Counselors-in-training's Perceptions of Clients:

The Influences of Client Weight

and Job Status

by

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ABSTRACT

It is crucial for counselors to be aware of their own attitudes and beliefs and to prevent them from influencing the counseling process. The prevalence of obesity is growing and biases against obese people are becoming more apparent. Counselors must become aware of the potential weight bias and what factors influence it. The purpose of the current study was to examine whether counselors-in-training hold negative attitudes toward obese clients and whether the career status of the client affects these perceptions. Seventy-six students in graduate level counseling programs at Arizona State University were randomly assigned one of four vignettes describing either an obese bookkeeper, a normal weight bookkeeper, an obese executive, or a normal weight executive. Negative attitudes were measured using two scales; one evaluating perceived personal characteristics of the client and one evaluating the perceived work efficacy. Results indicated that counselors-in-training perceived the client with more negative characteristics when the client was described as obese rather than normal weight, and also when she was described as having a low status job compared to a high status job. The perceived work efficacy of the presented client was not affected by the client's weight or job status. It is important for students in counseling programs to receive training regarding weight biases and job status biases.

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Chapter 1

Problem in Perspective

Obesity is an increasing concern in today's society and has become a, "national health threat and a major public health challenge" (NIH, 2009). The prevalence of obesity in the United States has almost doubled in the past 20 years, leading to an increased health concern. According to the National Institute of Health (2007), 34% of Americans are considered overweight, as defined as having a Body Mass Index (BMI), a weight to height ratio, of 25 to 29.9, and 34% are clinically obese, having a BMI equal to or greater than 30. A BMI indicating normal weight ranges from 18.5 to 24.9. While the prevalence of obesity continues to rise, emerging evidence suggests that weight stigma is also intensifying (Puhl, Moss-Racusin, Schwartz, & Brownell, 2008).

Despite research demonstrating that biological and environmental factors contribute highly to one's body weight (Fairborn & Brownell, 2001), obese people are continuously judged and blamed for being overweight (Crandall, 1994; Crandall & Cohen, 1994; Crandall & Martinez, 1996; Puhl, 2001). For example, when individuals were ranked by students as to whom they were least inclined to marry, the obese person was placed as the fifth lowest on preference for a mate, with the embezzler, cocaine user, ex-mental patient, shoplifter, sexually promiscuous, communist, blind person, atheist, and marijuana user ranked as more preferable (Rothblum, 1992). Obese people report significantly higher levels of experiencing disrespectful treatment and harassment/teasing and being treated as if they have a character flaw (Carr, Jaffe, & Friedman, 2008). There is

a need for additional research to discover the reasons for and contributors to perceptions and stereotypes of obese people. The purpose of this study was to examine whether counselors-in-training hold negative attitudes toward obese clients and if the career status of the client affected these perceptions.

Despite evidence suggesting that one's body weight is a result of complex biological, environmental, social, economic, and behavioral interactions (Fairborn & Brownell, 2001; NIH, 2010), people tend to believe that obese individuals are the cause of their own weight and that their weight gain or loss is under their personal control (Puhl & Brownell, 2001). Since controllability is an important factor in the formation of stereotypes about obese people, it is helpful to understand from where these responsibility and blame bound beliefs may come. Causality and just-world beliefs are similar ideas that are thought to be two of the core components contributing to the stigma of obese individuals. The 'just- world bias' is when people portray the world as a predictable environment where all outcomes are based on effort and ability (Dion & Dion, 1987; Lerner, 1980). It is also associated with the tendency to attribute positive qualities to those physically attractive and negative qualities and feelings of dislike to those who are not (Dion & Dion). For instance, Dion and Dion found that those who believed in a just world relied on one's physical attractiveness when forming attributional judgments of the person, whereas those who did not believe in a just world did not use attractiveness as an influence on their judgments. Those with a just-world

bias were more likely to assume obese people have control of their weight and to blame them for their size. Crandall (2003) viewed these beliefs as ideologies that not only justify stigma but also remove feelings of guilt about biased attitudes and discriminatory acts resulting from them. Additionally, external influences in society sometimes portray the impression that weight is always controllable. For instance, Rogge et al. (2004) identified medical associations such as Centers for Disease Control (CDC) and the American Heart Association as emphasizing that overweight individuals have control over the disease through diet and exercise. This influences medical professionals and other members of the public to place blame on individuals struggling with obesity. Although weight can often be managed through diet and exercise, some people may be constrained by biological or medical limits.

Attributions, Perceptions, and Stereotypes

Receiving impressions from medical professionals and the media, people often attribute excess weight as a result of laziness and low self-discipline, which may contribute to the beliefs that merely out of control impulses and behaviors cause obesity (Roehling, 1999). However, numerous overweight individuals diet, exercise regularly, take medication that causes weight gain, or have medical conditions that prevent them from losing weight (Glenn & Chow, 2002). Some people are genetically and environmentally predisposed to becoming overweight. For instance, Button (1997) stated that a child with thin parents has a three to seven percent chance of becoming overweight, while a child with one overweight

parent is 40% more likely and a child with two overweight parents is more than 80% more likely to be overweight. Additionally, low birth weights in infants are linked to being overweight later in life, possibly due to food hording behaviors caused by starvation in the womb (Candib, 2007). Unfortunately, many people are unaware of the uncontrollable causes of weight gain and focus solely on the controllable factors. Learning about the sources of weight gain that are not a result of behaviors and eating habits may influence how obese people are viewed.

Several studies conducted by DeJong (1993; 1980) explored this issue by assessing the influence of causal beliefs on attributions of obesity. One study found that if no medical condition that may contribute to weight gain, such as a thyroid problem, was mentioned in a description of an obese figure, the target was perceived more negatively than if there was an explained medical cause present (DeJong, 1980). A similar study found that people who believed that weight is controllable had more negative attitudes toward the obese and extremely obese figures relative to the people who felt that weight is not controllable (Carels & Musher-Eizenman, 2010). Controllability appears to be a prevalent contributing factor in creation of negative stereotypes of obese people in today's society.

It is also important to be aware of the processes of forming and acting on stereotypes, which can lead to prejudices and discriminatory deeds, particularly as they relate to individuals who are obese. Perceptions, people's automatic impressions of others, can be triggered by someone's visible features, which can then activate stereotypes associated with the group of which that person is a

member (Bargh, & Williams, 2006). Assigning characteristics to a person based on stereotypic beliefs can often lead to prejudices or attitudes about the person based on the group with which he or she is associated (Brehm, Kassin, & Fein, 2005). Prejudices can then develop and result in discriminatory behaviors toward the stereotyped targets or groups.

Michener and DeLamater (1999, p.101) explain that,"social perceptions are impressions that are formed by using the information known about a person and creating an opinion of them". When judgments are made about one or two members of an inferior group, such as the obese population, those opinions are then applied to all members of that group (Puhl & Brownell, 2003). Research has yielded evidence of a relationship between perceived negative traits and individuals perceived as overweight or obese. For instance, multiple studies have shown that obese people are more likely to be considered lazy, lonely, unintelligent, immoral, dishonest (Glenn & Chow, 2002; Polinko & Popovich, 2001; Puhl & Brownell; Puhl, Schwartz, & Brownell, 2005), less productive, inactive, indecisive, mentally lazy, less successful, unhappy, disorganized, less aggressive, less self-disciplined, and unpopular (Harris, Harris, & Bochner, 1982; Tiggerman & Rothblum, 1988). Moreover, obese people were viewed as less attractive and less desirable partners in social and work situations than those not viewed as obese (Hebl, Ruggs, Singletary, & Beal, 2008). Among numerous studies, the perceived characteristic that is attributed to overweight and obese

people most frequently is 'lazy'. As shown in a study conducted by Puhl, Moss-Racusin, Schwartz, and Brownell (2008), 62% of adults who belonged to a national weight-loss support organization labeled the obese figures as lazy. Both children and adults have been found implicitly to believe that obese individuals are more likely to be carrying communicable pathogens than are non-obese individuals (Klaczynski, 2008; Park, Schaller, & Crandall, 2007). On the other hand, although negative traits have often been found, positive characteristics, such as warm and friendly, have also been attributed to obese people (Tiggerman & Rothblum, 1988; Harris et al., 1982).

Once perceptions are made and characteristics are assigned to a person, related positive or negative stereotypes are often formed and applied to the entire group of which the person is a member. Furthermore, the strength of these opinions often leads to stereotyping, which can considerably influence the individuals being stereotyped in various social and work settings. Some theories, such as the attribution theory (Heider, 1958), state that stereotypes are created when people search for a cause for something that appears to be abnormal (Puhl & Brownell, 2003). Once a stereotype is created as an explanation for a person's specific feature or set of features, it has a strong influence on the formation of opinions about the person. For example, according to two influential models of impression formation, the Dual-Process Model (Brewer, 1988) and the Continuum Model (Fiske & Neuberg, 1990), stereotypes often dominate

impressions, and as a result, the believed stereotype carries greater weight than any other individuating information such as behavior or attire (Chaiken & Trope, 1999). Due to the power of the formed stereotype, it becomes the overriding judgment of the individual, "unless one is strongly motivated to gain deep understanding of a person," (Chaiken & Trope, p. 315) or unless the individuating information is considerably contrary to the stereotype. Theories such as the Perceived Social Consensus Model (Stangor, Sechrist, & Jost, 2001a, 2001b), also suggest that the resulting stereotypes are not only formed from often-observed perceptions of members of a group but are also are functions of the perceptions of other people's stereotypical beliefs. This was partially explained by Stangor and Schaller (2000) who believe that people often obtain membership, attention, acceptance, and approval in social groups by sharing similar beliefs and attitudes.

While stereotypes can lead to beliefs about an individual based solely on the individual's membership in a specific group, those beliefs commonly develop into attitudes or prejudices. Prejudices against obese people can adversely affect multiple aspects of their lives, such as career opportunities, friendships, self-esteem, and physical and mental health (Crandell, Neirman, & Hebl, 2009). Similar to common prejudices against race and gender, these negative attitudes limit opportunities and, "involve the domination of powerful, unstigmatized individuals or groups over stigmatized less powerful individuals or groups" (p.

469). Negative attitudes toward less powerful groups, such as the obese population, are portrayed in behaviors and become acts of discrimination.

Effects of Negative Attitudes toward Obesity

Although attitudes and feelings toward a person are not always intentional, the obese population is aware of the judgments that are being formed about them. Features that lead to stigmatization, such as excessive weight, are linked to a devalued social identity, and those who possess the feature are ascribed labels that result in unfair treatment such as teasing, bullying, harassment, hostility, and discrimination (Puhl et al., 2008). The most common types of stigma obese men and women report encountering were, "encountering negative assumptions from others, receiving negative comments from children, encountering physical barriers and obstacles, and receiving inappropriate comments from doctors and family members" (Puhl & Brownell, 2006, p. 1812).

These behaviors affect those who experience them and likely alter the way the targets view themselves. One survey reported that 17% of men and 24% of women stated that they would give up three or more years of their lives in order to be the weight they wanted, some also chose to risk the health concerns of smoking cigarettes in hopes of staying thinner (Puhl & Brownell, 2003). These thoughts and struggles are not usually openly discussed in public. Adults who belonged to a national weight-loss support organization reported that, "they would like the public to gain a better understanding of the difficulties of weight loss, the causes of obesity and the emotional consequences of being stigmatized" (Puhl et al., 2008, p. 347). Over one-third commented on the difficulty involved in

achieving and maintaining weight loss despite their consistent efforts to do so. In a similar study by Ogden and Clementi (2010), obese or previously obese participants with varying degrees of weight management success described the ways that being obese affected their lives. The majority stated that, "the consequences were negative, involved a negative sense of self, negative affect, a sense of dissociation and concerns about their health," (p. 2) and also described themselves as having a sense of dissociation, as experiencing a range of effects on their mood, and as having increased worries about their health. Within the descriptions, they commonly referred to themselves using powerful terms such as "freak", "ugly", and "blob" (Ogden & Clementi, 2010).

Being perceived by others as overweight with the accompanying negative judgments affects many aspects of one's life including interpersonal relationships and physical and mental health. The interpersonal relationships of obese people is a domain that is commonly affected by stigmatization. Two studies reported that obese and non-obese people rate similarly in self-reported social skills and social support (Dierk et al., 2006; Miller et al., 1995). Although obese people may rate themselves with equivalent social skills, research suggests increased relationship difficulties among obese people. Perceptions of obese people can differ from how they actually view themselves, raising the risk of the assumed characteristics interfering with relationships. Regardless of how people viewed themselves, participants in several studies have categorized obese people as being lonely, which may put them at a disadvantage in various interpersonal settings. Intimate relationships are an important aspect in the lives of most people and adding an

additional obstacle to the process of finding a mate is less than desirable. Sheets and Ajmere (2005) found evidence that overweight women were less likely to be dating than were their thinner peers and that body weight was negatively correlated with overweight women's relationship satisfaction.

Being viewed negatively, belittled, and disadvantaged as a result of untrue assumptions is stressful and can lead to physical and mental consequences. As shown by research with people who faced racial discrimination, victims of discrimination experienced extra stress, leading to a higher risk of negative health consequences such as high diastolic blood pressure (Guyll, Matthews, & Bromberger, 2001). Additionally, according to several recent studies, obese individuals who experienced stigmatization based on their weight or who internalized society's negative attitudes toward weight were more likely to suffer from psychological distress, binge eating, and body image disturbance (Ashmore, Friedman, Reichmann, & Musante, 2008; Carels et al., 2009; Durso & Latner, 2008; Friedman et al., 2005; Myers & Rosen, 1999). For instance, in a large survey of 9,000 adults, obesity was associated with an increased lifetime diagnosis of depression-related problems (Simon et al., 2006).

Derogatory remarks and teasing are common contributors to these mental health and self-esteem issues, especially among children. For example, in a study with adolescent females, being obese predicted future development of depressive symptoms (Boutelle et al., 2010). Research suggests that the resulting teasing and other adverse childhood experiences advance the development of depression and

obesity (Stunkard, Faith, & Allison, 2003). Irving (2000) found that 91% of overweight children felt ashamed of being fat, 90% believed that teasing and humiliation from peers would stop if they lost weight, and 69% believed that they would have more friends if they lost weight. An often-cited study conducted in the 1960s provides an example of the negative social impact obesity has on children (Richardson, Goodman, Hastorf, & Dornbusch, 1961). Six hundred children in public school and summer camp settings were asked to rank pictures of children with varying physical characteristics and disabilities in order of whom they would like most as a friend. The majority of children ranked the picture of an obese child last among children with crutches, in a wheelchair, with an amputated hand, and with a facial disfigurement. The study has since been replicated, and the results portrayed an increased bias against the depicted obese child (Latner & Stunkard, 2003).

Not only do obese people face personal judgments and damaging stigmatization, research has also provided evidence of negative stereotyping of those who are in close proximity to an obese person. In a study conducted at Rice University, when job applicants were seen with an overweight female, the applicants were rated more negatively than applicants near a normal weight female. Being in the mere proximity of an overweight woman was enough to trigger stigmatization toward the applicant (Hebl & Mannix, 2003). In the same study, applicants were seated either next to an average weight woman or to an overweight woman. When applicants sat next to the overweight woman, they

were consistently degraded. This pattern remained true regardless of the participants' anti-fat attitudes, gender, the perceived depth of the relationship they had with the seated woman, and whether or not positive information was presented about the woman.

Negative stereotyping does not occur to every obese individual in society; therefore, further explanation is needed to learn which people are stereotyped. Conflicting research has been found investigating the differences in bias toward obese women and obese men. Some research suggests that stereotyping may be more prevalent against women, whereas comparable research has failed to find a gender difference (Carels & Musher-Eizenman, 2010). For instance, a study of obese individuals applying for bariatric surgery found that despite having a significantly lower average BMI than men, women experienced more negative quality-of-life effects, such as lower self-esteem, poorer sexual life, and more public distress, than did men (White, O'Neill, Kolotkin, & Byrne, 2004). Research conducted at UCLA also indicated elevated negative perceptions of their weight among women (Yancey et al., 2006). It was found that regardless of their actual BMI, women were more likely than men to consider themselves overweight. Women may perceive their weight more negatively as a result of experiencing devaluing attitudes. Even in private and medical settings, such as visiting the doctor's office, physicians were more likely to make a recommendation for women with a normal BMI to lose weight than they were for their male patients with the equivalent BMI (Anderson et al., 2001).

Since these bias perceptions commonly lead to negative behaviors, it is not surprising that women were more likely than men to report experiencing discrimination (Carr, 2005) and that several studies have highlighted the prevalence of wage discrimination among obese women in employment settings as compared to among obese men (Puhl & Brownell, 2001). As discussed earlier, attitudes and acts of discrimination have a psychological impact on the targets, possibly contributing to the evidence found that obese women have also reported higher rates of depression than have obese men (Fabricatore & Wadden, 2006).

Although studies have shown a trend in obese women being more stigmatized than men, there is also an abundance of research that has failed to find a gender difference among obese individuals. Based on their findings with more than 2,600 adults, experts in the field of obesity, Puhl and Brownell (2006), stated, "men and women do not differ with respect to the types or amount of stigma they experience, nor with the types or amount of coping strategies they use to deal with stigma"(p. 1813). Similarly, Friedman (2005) found no significant differences between genders in the frequency of stigmatizing experiences, body image distress, or depression in relation to obesity. While data either suggest no differences in obesity stigmatization between genders or that women experience more, Hebl and Turchin (2005) highlighted the fact that stereotyping and discrimination does, in fact, occur and affect obese males as well. Furthermore, at times while gender differences may not exist in overall frequency or perception of obesity-related stigma, the way in which gender is perceived or discriminated against may differ. For instance, obese women reported that they were treated as

if they had a character flaw, while obese men stated they believed they are treated with less respect in comparison to their thinner peers (Carr, Jaffe, & Friedman, 2008).

Discrimination Against Obese Individuals

Obese men and women are viewed differently, but both experience widespread prejudice (Puhl & Brownell, 2001); consequently, discrimination becomes a common occurrence in their lives. The prevalence of discrimination toward obese individuals is relatively close to the reported race and age discrimination rates (Andreyeva, Puhl, & Brownell, 2008); therefore, gaining a better understanding of the dynamics of these judgments is crucial in today's society. Data has suggested that overweight people experience discrimination more often than those with physical abnormalities (Glenn & Chow, 2002) and encounter more disadvantages compared to those viewed as lean (Crandell, Neirman, & Hebl, 2009). Discrimination takes place in an infinite number of settings, for instance, obese people have been rated less likely to be helped following a fictional minor accident than the average size depicted people (Swami, Chan, et al., 2008).

Discrimination often occurs in education, employment, and healthcare settings (Puhl, & Brownell, 2001). Neumark-Sztainer, Story, and Harris (1999) demonstrated that obese students face discrimination from teachers, staff, and parents. They reported that 28% of 115 junior and senior high school teachers stated that becoming obese is the worst thing that can happen to a person, 24% of the nurses said that they were repulsed by obese persons, and after controlling for

income and grades, parents reported providing less college support for their overweight children than for their thin children. Additionally, Crandall (1995) found heavy students at the University of Florida were underrepresented based on the national average, which suggests that some colleges may discriminate in their acceptance of overweight individuals. In a study conducted in Sweden with over 700,000 Swedish men, after adjusting for intelligence and parental socioeconomic status, those who were obese at age 18 had a lower probability of starting college as compared to their normal-weight peers (Karnehed, Rasmussen, Hemmingsson, & Tynelius, 2006).

Discrimination in employment settings is also proving to be a competitive environment that uses physical appearance as a deciding factor. Polinko (2000) found that physically attractive job applicants were recommended for hire for positions that called for social competence more often than were their unattractive competitors. There was no evidence of the bias, however, when the applicants were being considered for positions that required more solitary tasks. Producing similar results, Marlowe, Schneider, and Nelson (1996) concluded that attractive men were perceived to be more suitable for hire and advancement than less attractive men and women with equal qualifications. For men, the bias decreased as managerial experience increased; however, a negative bias toward less attractive female job applicants remained consistent regardless of their managerial experience. They also found that the physical attractiveness of an individual influenced the expected and perceived job performance of the applicants. The performance expectations of the attractive applicants were also higher, and they

were perceived as having a higher potential of being successful. Perceptions can be influenced by a number of factors such as one's occupation. Leone (2003) examined whether occupational status would alter the perceived attractiveness of targets and found that the males with a high job status were rated more attractive than were the males with a lower job status. In contrast, status did not have a significant effect on the ratings of females.

Since obese individuals are typically perceived with a lower level of attractiveness (Rudolph, Wells, Weller, & Baltes, 2009), the competence and success-related characteristics that have been associated with attractive and unattractive persons may also be true for the obese and non-obese population. Three reviews (Rudolph et al., 2009; Roehling, 1999; Paul & Townsend, 1995) of studies examining weight-based biases in the workplace reported that overweight employees were assumed to lack self-discipline and to be lazy, less competent, sloppy, disagreeable, untidy, and emotionally unstable. Obese employees were also perceived as thinking slower, having poorer attendance records, possessing bad work habits, and being poor role models. Obtaining a desired employment position can be difficult when such opinions are ascribed to an applicant. Puhl and Brownell (2003) suggested that employers often hire candidates whom they view as having a normal body size, rather than an overweight applicant who has an equivalent resume and skill set. Positions that require applicants to represent the company in a visible manner are even more difficult to obtain for overweight individuals (Polinko & Popovich, 2001). These acts of discrimination can be financially damaging by unfairly affecting the wages, promotion, and termination

of obese individuals. In a study by Puhl and Brownell (2006), 25% of overweight and obese women experienced job discrimination because of their weight, 54% reported weight stigma from co-workers or colleagues, and 43% from their employers or supervisors. Moreover, of those individuals who reported weight discrimination in employment settings, 60% experienced not being hired for a job, not receiving a promotion, or wrongful termination an average of four times in their life (Stunkard & Storensen, 1993). Although both overweight men and overweight women endure discriminatory acts, women were found to be 16 times more likely to report weight-related employment discrimination in comparison to men (Roehling, Roehling, & Pichler, 2007).

People at all levels of the professional ladder experience the effects of workplace discrimination, but research has suggested that people in high status occupational positions may be at an additional disadvantage. Carr and Friedman (2008) found obese upper white-collar workers, such as executives, professionals, or managers, were more likely to report daily and work-related discrimination compared not only to their thinner peers but also to obese lower white-collar and blue-collar workers (i.e. sales, clerical, crafts, farm, operative positions). Excessive weight on men categorized as professionals has been viewed as a sign of having a lack of self-discipline or work ethic and obese professional women were viewed as failing to uphold the high morals that a woman is expected to possess (Gilligan, 1992).

Healthcare Professionals

Within healthcare settings, obese patients are also vulnerable to being perceived and treated differently. In a study of over 600 primary care physicians, more than 50% viewed obese patients as unattractive, noncompliant, and awkward, and approximately one-third described them as weak-willed, sloppy, or lazy. However, only 9% labeled the obese individuals as unpleasant and just 3% as dishonest (Foster et al., 2003). As discussed earlier, these negative opinions are often manifested in attitudes and behaviors. Evidence from a study by Hebl and Xu (2001) showed that:

> Physicians reported that seeing patients was a greater waste of their time the heavier that they were, that physicians would like their jobs less as their patients increased in size, that heavier patients were viewed to be more annoying, and that physicians felt less patience the heavier the patient was… physicians indicated having significantly less personal desire to help patients the heavier they were (p. 1250).

Physicians also had more negative attitudes toward obese patients than those patients had about themselves (Betfort et al., 2006). These attitudes of physicians do not go unnoticed by obese patients. In a study by Puhl and Brownell (2006) that involved more than 2,500 overweight or obese members of a weight loss organization, doctors were ranked as the second most common source of stigmatization or discrimination among a list of over 20 other possible sources. Additionally, participants reported experiencing frequent stigma from various

other health professionals such as nurses, dietitians, and mental health professionals.

People seek help from mental health professionals and hope not to be judged and expect to be in a safe, unbiased space. Several studies have examined whether mental health professionals meet the public's non-judgmental expectations toward overweight persons (Amici, 2002; Davis-Coelho, Waltz, & Davis-Coelho, 2000; Hassel & Lynn, 2002; Loewy, 1995). Evidence suggested that negative biases toward obese clients were prevalent and also that the weight of the clients had an effect on the clinical judgments and treatment planning of counselors (Davis-Coelho et al., 2000). For example, to assess the likelihood of weight biases among mental health professionals, Amici (2002) provided professionals involved in clinical work with a generic description of a client case study along with a photograph of either an average weight or overweight client. They were then asked to assign a diagnosis and characteristics to the client. Overall, more pathology and lower Global Assessment of Functioning (GAF) scores were ascribed to the obese clients. Davis-Coelho et al. also found that when a photo of an obese person was attached to the description of a client, practicing psychologists and members of various counseling-related divisions of the American Psychological Association predicted a lesser degree of effort in therapy and also assigned these clients a lower GAF score. Mental health professionals were also found to ascribe negative attributes, more severe psychological

symptoms, such as self-injurious behaviors and emotional behaviors, and to have a significantly more negative view of obese clients than of average weight clients (Hassel, Amici, Thurston, & Gorsuch, 2001; Young & Powell, 1985).

Although numerous studies have suggested there is a bias toward obese clients, not all mental health professionals hold these judgments. Female mental health professionals were found to assign lower levels of functioning and more negative attributes than did their male colleagues (Amici, 2002). In addition, data also indicated that younger and less experienced respondents predicted the worse prognosis for the obese clients (Adams, 2009; Davis, 1998; Young & Powell, 1985), suggesting that more life and career experience may decrease such biases in the mental health field.

Adams (2009) reported similar findings among 56 graduate students training to become counselors. The counselor trainees identified more psychological symptoms for clients depicted as overweight than for the normal weight clients. They were perceived as, "more agitated, emotional, suspicious, impulsive, intolerant of change, and as demonstrating inappropriate behavior than the normal weight client" (p. 73). They were also seen as, "being limited by feelings of inferiority and inadequacy, having self-defeating beliefs, and unwillingness to accept personal freedom and the responsibility that comes with it" (p. 85). A study conducted in 1991 found somewhat different results when examining the weight bias among psychologists. Although Agell and Rothblum (1991) provided evidence that psychologists rated obese clients as more

physically unattractive and more embarrassed compared to non-obese clients, the obese clients were also described as softer and kinder. The study did not find significant effects of client weight influencing therapy recommendations. The differences found for respondents' gender paralleled with previously discussed findings. Female respondents rated all clients, both obese and non-obese, as sadder, tenser, more depressed, harder, and crueler than did the male respondents.

Helping professionals, such as counselors, may unintentionally portray a sense of defeatism to their clients due to their negative stereotypes about them as well (Pedersen, 1991). The first impressions and opinions that counselors form about their clients are related to the diagnosis, treatment, and outcome of counseling (Wills, 1978), making it essential for counselors to be aware of their own biases and beliefs about various attributes and populations. Remaining objective and unbiased toward clients is an ethical principle that counselors are expected to practice successfully. According to the American Counseling Association Code of Ethics (2005), "counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that are inconsistent with counseling goals" (Standard A.4.b.). The American Psychological Association (2010) promotes the similar assumed standard that psychologists are to, "exercise reasonable judgment and take precautions to ensure that their potential bias, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices."

Monitoring potential biases among counselors is difficult, therefore, providing effective training to educate counselors-in-training and help prevent

biases from occurring in is essential. For the client's welfare, counselors must provide equal treatment to all clients, as equal people should be treated equally (Kitchener, 1984). In order to achieve the goal of fair treatment among clients, counselors must first be aware of their own attitudes and beliefs toward various populations. Although this principle is taught to counselors-in-training and valued throughout the careers of counselors, the extent to which they are aware of their own biases and actively prevent those attitudes from being imposed on clients is unknown.

Summary and Purpose of this Study

Stereotyping can occur unconsciously by anyone. Counselors are not an exception to this rule, hence it is important that they become aware of the common biases toward obese clients and what influences their own biases. Obese people experience discrimination and negative attitudes in numerous settings and should be able to be free of prejudice in the safe space of the counseling setting. Counselors work with a diverse population of clients, and based on the increasing prevalence of obesity among the general population, a significant proportion of clients will be obese. Although multicultural training in counseling programs is common, curricula tend to focus primarily on various races and ethnicities and may not address the issues related to working with overweight clients. The need and demand for mental health professionals to participate in the assessment and treatment of overweight and obese clients is increasing (Bean, Stewart, & Olbrisch, 2008). Psychological consequences such as depression, eating disorders, social discrimination, and poor quality of life have been associated with

obesity (Fabricatore & Wadden, 2006) making it important to recognize obesity as a possible comorbidity and if necessary, to approach clients' weight concerns as part of treatment (Bean et al.). An increased risk of depression, low self-esteem, binge eating, and impaired quality of life has also been observed in obese children and adolescents (Walker & Hill, 2009), increasing the need for counselors to be aware of what contributes to their personal beliefs about excess weight. Although research has shown that biases do exist toward obese clients, not all obese clients are perceived negatively; therefore, exploring which aspects of clients influence the opinion of counselors is needed.

The current study examines the attitudes and potential biases of counselors-in-training toward obese clients at different levels of occupation statuses. This study investigates the prevalence of bias towards obese clients and whether the client's job status plays a role in how counselors perceive them. Two research questions and corresponding hypotheses were posed:

1. Do counselors-in-training hold negative attitudes toward obese clients?

   H1: Counselors-in-training will have more negative attitudes about obese clients than they will have about normal weight clients.

2. Do counselors-in-training perceive clients with a high status job differently than clients with a low status job?

   H2: Counselors-in-training will have more negative attitudes about clients with a low status job than they will have about clients with a high status job.

Chapter 2

Method

Participants

Participants for this study included 76 students in various master's level graduate counseling programs at Arizona State University during the Spring 2011 semester, 47 (61%) from the mental health counseling program, 13 (17.1%) from the marriage and family program, eight (10.5%) from the counseling psychology program, and six (7.9%) from the school counseling program. Two individuals did not indicate their program on the demographics form. Informed consent was obtained prior to participation (see Appendix A). Participation was voluntary, and respondents were not offered course credit or financial reimbursement.

Of the 76 counselor trainees in this study, 13 (17.1%) self-identified as male, 61 (80.3%) as female, and two did not report their gender. The most frequent age range was under 24 years-old, with 30 (39%) respondents selecting it. The next largest age group was 25-30 years-old with 28 (36.4%) respondents, six reported being 31-35 years-old, seven reported 36-40 years-old, four reported 41-45 years-old, and two individuals did not report their age. In this study, 59 (77.6%) reported their ethnicity as Caucasian, five (6.6%) as Latino/a American, four (5.3%) as African American, three (3.9%) as Asian American, two (2.6%) as multi-ethnic, and two (2.6%) did not respond. The participants were asked to indicate their experience by the number of semesters they had directly counseled

clients. Thirty-one (40.8%) reported they have had "0+" semesters of experience, 24 (31.6%) reported "1+" semesters, nine (11.8%) reported having counseled clients for "2+" semesters, seven (9.2%) reported "3+" semesters, two (2.6%) reported "4+" semesters, and one participant (1.3%) reported "7+" semesters. Two individuals did not report their amount of experience. Of the participants, 27 (35.1%) reported they had not taken a multicultural course, 35 (45.5%) had taken one multicultural course, eight (10.4%) took two courses, and five (6.5%) reported having taken 3 or more.

Design

This study utilized vignettes to manipulate the independent variables, creating a 2 (client weight) by 2 (client job) factorial design. Respondents were randomly assigned to one of four vignettes, depicting either an obese or a normal weight female client who either worked at a four-star hotel as an office bookkeeper or as a hotel executive manager. There were two dependent variables, perceived personal characteristics and perceived work efficacy, to measure attitudes about the client.

Vignettes

The vignettes described a 37-year-old Caucasian female who was dissatisfied with her life, was grieving her husband's death, and was having difficulty balancing her work and family life. Caucasian was chosen as the race of the woman because research has indicated that Caucasian women are stigmatized

for being overweight more than other groups (Brownell, 2005; Crossrow, Jeffrey, & McGuire, 2001; Heo et al., 2006; Herva et al., 2006; Loh, 1993; Pingitore et al, 1994; Roehling, 1999; Teachman & Brownell, 2001; Young & Powell, 1985). The four versions of the vignette were identical except for information directly related to the client's weight and job status. To reduce influences that may impact responses to the survey, the presenting problem of the target client was written in attempt to have minimal descriptors that would suggest aspects of the client's personality. The age of 37 was selected to provide reasonable time for the client to have attainted both occupations. All four vignettes can be found in Appendix D, the following is the vignette for the client described as an obese woman with a low status job:

> Jennifer is a 37 year-old Caucasian woman seeking individual counseling. She stated on her intake paperwork that she is a widowed mother of two children, a boy who is nine and a girl who is 12. She reports no history of any mental diagnosis and is seeking counseling for the first time. She describes herself as short (5'4"), very overweight (235 lbs), and as being in relatively good health other than constantly struggling with her weight. Jennifer has an associate's degree.
>
> She works full-time at a four-star hotel as an office bookkeeper and finds it difficult balancing work and family demands. She feels as though her job consumes a lot of her time and has been frustrated with her

supervisor's demands that she work overtime, which means having less time to spend with her children. She reports that her social support network consists primarily of her sister and her best friend who both live nearby. She also has work friends whom she meets for coffee or an occasional movie night.

Jennifer describes her presenting issue as being dissatisfied with life and frustrated with work and with her kids. Her husband passed away two years ago, and she is still grieving his loss. She has had difficulty adjusting to being a single mother and thinks that her 12-year-old daughter is acting out in school as a result of losing her father.

Outcome Measures

Two scales were used to measure attitudes about the presented client in regards to the personal characteristics and work efficacy. The scale chosen to measure perceptions of personal characteristics was the Fat Phobia Scale: Short Form (see Appendix C), created by Bacon, Scheltema, and Robinson (2001). This scale measures the negative attitudes and stereotypes toward overweight or obese people. The original 50-item scale was reduced to 14 items for the short form, and from six subcategories (Undisciplined, inactive and unappealing; grouchy and unfriendly; poor hygiene; passivity; emotional psychological problems; and stupid and uncreative) to one category (Undisciplined, inactive, and unappealing). In a review of over 20 similar measures, Yuker et al. (1995) stated that the Fat

Phobia Scale is one of the best three scales to assess attitudes toward fat people and suggested that it should be incorporated in future research. The short form correlated highly with the original version, r = .90 and maintained an excellent internal consistency reliability of .91. The scale was adapted to this study by altering the directions to address perceived characteristics about normal weight people as well as obese. The total score was calculated by adding each question's rating and dividing by the total number of questions responded to with a potential total score ranging from zero to five. The mean score was 2.78, SD = .52, and ranged from 1.3 to 3.9. Based on the responses of the participants in this study, the personal characteristics scale yielded high internal consistency, with a Cronbach alpha coefficient of .84.

To evaluate the attitudes counselors-in-training have toward the client's ability and confidence in her job skills, an adaptation of the Personal Efficacy Beliefs scale, developed by Riggs, Warka, Babasa, Betancourt, and Hooker (1994) was used. The scale originally assessed the respondents' self-beliefs; however, the wording was modified to present the statements in reference to the specific client in each vignette. The scale measures respondents' perceptions of the degree to which the client possesses the skills and ability for her job. It consists of 10 items that are rated on a 6-point scale ranging from "strongly disagree" to "strongly agree." The total score for each survey was calculated by adding the score for each question after six items were reverse coded. The total possible score range was 10 to 60, and this study produced a scale mean of 44.94, SD =4.97. Higher scores

indicate greater belief in the client's work ability. The reliability for the scale has ranged from .85 to .88 (Riggs et al.). Based on the responses of the participants in this study, the scale produced a Cronbach alpha coefficient of .70.

Additionally, participants were asked to complete a brief demographic questionnaire including questions regarding the following: sex, age, height, weight, ethnicity, degree currently enrolled in, area of study, and number of semesters spent counseling clients.

Procedure

Participants were recruited from various courses within graduate counseling programs. Permission from each professor was obtained prior to approaching any students. Those who choose to participate were personally handed surveys to complete and return. Participation was voluntary, and no compensation was offered. Participants were informed that the purpose of the study was to evaluate perceptions of clients.

The packet consisted of an informed consent, one of four vignettes, two outcome measures, and the demographic questionnaire. Students were then asked to complete the surveys independently and during class time. Other than the differing vignettes, all other information and questions remained constant across all packets.

Packets were arranged randomly within clusters of four, and each cluster contained one of each vignette. All packets were then randomly distributed to

participants by gender in order to have a more even distribution of males within each condition. The order of the two outcome measures in each packet varied to control for any order effect in responses. The entire research packet took approximately five to seven minutes to complete.

Chapter 3

Results

Prior to analyzing the study hypotheses, a manipulation check was conducted and indicated that 100% of the participants accurately reported the weight and job status of the vignette they read. A procedural check was also conducted to assess potential differences in the responses between the four counseling programs of the participants. No significant differences were found between the mental health, school counseling, counseling psychology, or marriage and family programs for either dependent variable; Personal Characteristics Scale, $F(3,70) = 0.013$, $p = .998$, Work Efficacy Scale, $F(3,70) = 0.249$, $p = .249$.

Next, the relationship between the amount of experience the respondents reported and the outcome variables was examined. Experience working with clients was not related to the responses selected on the Personal Characteristics Scale, $r = -.118$, $p = .319$, or the Work Efficacy Scale, $r = -.107$, $p = .362$.

The internal consistencies were also examined for the outcome variables. These are reported in the Method section. The relationship between the dependent variables was assessed, and no significant was relationship was found, $r = -.21$, $p = .074$.

To test the two hypotheses, two 2 x 2 analysis of variances (ANOVA) were conducted. The first two (client weight) by two (client status) ANOVA conducted addressed attitudes regarding personal characteristics counselors-in-

training have about clients, measured by ratings on the Personal Characteristics Scale. The ANOVA indicated a significant main effect for client weight, $F(1,72) = 12.53$, $p = .001$, partial $\eta^2 = .148$, explaining 14.8% of the total variance in perceived negative personal characteristics ratings and also a significant main effect for client job status, $F(1,72) = 4.51$, $p = .037$, partial $\eta^2 = .059$. Counselors-in-training perceived more negative personal characteristics about the obese client ($M = 2.97$, $SD = 0.49$) than the normal weight client ($M = 2.57$, $SD = 0.50$). In addition, counselors-in-training perceived more negative personal characteristics about the client employed as a bookkeeper ($M = 2.90$, $SD = 0.49$) than about the client employed as an executive manager ($M = 2.65$, $SD = 0.55$). No significant interaction was found, $F(1,72) = 0.54$, $p = .47$, partial $\eta^2 = .007$.

A second two (client weight) by two (job status) ANOVA was conducted to evaluate counselors-in-training's attitudes regarding clients' work efficacy. The ANOVA failed to reveal a main effect for client weight, $F(1,72) = 0.122$, $p = .728$, partial $\eta^2 = .002$, or for client job status, $F(1,72) = 0.629$, $p = .430$, partial $\eta^2 = .009$. Additionally, no significant interaction was found, $F(1,72) = .001$, $p = .979$, partial $\eta^2 < .001$. The means and standard deviations for each group can be found in Table 1. The attitudes counselors-in-training held toward clients regarding their work efficacy was not significantly influenced by the client's weight or job status, which does not support the hypothesis.

Chapter 4

Discussion

Two hypotheses were tested in the current study. The first hypothesis predicted counselors-in-training would have more negative attitudes about obese clients than they would have about normal weight clients. Negative attitudes were assessed using two scales: the Personal Characteristics Scale that examined perceptions of personal characteristics, and the Work Efficacy Scale that measured attitudes regarding one's work efficacy. Analysis of perceptions of personal characteristics produced a significant main effect for client weight. Students training to be mental health professionals had more negative perceptions of a female client described as obese, regardless of the client's job status. This finding is consistent with similar studies that have found that mental health professionals ascribe more negative attributes, more severe psychological symptoms, and have more negative views of obese clients than of average weight clients (Hassel et al., 2001; Young & Powell, 1985). As research evolves in this area, evidence suggests that mental health professionals and those still in training hold negative beliefs about what type of people obese individuals are. These views have often been found in the general public, and it appears that mental health professionals are no different from their lay counterparts.

Examination of the personal characteristics ascribed to the client, the findings of the current study conflict with findings from several other studies

(Glenn & Chow, 2002; Polinko & Popovich, 2001; Puhl & Brownell, 2003; Puhl, Schwartz, & Brownell, 2008). In the current study, both the obese client and the normal weight client were perceived as being more industrious than lazy. This finding contradicts many similar studies, making it questionable whether other factors related to the vignette influenced the ratings. Almost one-third of the participants viewed the obese client as having poorer self-control as opposed to less than one-tenth rating the normal weight client as having poor self-control. It is possible that this rating may reflect the participants' belief that the obese client lacked self-control related to eating. This conclusion is supported by the rating of the overeating item: The obese client was rated by over 60% of the participants as overeating, while a mere 8% ascribed overeating to the normal weight client. The views of overeating and having poor self-control relate to the concept of controllability, which reiterates previous findings that people tend to believe that obese individuals are the cause of their own weight and that their weight gain or loss is under their personal control (Puhl & Brownell, 2001). The obese client was also rated more frequently as inactive, having no endurance, no will power, insecure, and having low self-esteem than the normal weight client. All of these could also be related to weight issues such as not staying on a diet (no endurance and no will power) and as a result not feeling positive about herself (insecure and low self-esteem).

Based on reviews of research that reported obese employees were perceived as thinking slower, having poorer attendance records, possessing bad work habits, and being poor role models (Rudolph et al., 2009), it was predicted that the obese clients would be viewed as being less efficacious at their job. However, the current study found no differences among the vignettes based on work efficacy. Although, counselors-in-training rated normal weight clients slightly higher than obese clients on their ability and competence at work, there was not a significant difference. Interestingly, in previous research many overweight and obese women reported experiencing job discrimination, stigma from co-workers and employers, not being hired for a job, not receiving a promotion, and wrongful termination because of their weight (Puhl & Brownell, 2006; Rippe, 1998; Storensen, 1993). In contrast, in this study the obese client was not viewed as less competent than the normal weight client, even though the actual value of the mean for the obese client was lower than that for the normal weight client. This suggests that workplace related discrimination reported by obese women may be unrelated to counselors-in-training perceptions of these women's ability to perform their job effectively. This finding may be related to the presented client's gender, as it is consistent with Carr, Jaffe, and Friedmans (2008) research that found obese women reported being treated as if they had a character flaw, while obese men stated they believed they are treated with less respect.

The second hypothesis predicted that counselor trainees would have more negative attitudes about clients with a low status job than they would have about clients with a high status job. In support of the hypothesis, participants held statistically significant more negative perceptions of personal characteristics about a client with a low status job, an office bookkeeper, than about the same client described as having a high status job, a hotel executive manager. This finding implies that the participants associated more negative characteristics to clients in less prestigious work positions regardless of the client's weight. Approximately 65% of participants who received the vignette describing the client as an office bookkeeper rated her as insecure while only 30% rated the executive manager as insecure. Less than three percent of the participants rated the office bookkeeper as having high self-esteem, whereas, 21% associated high self-esteem with the client in the hotel executive manager position. The client with a low status job was also more frequently rated as inactive and having no will power, however, she was perceived as having good self-control more often than the client with a high status job.

According to research conducted by Carr and Friedman (2008), obese workers in higher status positions reported more work-related discrimination compared to obese peers in lower status positions and compared to their thinner peers in various positions. Weight appears to influence the feelings of being discriminated against in the workplace, as suggested by Carr and Friedman. In the

current study, however, the perceptions of others, not an employee, were assessed. Others' perceptions of an employee's ability to do well at work may not be dependent on the employee's weight or job status. Although there were negative perceptions of personal characteristics found, the client's job status did not significantly influence the perceptions of the client's work efficacy. This implies that counselors-in-training do not have more negative attitudes regarding a person's work efficacy about clients with low status jobs, regardless of the person's weight. This suggests that perhaps counselor judgments about a client's ability to do her job are not biased.

Overall, counselors-in-training perceived the obese client as compared to normal weight client and the client in a low status job compared to the client in a high status job as having more negative personal characteristics. The perceived work efficacy of the presented clients was not affected by the client's weight or job status.

Limitations

This study has limitations that should be noted. First, the obese client presented in the vignette was female, which limits the study to be generalized only to obese females. Research has not consistently found gender differences in stereotyping of obese individuals; however, some research has suggested that negative attitudes may be more prevalent against women (Carels & Musher-Eizenman, 2010). It is possible that the attitudes about the obese client were

influenced by the client's gender. Additionally, the client's job title may not have successfully captured the job status manipulation. The positions of office bookkeeper and hotel executive manager may have triggered perceptions about the client more than merely the jobs being either high or low status. Participants may have attributed characteristics to the client based on their perception of what the job duties entail. For example, the executive manager could have been viewed as industrious because there is a level of intelligence and organization necessary to manage and track tasks commonly associated with the title. Similarly, the bookkeeper may have been rated as having lower self-esteem or being insecure because she was not in a position associated with social interactions. In summary, the ratings that the client's received may be attributed to characteristics of the job rather than the status of the job; therefore, it is difficult to generalize the finding to all low or high status jobs. Furthermore, it is possible that the two positions were not good choices to represent high and low status jobs, since they were both white collar office positions in a luxury hotel.

The majority of the participants in the study identified as female. Research has demonstrated that female mental health professionals may perceive clients differently than do male professionals. For example, Amici (2002) found that female mental health professionals assigned lower levels of functioning and more negative attributes to clients than did their male colleagues. Additionally, research by Agell and Rothblum (1991) suggested that females rate clients as

sadder, tenser, more depressed, harder, and crueler than do male respondents. Students training to be mental health professionals are primarily young women, similar to the respondents in this study; however, this study may not be a fully accurate representation of the counselors-in-training population, especially since all participants were attending one state university in the Southwest. Caution in generalizing the results of this study must also occur when applying it to the population of all obese clients and clients in low status positions as the ethnicity of the client and ethnicity of the student may influence trainees' perceptions.

In spite of these limitations, this study makes a significant contribution to the knowledge base related to counselors-in-trainings biases, particularly when a potential client is obese. These findings suggest that client weight is an issue of diversity that requires attention during coursework and clinical practice to ensure that all clients, regardless of weight, are treated with equality and respect.

Implications

People seek help from mental health professionals expecting to have an unbiased therapist; however, therapists are human and their attitudes and perceptions are subject to bias. The American Psychological Association (APA, 2010, Standard A.4.b) and the American Counseling Association (ACA, 2005) note the potential impact biased attitudes can have on clients and, therefore, state in their ethical codes that professionals need to become aware of their biases and take the appropriate precautions to prevent them from influencing counseling

goals. To prevent their attitudes from intruding on therapy, mental health professionals must be trained to become aware of what influences their perceptions and attitudes.

Based on this study, counselor trainees' perceptions appear to be influenced by a client's weight. Many counselor training programs require courses regarding multicultural counseling due to the extensive research that has shown biases do exist toward clients of different ethnic backgrounds. These courses educate students about potential attitudes they may hold and the importance of becoming aware of and managing them. The reported prevalence of discrimination toward obese individuals is relatively equal to the reported race and age discrimination rates (Andreyeva, Puhl, & Brownell, 2008), signifying that this bias is widespread and deserves attention. Students are taught about ethnicity-related perceptions but are potentially unaware of the biases they may hold about obese individuals. Furthermore, the extent to which these attitudes are imposed on clients needs to be addressed to a greater degree in research and in counselor educational programs.

It is essential that additional research in this area be conducted and that awareness of attitudes toward obese persons is highlighted. Not only do mental health professionals seem to have negative attitudes about obese people, but seemingly so do people in general. According to research, many obese persons would like the general public to gain a better understanding of the causes of

obesity, the difficulties with weight loss, and the emotional burdens that are attached to being stigmatized (Puhl et al., 2008, p. 347). Stereotyping and discrimination are experienced and/or witnessed from the early years of childhood and they continue to happen in schools, in the media, in the work place, and in many other areas of life. Repeated exposure to stereotyping and discrimination is a likely contributor to the formation of negative attitudes about the obese population, making this an area of concern. Mental health professionals work with diverse populations and a portion of those clients will be obese; therefore, it is necessary that educators, students, professionals, and clients should be aware of this issue.

In addition to weight biases, counselors-in-training were found to view clients with a low status job as having more negative personality characteristics. It cannot be forgotten that mental health professionals work with clients on a wide variety of issues, including career concerns. Although the perception of a client's ability to do their job may be not compromised by their job status, how they are viewed as person may be. For the client's welfare, counselors must provide equal treatment to all clients, as equal people should be treated equally (Kitchener, 1984). If a client is viewed as being more insecure or as having less self-control based on their job title, their treatment in counseling and counseling goals may be negatively influenced. Regardless of their goals for seeking counseling, the

information that the counselor learns about clients impacts their perceptions of the clients.

Although the vignettes provided a limited amount of information about an individual and in reality counselors learn more about their clients during sessions, trainees' first impressions of the client were also based on this limited information. Wills (1978) stated that the first impressions that counselors form about their clients influence the diagnosis, treatment, and outcome of counseling. If helping professionals form negative attitudes about clients based on the client's weight, the helping professional may unintentionally portray a sense of defeatism to the client during the counseling process (Pedersen, 1991). This negative attitude not only hurts the client and also the counselor's ability to be effective with these clients.

Future Research

Weight bias has been found repeatedly in research; nonetheless, the contributors to this bias are unknown. This study investigated job status as potentially influencing the perceptions about obese individuals; however, many other aspects could be examined in future research such as ethnicity, social skills, personal history, or perceived confidence. Previous research has indicated that there is a tendency to attribute positive qualities to those physically attractive and negative qualities to those who are not (Dion & Dion, 1987). In the current study, as the perceived attractiveness of the client increased the total rating of negative

characteristics decreased. Future research may want to focus on the influence of attractiveness on the assigned attributes about obese people.

Previous research has suggested that a man's job status impacts his perceived level of attractiveness (Leone, 2003) and the current study found that perceptions of a client were also influenced by her job status. Research in this area is fairly new and additional exploration of the topic is needed.

Additionally, due to the limited sample of the current study, future research is needed to confirm and expand on the results. This study examined the attitudes of counselors-in-training by using a paper and pencil survey, which did not assess whether the participants' views would be portrayed in reality. Additional research could expand on this study by evaluating the extent of biases influencing counselor interactions with clients.

REFERENCES

Adams, L. (2009). Weight bias among counselors-in-training: A qualitative inquiry. Dissertation Abstracts International, 70(2-A), 481.

Agell, G., & Rothblum, E. D. (1991). Effects of clients' obesity and gender on the therapy judgments of psychologists. *Professional Psychology: Research and Practice*, *22*(3), 223-229.

American Psychological Association (2010). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC.

Amici, Carol J. (2002). *Effects of client body size on the attitudes and assessment of pathology by female and male mental health professionals* (Psy.D. dissertation). Fuller Theological Seminary, School of Psychology, Pasadena, California. Retrieved October 17, 2010, from Dissertations & Theses.

Anderson, C., Peterson, C. B., Fletcher, L., Mitchell, J. E., Thuras, P., & Crow, S. J. (2001). Weight loss and gender: an examination of physician attitudes. *Obesity Research*, *9*(4), 257-263.

Andreyeva, T., Puhl, R. M., & Brownell, K. D. (2008). Changes in Perceived Weight Discrimination Among Americans, 1995-1996 Through 2004-2006. *Obesity*, *16*(5), 1129-1134.

Ashmore, J. A., Friedman, K. E., Reichmann, S. K., & Musante, G. J. (2008). Weight-based stigmatization, psychological distress, & binge eating behavior among obese treatment-seeking adults. *Eating Behaviors*, *9*(2), 203–209.

Bacon, J. G., Scheltema, K. E., & Robinson, B. E. (2002). Fat phobia scale revisited: the short form. *International Journal of Obesity*, *25*, 252-257.

Bargh, A.J., & Williams, E.L. (2006). The automaticity of social life. *Current Directions in Psychological Science*, *15*(1), 1-4.

Bean, M. K., Stewart, K., & Olbrisch, M. E. (2008). Obesity in america: implications for clinical and health psychologists. *Journal of Clinical Psychology in Medical Settings*, *15*(3), 214-224.

Befort, C. A., Greiner, K. A., Hall, S., Pulvers, K. M., Nollen, N. L., Charbonneau, A., & Kaur, H. (2006). Weight-related perceptions among patients and physicians: How well do physicians judge patients' motivation to lose weight? *Journal of General Internal Medicine*, *21*(10), 1086-1090.

Boutelle, K. N., Hannan, P., Fulkerson, J. A., Crow, S. J., & Stice, E. (2010). Obesity as a prospective predictor of depression in adolescent females. *Health Psychology*, *29*(3), 293-298.

Brehm, S.S., Kassin, S.M, & Fein, S. (2005). *Social psychology*. Boston, MA: Houghton Mifflin

Brewer, M.B. (1988). *A Dual process model of impression formation*. Hillsdale, NJ: L. Erlbaum Associates.

Brownell, K. D. (2005). *Weight bias: nature, consequences, and remedies* (20). New York: Guilford Press.

Button, E. J. (1997). Self-esteem, eating problems, and psychological well-being in a cohort of schoolgirls aged 15-16: A questionnaire and interview study. *The International journal of eating disorders*, *21*(1).

Candib, L. M. (2007). Obesity and diabetes in vulnerable populations: Reflection on proximal and distal causes. *Annals of Family Medicine*, *5*(6), 547–556.

Carr, D., Jaffe, K. J., & Friedman, M. A. (2008). Perceived interpersonal mistreatment among obese americans: do race, class, and gender matter? *Obesity*, *16*(S2), S60-S68.

Carels, R A. & D R. Musher-Eizenman. (2010). Individual differences and weight bias: do people with an anti-fat bias have a pro-thin bias? *Body Image,* 7, 143-48.

Carels, R. A., Young, K. M., Coit, C., Harper, J., Gumble, A., Wagner, M., et al. (2009). Internalized weight stigma and its ideological correlates among treatment-seeking adults. *Eating and Weight Disorders*, *14*(2-3), 92–97.

Carr, D., & Friedman, M. A. (2005). Is obesity stigmatizing? body weight, perceived discrimination, and psycholgical well-being in the united states. *Journal of Health and Social Behavior*, *46*(Sept), 244-259.

Cawley, J. Body Weight and Women's Labor Market Outcomes (2000). NBER Working Paper Series, Vol. w7841, pp. 2000. Available at SSRN, http://ssrn.com/abstract=239096.

Chaiken, S., & Trope, Y. (1999). *Dual-process theories in social psychology* (pp. 314-322). New York, NY: Guilford Press.

Crandall, C. S. (1994). Predjudice against fat people: ideology and self-interest. *Journal of Personality and Social Psychology*, *66*(5), 882-894.

Crandall, C. S. (1995). Do parents discriminate against their heavyweight daughters? *Personality and Social Psychology Bulletin, 21*, 724-735

Crandall, C.S. (2003). Ideology and lay theories of stigma: the justification of stigmatization. In T. Heatherton (Ed.), *The social psychology of stigma* (pp. 126-152). New York, NY: Guilford Press.

Crandall, C. S., & Cohen, C. (1994). The personality of the stigmatizer: cultural word view, conventionalism, and self-esteem. *Journal of Research in Personality*, *28*(4), 461-480.

Crandall, C. S., & Martinez, R. (1996). Culture, ideology, and antifat attitudes. *Personality and Social Psychology Bulletin*, *22*(11), 1165-1176.

Crandall, C. S., Neirman, A., & Hebl, M. (2009). *Handbook of prejudice, stereotyping, and discrimination* (pp. 469-487). New York, NY: Psychology Press.

Crossrow, N. F., Jeffery, R. W., & McGuire, M. T. (2001). Understanding weight stigmatization: A focus group study. *Journal of Nutrition Education*, *33*(4), 208-214.

Davis-Coelho, K., Waltz, J., & Davis-Coelho, B. (2000). Awareness and prevention of bias against fat clients in psychotherapy. *Professional Psychology: Research and Practice*, *31*(6), 682-684.

Dierk, J., Conradt, M., Rauh, E., Schlumberger, P., Hebebrand, J., & Reif, W. (2006). What determines well-being in obesity? Associations with BMI, social skills, and social support. *Journal of Psychosomatic Research*, *60*(3), 219-227.

Dion, K L., and K K. Dion. (1987). Belief in a just world and physical attractiveness stereotyping. *Journal of Personality and Social Psychology,* 52(4), 775-80.

Durso, L. E., & Latner, J. D. (2008). Understanding self-directed stigma: Development of the Weight Bias Internalization Scale. *Obesity*, 16(suppl2), s80–s86.

Fabricatore, A. N., & Wadden, T. A. (2006). Obesity. *Annual Review of Clinical Psychology*, *2*(1), 357-377.

Fairburn, C. G., & Brownell, K. D. (2002). *Eating disorders and obesity: a comprehensive handbook* (2nd ed.). New York: Guilford Press.

Fiske, S. T. and Neuberg, S. L. (1990). *A Continuum of Impression Formation, from Category-based to individuating processes: influences of information and motivation on attention and interpretation*, volume 23, pages 1-74.

Foster, G. D., Wadden, T. A., Makris, A. P., Davidson, D., Sanderson, R. S., Allison, D. B., & Kessler, A. (2003). Primary care physicians' attitudes about obesity and its treatment. *Obesity*, *11*(10), 1168-1177.

Friedman, K. E., Reichmann, S. K., Costanzo, P. R., Zelli, A., Ashmore, J. A., & Mustante, G. J. (2005). Weight stigmatization and ideological beliefs: relation to psychological functioning in obese adults. *Obesity Research*, *13*(5), 907-916.

Gilligan, C. (1992). *In a different voice: psychological theory and women's development*. Cambridge, MA: Harvard University Press.

Glenn, C. V., & Chow, P. (2002). Measurement of attitudes toward obese people among a canadian sample of men and women. *Psychological Reports*, *91*(2), 627-640.

Guyll, M., Matthews, K. A., & Bromberger, J. T. (2001). Discrimination and unfair treatment: relationship to cardiovascular reactivity among african american and european american women. *Health Psychology*, *20*(5), 315-325.

Harris, M. B., Harris, R. J., & Bochner, S. (1982). Fat, four-eyed, and female: Stereotypes of obesity, glasses, and gender. *Journal of Applied Social Psychology*, *12*(6), 503-516.

Harris, M. B., Walters, L. C., & Waschull, S. (1991). Gender and ethnic differences in obesity-related behaviors and attitudes in a college sample. *Journal of Applied Social Psychology*, *21*(19), 1545-1566. doi:10.1111/j.1559-1816.1991.tb00487.x

Hassel, T. D., Amici, C. J., Thurston, N. S., & Gorsuch, R. L. (2001). Client weight as a barrier to non-biased clinical judgment. *Journal of Psychology and Christianity*, *20*(2), 145-161.

Hassel, T.D., Lynn, T. (2002). Effects of obesity on the clinical judgments by Christian and non-Christian mental health professionals. *Dissertation Abstracts International, 63(3-B)*, 1559. Retrieved October 30, 2010, from PsycINFO database.

Hebl, M R., & Mannix, L.M. (2003). The weight of obesity in evaluating others: a mere proximity effect. *Personality and Social Psychology Bulletin,* 29(1), 28-38.

Hebl, M. R., Ruggs, E. N., Singletary, S. L., & Beal, D. J. (2008). Perceptions of obesity across the lifespan. *Obesity*, *16*(2), s46-s52.

Hebl, M. R., & Turchin, J. M. (2005). The stigma of obesity: what about men? *Basic and Applied Social Psychology*, *27*(3), 267-275.

Hebl, M. R., & Xu, J. (2001). Weighing the care: physicians' reactions to the size of a patient. *International Journal of Obesity*, *25*, 1246-1252.

Heider, F. (1958). *The psychology of interpersonal relations* (99th ed.). New York: Wiley.

Heo, M., Pietrobelli, A., Fontaine, K. R., Sirey, J. A., & Faith, M. S. (2006). Depressive mood and obesity in US adults: Comparison and moderation by sex, age, and race [Electronic version]. *International Journal of Obesity*, *30*(3), 513-519. doi:10.1038/sj.ijo.0803122

Herva, A., Laitinen, J., Miettunen, J., Veijola, J., Karvonen, J. T., Laksy, K., & Joukamaa, M. (2006). Obesity and depression: Results from the longitudinal Northern Finland 1966 Birth Cohort Study. *International Journal of Obesity*, *30*(3), 520-527.

Irving, L.M. (2000) Promoting size acceptance in elementary school children: the EDAP puppet program. *Eating Disorders: The Journal of Treatment and Prevention,* 8(3), 221–232.

Karnehed, N., Rasmussen, F., Hemmingsson, T., & Tynelius, P. (2006). Obesity and attained education: cohort study of more than 700,000 swedish men. *Obesity*, *14*(8), 1421-1428.

Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *The Counseling Psychologist*, *12*(3), 49-50. doi:10.1177/0011000084123005

Klaczynski, P. A. (2008). There's something about obesity: Culture, contagion, rationality, and children's responses to drinks "created" by obese children. *Journal of Experimental Child Psychology.*, *99*(1), 58-74.

Latner JD, Stunkard AJ. (2003). Getting worse: The stigmatization of obese children. *Obesity Research*, *11*(3), 452-456.

Leone, P.A. (2003). The effects of job status on perceptions of attractiveness: Do our jobs make us look better? *Dissertation Abstracts International, 63(12-B)*, 6128. Retrieved October 30, 2010, from PsycINFO database.

Lerner, M J. (1980). *The belief in a just world: a fundamental delusion*. Plenum Press, New York.

Libra, K. L. (1998). *Fat bias among psychologists: impact of client weight on clinical judgments and treatment planning* (Doctoral dissertation). University of Montana, Missoula, Montana.

Loewy, M. I. (1995). *Size bias by mental health professionals: Use of the illusory correlation paradigm*. (Doctoral dissertation, US: ProQuest Information & Learning. 1995). *56* (3-B). Retrieved September 10, 2010

Loh, E. S. (1993). The economic effects of physical appearance. *Social Science Quarterly*, *74*(2), 420-438.

Marlowe, C. M., Schneider, S. L., & Nelson, C. E. (1996). Gender and attractiveness biases in hiring decisions: are more experienced managers less biased? *Journal of Applied Psychology*, *81*(1), 11-21.

Michener, H. D., & DeLamater, J. D. (1999). *Social psychology* (4th ed., pp. 101). Orlando, FL: Harcourt Brace College Publishers.

Miller, C.T., Rothblum, E.D, Brand, P.A., & Felicio, D.M. (1995). Do obese women have poorer social relationships than nonobese women? reports by self, friends, and coworkers. *Journal of Personality*, *63*(1), 65-85.

Myers, A., & Rosen, J. C. (1999). Obesity stigmatization and coping: Relation to mental health symptoms, body image, and self-esteem. *International Journal of Obesity*, *23*(3), 221–230.

National Institute of Health. (2010). *About nih obesity research*. Retrieved September 23, 2010, from http://obesityresearch.nih.gov/About/about.htm

Neumark-Sztainer, D., Story, M., & Harris, T. (1999). Beliefs and attitudes about obesity among teachers and school health care providers working with adolescents. *Journal of Nutrition Education*, *31*(1), 3-9.

Ogden, J., & Clementi, C. (2010). The Experience of being obese and the many consequences of stigma. *Journal of Obesity*, *2010*, 1-9.

Park, J.H., Schaller, M., Crandall, C.S. (2007) Pathogen-avoidance mechanisms and the stigmatization of obese people. *Evolution and Human Behavior*, 28(6), 410–414.

Paul, R.J., & Townsend, J.B. (1995) Shape up for ship out? Employment discrimination against the overweight. *Employee Responsibilities and Rights Journal, 8(*2), 133-145.

Pedersen, P. B. (1991). Multiculturalism as a generic approach to counseling. *Journal of Counseling and Development*, *70*(1), 6-12.

Pingitore, R., Dugoni, B. L., Tindale, R. S., & Spring, B. (1994). Bias against overweight job applicants in a simulated employment interview. *Journal of Applied Psychology*, *79*(6), 909-917.

Polinko, N. K. & Popovich, P. M. (2001). Evil thoughts but angelic actions: Responses to overweight job applicants. *Journal of Applied Social Psychology, 31,* 905-924.

Puhl, R.M., & Brownell, K.D. (2001). Bias, discrimination, and obesity. *Obesity*, *9*(12), Retrieved from http://dx.doi.org/10.1038/oby.2001.108

Puhl, R. M., & Brownell, K. D. (2003). Psychosocial origins of obesity stigma: toward changing a powerful and pervasive bias. *Obesity Reviews*, *4*, 213-227.

Puhl, R. M., & Brownell, K. D. (2006). Confronting and coping with weight stigma: an investigation of overweight and obese adults. *Obesity*, *14*(10), 1802-1815.

Puhl, R.M., Moss-Racusin, C.A., Schwartz, M.B, & Brownell, K.D. (2008). Weight stigmatization and bias reduction: perspectives of overweight and obese adults. *Health Education Research*, *23*(2), 347–358.

Puhl, R. M., Schwartz, M. B., & Brownell, K. D. (2005). Impact of perceived consensus on stereotypes about obese people: a new approach for reducing bias. *Health Psychology*, *24*(5), 517-525.

Richardson, S. A., Goodman, N., Hastorf, A. H., Dornbusch, S. M. (1961). Cultural uniformity in reaction to physical disabilities. *American Sociological Review*, *26*(2), 241–247.

Riggs, M. L., Warka, J., Babasa, B., Betancourt, R., & Hooker, S. (1994). Development and validation of self-efficacy and outcome expectancy scales for job-related applications. *Educational and Psychological Measurement*, *54*, 793-802. doi:10.1177/0013164494054003026

Roehling, M V. (1999). Weight-based discrimination in employment: Psychological and legal aspects. *Personnel Psychology,* 52(4), 969-1016.

Roehling, M. V., Roehling, P. V., & Pichler, S. (2007). The relationship between body weight and perceived weight-related employment discrimination: The role of sex and race. *Journal of Vocational Behavior*, *71*(2), 300-318.

Rothblum, E D. (1992). The stigma of women's weight: social and economic realities. *Feminism & Psychology,* 2(1), 61-73.

Rudolph, C. W., Wells, C. L., Weller, M. D., & Baltes, B. B. (2009). A meta-analysis of empirical studies of weight-based bias in the workplace. *Journal of Vocational Behavior*, *74*(1), 1-10.

Sheets, V., & Ajmere, K. (2005). Are romantic partners a source of college students' weight concern? *Eating Behaviors*, *6*(1), 1-9.

Simon, G. E., Von Korff, M., Saunders, K., Miglioretti, D. L., Crane, P. K., Van Belle, G., & Kessler, R. C. (2006). Association between obesity and psychiatric disorders in the US adult population. *Archives of General Psychiatry*, *63*(7), 824-830.

Stangor, C., & Schaller, M. (2000). Stereotypes as individual and collective representations. In C. Stangor (Ed.), *Stereotypes and prejudice: Essential readings (Key readings in social psychology)* (pp. 64–82). Philadelphia, PA: Psychology Press and Taylor & Francis.

Stangor, C., Sechrist, G. B., & Jost, J. T. (2001a). Changing beliefs by providing consensus information. *Personality and Social Psychology Bulletin, 27,* 486–496.

Stangor, C., Sechrist, G. B., & Jost, J. T. (2001b). Social influence and intergroup beliefs: The role of perceived social consensus. In J. P. Forgas & K. D. Williams (Eds.), *Social influence: Direct and indirect processes* (p. 235–252). Psychology Press, Philadelphia.

Stunkard, A. J., Faith, M. S., & Allison, K. C. (2003). Depression and obesity. *Biological Psychiatry*, *54*(3), 330-337.

Stunkard, A. J., & Storensen, T. I. (1993). Obesity and socioeconomic status- a complex relation. *New England Journal of Medicine*, *329*(14), 1036-1037.

Stunkard, A., Sorensen, T.I., & Schlusinger, F. (1983). Use of Danish adoption register for the study of obesity and thinness. In: Kety, S., Rowland L.P., Sidman, R.L., & Matthysse, S.W. *The genetics of neurological and psychiatric disorders*. Raven Press, New York, NY pp. 115–120.

Swami, V., Chan, F., Wong, V., Furnham, A. & Tovee, M. J. (2008). Weight-based discrimination in occupational hiring and helping behavior. *Journal of Applied Social Psychology,* 38, 968-981 10.1111/j.1559-1816 .2008.00334.x.

Teachman, B. A., & Brownell, K. D. (2001). Implicit anti-fat bias among health professionals: Is anyone immune? *International Journal of Obesity*, *20*(10), 1525-1531.

Tiggerman, M., & Rothblum, E. D. (1988). Gender differences in social consequences of perceived overweight in the united states and australia. *Sex Roles*, *18*(1-2), 75-87.

Walker, L., & Hill, A. J. (2009). Obesity: the roll of child mental health services. *Child and Adolescent Mental Health*, *14*(3), 114-120.

White, M. A., O'Neil, P. M., Kolotkin, R. L., & Byrne, T. K. (2004). Gender, race, and obesity-related quality of life at extremem levels of obesity. *Obesity Research*, *12*, 949-955.

Wills, T. A. (1978). Perceptions of clients by professional helpers. *Psychologicak Bulletin*, *85*(5), 968-1000.

Yancey, A. K., Simon, P. A., McCarthy, W. J., Lightstone, A. S., & Fielding, J. E. (2006). Ethnic and sex variations in overweight self-perception: relationship to sedentariness. *Obesity Research*, *14*, 980-988.

Young, L. M., & Powell, B. (1985). The effects of obesity on the clinical judgments of mental health professionals. *Journal of Health and Social Behavior*, *26*(3), 233-246

Yuker, H.E., Allison, D.B., Faith, M.S. (1995) Methods for measuring attitudes and beliefs about obese people. In: Allison DB (ed). Handbook of assessment methods for eating behaviors and weight-related problems: Measures, theory, and research. Sage Publishing, Thousand Oaks, CA, pp. 81-1

APPENDIX A

INFORMED CONSENT

COVER LETTER

January 18, 2011

Dear Potential Participant,

I am a graduate student in the Master of Counseling Program at Arizona State University. I am working under Dr. Robinson Kurpius and would like to invite you to participate in a study that investigates counselors' perceptions of clients and their concerns. This study is intended to provide additional information regarding how counselors-in-training perceive various clients.

The current study involves reading a client case scenario and filling out two short surveys regarding the presented client, totaling 24 items. Completion of this study should take approximately 5 minutes. You must be 18 years of age or older to participate in this study.

Your participation in this research study is voluntary. There are no direct benefits or foreseeable risks involved in completion of this study. There will be no penalty or loss of benefits if you choose not to participate. You may discontinue your participation in the study at any time and you may skip any items that you do not wish to answer.

You will also be asked to fill out a brief demographic questionnaire. No identifying information will be solicited and your responses will be kept anonymous. Your responses will be stored in a secure filing cabinet to which only Dr. Kurpius and I, Brittani Pascal, will have access. Although the results of this study may be used in publications, presentations, or reports, no identifying information will be used.

Should you have any questions or concerns regarding this research study, please feel free to contact the research team at (480) 965-6104 or sharon.kurpius@asu.edu. If you have any questions regarding your rights as a research participant, or feel you have been exposed to risks, you may contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance at (480) 965-6788.

Your consent to participate will be assumed upon returning this packet to Dr. Sharon Kurpius or Brittani Pascal.

Sincerely,

Sharon E. Robinson Kurpius, Ph.D.
Professor
Counseling & Counseling Psychology
446K Payne Hall
Arizona State University

Brittani Pascal
Masters in Counseling
Arizona State University

APPENDIX B

PERSONAL CHARACTERISTICS SCALE

Directions: Fill out the client demographics and scale below based on provided vignette. You may review vignette if desired. Listed below are 14 pairs of adjectives. For each adjective pair, place an X on the line closest to the adjective that you feel bes expresses your feelings and beliefs about the described client.

Client Demographics:

a. Today's Date _____ b. Height _____ c. Weight _____ d. Age _____ e. Sex _____

f. Education Level _____ g. Occupation _____ h. Race/ ethnicity _____

1.	lazy	_____	_____	_____	_____	_____	industrious
2.	no will power	_____	_____	_____	_____	_____	has will power
3.	attractive	_____	_____	_____	_____	_____	unattractive
4.	good self-control	_____	_____	_____	_____	_____	poor self-control
5.	fast	_____	_____	_____	_____	_____	slow
6.	having endurance	_____	_____	_____	_____	_____	having no endurance
7.	active	_____	_____	_____	_____	_____	inactive
8.	weak	_____	_____	_____	_____	_____	strong
9.	self-indulgent	_____	_____	_____	_____	_____	self-sacrificing
10.	dislikes food	_____	_____	_____	_____	_____	likes food
11.	shapeless	_____	_____	_____	_____	_____	shapely
12.	undereats	_____	_____	_____	_____	_____	overeats
13.	insecure	_____	_____	_____	_____	_____	secure
14.	low self-esteem	_____	_____	_____	_____	_____	high self-esteem

APPENDIX C

WORK EFFICACY SCALE

Directions: Fill out the client demographics and scale below based on provided vignette. You may review vignette if desired. Then please mark each statement below with the number most representative of how much you agree or disagree with it.

Client Demographics:

a. Today's Date _____ b. Height _____ c. Weight _____ d. Age _____ e. Sex _____

f. Education Level _____ g. Occupation _____ h. Race/ ethnicity _____

1	2	3	4	5	6
Strongly Disagree					**Strongly Agree**

1. _____ Jennifer has confidence in her ability to do her job.
2. _____ There are some tasks required by Jennifer's job that she cannot do well.
3. _____ When Jennifer's performance is poor, it is due to her lack of ability.
4. _____ I doubt Jennifer's ability to do her job.
5. _____ Jennifer has all the skills needed to perform her job very well.
6. _____ Most people in Jennifer's line of work can do her job better than she can.
7. _____ Jennifer is an expert at her job.
8. _____ Jennifer's future in her job is limited because of her lack of skills.
9. _____ Jennifer is very proud of her job skills and abilities.
10. _____ Jennifer feels threatened when others watch her work.

APPENDIX D

CLIENT VIGNETTES

Vignette One

Weight Variable: Obese
Job Status Variable: Office Bookkeeper

Jennifer is a 37 year-old Caucasian woman seeking individual counseling. She stated on her intake paperwork that she is a widowed mother of two children, a boy who is nine and a girl who is 12. She reports no history of any mental diagnosis and is seeking counseling for the first time. She describes herself as short (5'4"), very overweight (235 lbs), and as being in relatively good health other than constantly struggling with her weight. Jennifer has an associate's degree.

She works full-time at a four-star hotel as an office bookkeeper and finds it difficult to balance work and family demands. She feels as though her job consumes a lot of her time and has been frustrated with her supervisor's demands that she work overtime, which means having less time to spend with her children. She reports that her social support network consists primarily of her sister and her best friend who both live nearby. She also has work friends whom she meets for coffee or an occasional movie night.

Jennifer describes her presenting issue as being dissatisfied with life and frustrated with work and with her kids. Her husband passed away two years ago and she is still grieving his loss. She has had difficulty adjusting to being a single mother and thinks that her 12-year-old daughter is acting out in school as a result of losing her father.

Vignette Two

Weight Variable: Obese
Job Status Variable: Hotel Executive Manager

Jennifer is a 37 year-old Caucasian woman seeking individual counseling. She stated on her intake paperwork that she is a widowed mother of two children, a boy who is nine and a girl who is 12. She reports no history of any mental diagnosis and is seeking counseling for the first time. She describes herself as short (5'4"), very overweight (235 lbs), and as being in relatively good health other than constantly struggling with her weight. Jennifer has an associate's degree.

She works full-time at a four-star hotel as the executive manager and finds it difficult to balance work and family demands. She feels as though her job consumes a lot of her time and has been frustrated with her supervisees' expectations to always be there to answer their questions, which means having less time to spend with her children. She reports that her social support network

consists primarily of her sister and her best friend who both live nearby. She also has work friends whom she meets for coffee or an occasional movie night.

Jennifer describes her presenting issue as being dissatisfied with life and frustrated with work and with her kids. Her husband passed away two years ago and she is still grieving his loss. She has had difficulty adjusting to being a single mother and thinks that her 12-year-old daughter is acting out in school as a result of losing her father.

Vignette Three

Weight Variable: Average
Job Status Variable: Office Bookkeeper

Jennifer is a 37 year-old Caucasian woman seeking individual counseling. She stated on her intake paperwork that she is a widowed mother of two children, a boy who is nine and a girl who is 12. She reports no history of any mental diagnosis and is seeking counseling for the first time. She describes herself as short (5'4"), average weight (135 lbs), and as being in relatively good health. Jennifer has an associate's degree.

She works full-time at a four-star hotel as an office bookkeeper and finds it difficult to balance work and family demands. She feels as though her job consumes a lot of her time and has been frustrated with her supervisor's demands that she work overtime, which means having less time to spend with her children. She reports that her social support network consists primarily of her sister and her best friend who both live nearby. She also has work friends whom she meets for coffee or an occasional movie night.

Jennifer describes her presenting issue as being dissatisfied with life and frustrated with work and with her kids. Her husband passed away two years ago and she is still grieving his loss. She has had difficulty adjusting to being a single mother and thinks that her 12-year-old daughter is acting out in school as a result of losing her father.

Vignette Four

Weight Variable: Average
Job Status Variable: Hotel Executive Manager

Jennifer is a 37 year-old Caucasian woman seeking individual counseling. She stated on her intake paperwork that she is a widowed mother of two children, a boy who is nine and a girl who is 12. She reports no history of any mental diagnosis and is seeking counseling for the first time. She describes herself as

short (5’4”), average weight (135 lbs), and as being in relatively good health. Jennifer has an associate’s degree.

She works full-time at a four-star hotel as the executive manager and finds it difficult to balance work and family demands. She feels as though her job consumes a lot of her time and has been frustrated with her supervisees’ expectations to always be there to answer their questions, which means having less time to spend with her children. She reports that her social support network consists primarily of her sister and her best friend who both live nearby. She also has work friends whom she meets for coffee or an occasional movie night.

Jennifer describes her presenting issue as being dissatisfied with life and frustrated with work and with her kids. Her husband passed away two years ago and she is still grieving his loss. She has had difficulty adjusting to being a single mother and thinks that her 12 year-old daughter is acting out in school as a result of losing her father.

APPENDIX E

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

Circle One:

1. Sex: Male Female Other: _____

2. Age: Under 24 25 – 30 31 – 35 36 – 40
41 – 45 46 - 50 51+

3. Ethnicity: Caucasian African American Asian American/ Pacific Islander
Latino/a American Native American Multiethnic
International Student Other: _____

4. Currently working toward which of the following degree:
Master's Ph.D. Other:_____

5. Area of Study: Mental Health Counseling School Counseling
Counseling Psychology Rehabilitation Counseling
Social Work Other: _____

6. Number of Multicultural Counseling courses taken: 0 1 2 3

7. Number of semesters you have directly counseled clients (practicum, internship, etc.):
0+ 1+ 2+ 3+ 4+ 5+ 6+ 7+

APPENDIX F

INSTITUTIONAL REVIEW BOARD LETTER OF APPROVAL

ASU Knowledge Enterprise Development

Office of Research Integrity and Assurance

To:	Sharon Kurpius EDB
From:	Mark Roosa, Chair Soc Beh IRB
Date:	12/20/2010
Committee Action:	**Exemption Granted**
IRB Action Date:	12/20/2010
IRB Protocol #:	1012005814
Study Title:	Perceptions of Couselors-in-Training toward Obese and Non-obese Clients in High and Low Status Occupations

The above-referenced protocol is considered exempt after review by the Institutional Review Board pursuant to Federal regulations, 45 CFR Part 46.101(b)(2) .

This part of the federal regulations requires that the information be recorded by investigators in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. It is necessary that the information obtained not be such that if disclosed outside the research, it could reasonably place the subjects at risk of criminal or civil liability, or be damaging to the subjects' financial standing, employability, or reputation.

You should retain a copy of this letter for your records.

APPENDIX G

PERMISSION TO USE FAT PHOBIA SCALE: SHORT FORM

Gmail by Google

Brittani Pascal <brittp33@gmail.com>

Re: Request Use of Fat phobia scale: short form

2 messages

Bean Robinson <brobinson@umphysicians.umn.edu> **Mon, Jan 24, 2011 at 5:43 PM**
To: Brittani Pascal <bpascal@asu.edu>
Cc: Karen Scheltema <kscheltema@comcast.net>, Jane at work Bacon <JaneGBacon@msn.com>, Robert Kirby <rkirby@umphysicians.umn.edu>

Dear Ms. Brittani Pascal,

Thank you so much for your interest in our work. I am happy to give you permission to use the Fat Phobia Scale: Short Form in your thesis study. It makes sense to alter the wording in the instructions in order for the participants to rate the presented client rather than obese or fat people in general.

I would be happy to send you copies of the short 14-item version of the Fat Phobia Scale (as well as any other items you request). Please contact Robert Kirby (rkirby@umphysician.umn.edu) and let him know what materials you would like.

If you do use our instrument, we would appreciate you letting us know how you used the scale, a description of the sample you used them with, how we can contact you in the future, and (most importantly) the results/findings from your work (including any articles or papers or reports you write using our instruments or materials). A copy of the changed instructions would also be appreciated.

Good luck in your work and keep us posted.

Sincerely,

Beatrice "Bean" E. Robinson, Ph.D.
Associate Director & Associate Professor
Licensed Psychologist, Marriage & Family Therapist
Program in Human Sexuality

Dept of Family Medicine & Community Health
University of Minnesota Medical School
1300 South 2nd Street, Suite 180
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Executive Director
World Professional Association for Transgender Health (WPATH)1300 South 2nd Street, Suite 180
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email: wpath@wpath.org
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(612) 624-9541 (fax)

Behavioral Science Faculty
Broadway Family Medicine Clinic
1020 North Broadway Avenue
Minneapolis, MN 55411
612-302-8200, Ext 295
612-302-8275 (fax)

>>> Brittani Pascal <bpascal@asu.edu> 1/24/2011 10:02 AM >>>
Dr. Robinson,

I am a graduate student at Arizona State University in the Masters of Counseling Program and am interested in using the Fat Phobia Scale: Short Form in a study I am conducting for my thesis. I am exploring the attitudes of counselors-in-training towards obese clients and believe that this scale would be ideal to include as an assessment tool. I may need to alter the wording in the instructions in order for the participants to rate the presented client rather than obese or fat people in general. I would like to request permission to use this scale in my research. If you need any additional information from me please feel free to ask. If I have contacted the wrong person for this request please let me know, and I apologize for the confusion.

Thank you for your time,

Brittani Pascal

Brittani Pascal <brittp33@gmail.com> **Mon, Jan 24, 2011 at 8:01 PM**
To: Bean Robinson <brobinson@umphysicians.umn.edu>

Dr. Robinson,

Thank you so much for your quick response, I will be sure to forward you all the requested information and findings once data is collected.

Thanks again,

Brittani Pascal
[Quoted text hidden]

Table 1

Means and Standard Deviations of Personal Characteristics and Work Efficacy Ratings

		Personal Characteristics Scale		Work Efficicay Scale	
Client Description		*M*	*SD*	*M*	*SD*
Obese					
	Executive	2.80	0.52	45.24	5.07
	Bookkeeper	3.12	0.42	44.23	4.47
	Total	2.97	0.49	44.74	4.73
Normal Weight					
	Executive	2.49	0.55	45.61	6.43
	Bookkeeper	2.65	0.45	44.72	3.97
	Total	2.57	0.50	45.17	5.28

BIOGRAPHICAL SKETCH

Brittani Pascal was born and raised in the Rockville, MD area since July of 1985. She earned her Bachelor of Arts degree in Psychology from Salisbury University in May 2007. She entered the Masters of Counseling program at Arizona State University in August of 2009 and earned her degree in August of 2011.