located away from the clients' parent's hometown. Client reports being an only child. Client expressed disappointment associated with a previous belief that moving to a new place and securing a better paying job would promote joy and feelings of success not only for oneself but from others including the client's family. Client expressed feeling disappointment for lacking those positive feelings. Client reports not knowing many people in town but hopes to make new friends at work and through neighbors. Throughout the session client was verbal and able to express emotions appropriately. Client appears to be of above average intelligence.

Vignette 2:

Read the following as information gathered in an initial session with a new client:

The client reports recovering from a painful breakup with a long-term romantic partner. Client expresses many different emotions, such as sadness, anger and relief, but overall expresses feelings of hurt. Client claims the partner ended the relationship after numerous attempts at reconciliation and couples counseling. Client is struggling with how to move on from this relationship and how to begin new healthy ones in the future. Client reports having some close friends and some family nearby as social supports. Client seems to jump around a lot in conversation and seems a little uncomfortable discussing some emotional topics, but does not seem resistant.

Vignette 3:

Read the following as information gathered in an initial session with a new client:

The client reports feeling increasingly anxious in social settings. Client discusses a situation that occurred two years ago that the client regards as the first time feelings of anxiousness were very prevalent in social settings. Client says the anxious feelings have been increasing since that incident but the client is still able to keep employment and to maintain a few close relationships. Though cooperative, Client is visibly anxious, as evident through trembling hands and nervous laughter. Client appears to be of average intelligence and oriented to present time and place.

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# BIOGRAPHICAL SKETCH

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