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Teaching Clinical Psychology Trainees about Weight Bias

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ABSTRACT

As an assistant professor who teaches clinical psychology trainees about social aspects of behavior, I devote one week to the topic of weight bias. In this class, I rely on the research literature to challenge common myths about "obesity," demonstrate the pervasiveness and harm of weight bias, and offer recommendations to trainees to apply to their own professional and personal lives. I encourage trainees to shift focus from weight and weight loss to health and well-being and to engage in self-reflection on the role of weight bias in their interactions with others. Here, I describe my weight bias seminar and outline common questions and my responses to them (e.g., Do you actually believe that "obese" people can be healthy?). Weight bias is a neglected topic in most clinical psychology training programs. Weight bias must be addressed in clinical psychology programs to produce culturally competent graduates who are aware of diversity issues.

KEYWORDS

Clinical psychology training; fat pedagogy; prejudice reduction; sizeism; weight bias

Psychologists need to learn about weight bias. Many mental health professionals report negative attitudes toward and stereotypes about higher bodyweight clients that are reflective of sociocultural biases (Brochu, Pearl, & Simontacchi, 2018). Weight bias is impactful; it is associated with a range of physical and psychological health consequences. One potential point of intervention for reducing weight bias is in clinical psychology training programs. As a social psychologist, I teach a course in social aspects of behavior in a graduate-level clinical psychology training program. The course covers such topics as social cognition, attitude change, prejudice and discrimination, attraction and rejection, and group processes. Trainees meet with me once each week for three hours over a semester. The course is seminar-style, in which I lecture for the first half of the class and show TED talks, lead trainees through activities (e.g., the Implicit Association Test [IAT]), and encourage discussion. For the second half of the class, one or two trainees lead discussion on two recent, social psychology research

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articles meant to deepen trainees' understanding of the research process and the clinical relevance of social psychological concepts.

As a course instructor, social psychologist, weight-bias researcher, and fat woman, I devote one week near the end of the semester to my own area of research. I examine weight bias from several perspectives, including processes underlying the expression of weight bias (Brochu, Gawronski, & Esses, 2011), consequences of weight bias on those who are targeted (Brochu & Dovidio, 2014), the effectiveness of interventions designed to reduce weight bias (Brochu, Pearl, Puhl, & Brownell, 2014), and, more recently, the influence of weight bias within the clinical context (Brochu, 2017). I appreciate this unique opportunity to integrate my teaching and research interests.

Weight Bias Class Session

In the first half of the weight-bias class, I divide my lecture into three sections. First, I discuss the definitions, causes, and consequences of "obesity"; my objective is to challenge myths about weight and health. Then, I discuss the definitions, impact, and consequences of weight bias; here, my objective is to demonstrate its pervasiveness and harm. Finally, I discuss the personal and professional implications of this critical, stigma-based perspective and encourage trainees to shift their focus from weight and weight loss to health and well-being. Trainees are encouraged to ask questions. Throughout the class, I utilize non-stigmatizing, counter-stereotypical, and positive portrayals of higher body-weight people on my lecture slides. Before the class, trainees read three articles on weight bias: Puhl and Heuer's (2009) review of weight stigma research and two of my articles on stereotype threat (Brochu & Dovidio, 2014) and media portrayals (Brochu et al., 2014). Trainees lead discussion on these articles during the second half of the class.

I start the class by providing trainees with a disclaimer; they are told that the information they are about to hear may be mind-bending and could shatter their worldviews. I acknowledge that everyone in the room has their own experiences with weight and that these experiences provide people with different filters through which they make sense of information. I urge trainees to remain open and curious, to sit in the discomfort they may feel, and to make an effort to engage reflective awareness and understanding. I also provide trainees with a primer on weight terminology, notify them that many people find medical weight terms stigmatizing, mention that person-first terminology (e.g., person with "obesity") is controversial, and explain that some people prefer to use the word *fat* as a process of reappropriation (Meadows & Daníelsdóttir, 2016). I explain the rationale for my

preference for the term *higher-body-weight* (Logel, Stinson, & Brochu, 2015).

In the first section of the lecture, I provide trainees with a critical perspective that challenges the dominant view that "obesity" is common, controllable, and a serious "problem." I introduce them to work that questions the so-called "obesity epidemic" (Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006). I challenge the notion that a lack of energy balance is the sole cause of weight status and introduce trainees to a range of genetic, biological, environmental, and psychological factors that are implicated in weight processes, including weight bias. I introduce trainees to research that indicates that "obesity" is a weak predictor of mortality and that "overweight" is a good predictor of longevity (Flegal, Kit, Orpana, & Graubard, 2013). Trainees learn about a number of variables that moderate the association between weight and health (e.g., physical fitness, healthy lifestyle habits, weight discrimination). Trainees also learn that dieting is typically not effective for long-term weight loss, that there is little evidence that weight loss actually improves health, and that, instead, weight loss efforts can be harmful to physical and mental health (Bacon & Aphromor, 2011; Mann et al., 2007; Tomiyama, Ahlstrom, & Mann, 2013). Given that weight bias is associated with belief in the personal controllability of weight, it is beneficial to debunk common misconceptions about weight and health in order to reduce weight bias (Crandall, 1994; Rothblum, 2016).

In the second section of the lecture, I review research that documents weight discrimination in health care, employment, education, interpersonal relationships, and the media (Puhl & Heuer, 2009). To bring these experiences to life, I share quotes from higher-body weight participants in qualitative studies (e.g., Puhl, Moss-Racusin, Schwartz, & Brownell, 2008) and stories from the news (e.g., Ingeno, 2013). Trainees learn that psychotherapists express negative attitudes toward and frustrations with higher-body-weight people, similar to what is observed among society more generally (Davis-Coelho, Waltz, & Davis-Coelho, 2000; Puhl, Latner, King, & Luedicke, 2014). I review consequences of weight bias (e.g., negative physical health outcomes, increased mortality risk, negative psychological health outcomes, weight gain, unhealthy behavior changes, social disconnection) that can lead to weight-based health disparities and social inequalities (Chrisler & Barney, 2017; Hunger, Major, Blodorn, & Miller, 2015; Puhl & Heuer, 2010).

To wrap up the lecture, I ask trainees to apply this information to their personal and professional lives. Here, I encourage them to shift their focus from weight and weight loss to health and well-being. I introduce trainees to the Health at Every Size® (HAES®) paradigm and urge them to consider endorsing weight-inclusive models of health. This includes: (a) promoting

healthful and weight-inclusive approaches to eating, physical activity, and behavior change more generally; (b) working to reduce weight stigma and discrimination; and (c) fostering strategies for coping with weight stigma (Logel et al., 2015). Because the lecture is an introduction to weight bias, I provide trainees with additional resources, including articles about "obesity" myths (e.g., Campos et al., 2006; Chaput, Ferraro, Prud'homme, & Sharma, 2014), the HAES® and intuitive eating books and website links (e.g., Bacon & Aphromor, 2016; lindabacon.org), websites that provide positive portrayals of higher-body-weight people, and the link to the IAT (implicit.harvard.edu).

Reactions and Questions

I have encountered numerous reactions from trainees that range from direct expressions of weight bias to confusion in distinguishing between weight and health to relieved (sometimes exuberant) expressions of gratitude and validation. Most of the trainees have never previously heard about, read about, discussed, or even considered the issue of weight bias and its clinical relevance. In my experience, psychology trainees tend to be a receptive audience for this information for several reasons. First, because of their training and desired occupation, they are concerned about psychological health and well-being, and they are concerned about how their biases may influence empathy, rapport, and their interactions with clients. Trainees tend to be open and willing to engage in reflection to gain self-awareness of their biases. Trainees are also driven by the desire to understand different perspectives, such as cultural viewpoints and life experiences. In addition, they are motivated to have accurate information about health-related issues because some of their work with clients is psychoeducation, and they know they need to have the tools to challenge faulty beliefs.

Nevertheless, trainees are embedded in the same sociocultural milieu in which weight is conflated with health and thin bodies are privileged over heavier bodies. Trainees are asked to reflect on the information covered during the lecture and evaluate how it fits with their personal experiences, interactions with clients, clinical training, and social understanding. As such, there are some predictable questions that trainees tend to ask during the weight bias class session. These questions are outlined below, as are my responses.

Do You Actually Believe That "Obese" People Can Be Healthy?

Trainees are surprised to learn about the *"obesity" paradox* (i.e., that "overweight" people have a longevity advantage), as their beliefs are

challenged by the scientific evidence. Part of tackling this question includes bringing students back to the research. I remind trainees that the association between weight and health is correlational and that there are plenty of other variables that can account for the association (e.g., health behaviors, genetics, stress, stigma). I present data to show the rather staggering misclassification of health based on weight (Tomiyama, Hunger, Nguyen-Cuu, & Wells, 2016). Another part of tackling this question involves asking trainees to consider how the question itself may be embedded within weight bias. For example, I ask trainees to reflect on stereotypes of higher-body-weight people that are reinforced through the media and consider how this may have informed their expectations.

Some trainees will inevitably share personal experiences that run counter to the information I cover in class (e.g., But I exercise 4 days a week and eat healthily; I used to be fat and I'm not anymore; I work really hard to look the way I do). Here, I point out that they are assuming that their behavior dictates their weight when this is not necessarily the case and remind them of the fundamental attribution error (i.e., emphasizing personal characteristics when explaining other people's circumstances). People with different genetics, circumstances, and experiences will not necessarily experience the same weight outcomes even if they engage in the same behaviors. My students are mental health professionals in training, and I urge them to broaden their understanding of health beyond something that is present or absent, but instead as something that exists on a continuum with multiple aspects (e.g., physical, psychological, social). I also warn against replacing weight with health as a barometer of value or worth. All clients are deserving of quality care and respect.

If Dieting Doesn't Produce Long-Term Weight Loss, Then What?

Trainees are also surprised to learn that dieting is largely ineffective for weight loss over time as the most common outcome of diets is weight gain. Occasionally, trainees will counter this information with some personal anecdote of weight loss that they have observed in their life. Again, I refer back to the scientific evidence and point out that this is the value of research; it can demonstrate how an intervention affects large groups of people. Although it may be easy to point to a personal example of successful weight loss, we fail to consider the landslide of failed weight loss attempts among everyone else we know. I also point out to trainees that, although they may observe successful weight loss due to dieting among clients in their practicum setting, this loss tends to be a short-term outcome. I ask trainees to imagine where clients may be one, two, or three years later

if their weight patterns follow what research typically shows and to reflect on the psychological consequences of multiple failed weight loss attempts.

For other trainees, learning that dieting is ineffective for weight loss over the long-term leads them to feel defeated; if clients are coming to them for help to lose weight, then what is the appropriate recommendation? One trainee openly asked, "Does this mean that I am going to be 'overweight' for the rest of my life?" I handle this sort of questioning in a few different ways. First, I ask trainees to reflect on what weight loss means to them and to their clients. Typically, an issue of health is raised, and I remind trainees that weight is a poor predictor of health. Rather than looking at weight and weight loss as the outcome of focus, I ask trainees to consider more health-based outcomes. I also ask trainees to consider other health behavior changes that will have a more positive, long-lasting impact on health outcomes, such as eating more fruits and vegetables, eating at regular intervals and/or following internal hunger and fullness cues, engaging in enjoyable physical movement of the body, getting regular health checkups, seeking social support, and getting quality sleep (Bacon & Aphromor, 2011; Tomiyama et al., 2013).

Inevitably, an issue related to appearance will also be raised. Here, I encourage trainees to reflect on the social construction of attractiveness and what attractiveness means to them. I ask trainees to think about what, aside from weight, serves as a cue for attractiveness. I encourage trainees to challenge the beauty ideal and to expose themselves to nontraditional forms of beauty through the media. We discuss body satisfaction and body positivity and what it means to explore these concepts at any size. When this issue is raised, I also ask trainees to think about qualities, not including attractiveness, that are important to them.

But Wouldn't Stigma Motivate Them To Lose Weight?

Rarely do trainees ask this question directly, but in one class, I skipped over this issue and later learned that after class, a couple of trainees were asking this question and using it as a basis to dismiss some of the information I covered in class. It is now a permanent aspect of my lecture. Some might think that stigma may motivate higher-body-weight people to make health-behavior changes and lose weight. This notion is based on at least two faulty assumptions. First, the evidence is clear that weight bias rarely motivates healthy behavior change; instead, unhealthy behavior changes are much more common, including binge eating, exercise avoidance, and health-care underutilization (Chrisler & Barney, 2017; Puhl & Heuer, 2009, 2010). Second, the evidence is also clear that weight is not under as much personal control as one might think. Although making behavior changes

may improve health, it will not necessarily lead to weight loss (Tomiyama et al., 2013). I emphasize to trainees that, even if weight bias led to health improvements or weight loss under a small set of circumstances, a strategy of weight bias is ethically problematic. Stigma and shaming cause harm, and mental health professionals have the responsibility first to do no harm to their clients (Vartanian & Smyth, 2013).

Resistance

In my years of teaching this weight-bias class, I have been directly challenged by a student only once. In this case, the trainee questioned the veracity of my claims regarding weight and health and argued that I was relying upon outliers of healthy, higher-body-weight people that do not accurately describe the typical experience. Even though the exchange became somewhat heated, I stuck to the research findings and maintained the consistent message that weight and health are not the same. This interaction seemed to have strengthened the overall message for other students, but did little to influence the challenging student. Slightly more frequently, students' resistance is seen through nonverbal body language, such as shaking one's head, or by seemingly unwitting expressions of weight bias, such as stating a weight stereotype. Occasionally, students will share experiences from their practicum placements in which weight discrimination is embedded within procedure (e.g., in the hospital setting, a patient being ineligible for a surgery until weight is lost). In these instances, as appropriate, I will name these situations for what they are—weight bias.

An Unmet Need in Clinical Psychology Training

Weight bias must be covered in clinical psychology programs to produce culturally competent graduates who are aware of diversity issues. Psychotherapists exhibit many of the same weight biases that are seen at the societal level and among other health professions (Puhl & Heuer, 2009). Encouraging students to gain awareness into their own biases, including weight bias and providing opportunities to learn how to manage their biases, is of utmost importance. As work on weight bias interventions and fat pedagogy (Cameron & Russell, 2016) continue to expand, this information must be incorporated into programs that train health professionals.

My weight bias class session is but one attempt to bridge the divide between clinical psychology training and weight bias intervention. More is needed. Clinical psychology programs should include weight and body shape in courses on diversity and multiculturalism. Issues pertaining to weight bias and higher-body-weight clients should be incorporated into all

courses, including those on assessment, diagnosis, and intervention (e.g., higher-body-weight clients should be featured in vignettes, role plays, and standardized cases). Faculty and supervisors should similarly be trained so that they can effectively mentor trainees in dealing with issues related to weight bias and psychoeducation. Accreditation agencies, such as the American Psychological Association (APA), should broaden their scope and understanding of diversity by including weight and body shape as legitimate issues of diversity. If they do not provide trainees with this knowledge, clinical psychology programs run the risk of producing psychologists who lack accurate information on the causes and consequences of "obesity"; perpetuate weight-based blame, shame, and stigma within the clinical context; and, ultimately, cause harm to the mental health and well-being of their higher-body-weight clients.

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