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The Broken Lens: How Anti-Fat Bias in Psychotherapy is Harming Our Clients and What To Do About It

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ABSTRACT

Anti-fat bias is a persistent and widespread barrier to body liberation that psychotherapists are ethically bound to do something about. Though academics and clinicians have written about the implications of weight stigma in psychotherapy, the prevalence of anti-fat bias in our profession remains and often goes unexamined. Here we explore the nature of anti-fat bias and reasons to shift to a weight-inclusive stance. We offer examples of how anti-fat bias operates in the therapy room and the harm it causes. Anti-fat bias and body-based oppression as forms of microaggressions are explored, and we make the case for body liberation as a social justice issue. We conclude with recommendations for addressing anti-fat bias, including: developing a liberatory consciousness, the importance of moving from awareness to action, examining our relationship to diet culture, ways to avoid stigmatizing language, bringing a social justice lens into the room, and doing our own work so that we stop locating the problem in people's bodies and provide truly bias-free psychotherapy.

KEYWORDS

Anti-fat bias; body liberation; Health At Every Size[®]; psychotherapy; social justice

Psychotherapy should be a safe haven for all bodies, in all of their diversity. Yet, given that bodies are sites of injustice, our therapy rooms can be sites of injury instead. As Sonya Renee Taylor, founder of *The Body is Not an Apology*, said in an interview (Kenny, 2016), “For me, this work is social justice work. I’m using the site that is the most impacted by social injustice, which is the body” (para. 26). We are not truly seeing our clients if we do not seek to understand the suffering that accompanies body-based oppression. Aza (2009) explained that the social stigma and anti-fat bias fat women face impacts their interpersonal interactions with others, including the therapeutic relationship. We cannot claim an inclusive, feminist, or culturally competent lens if we do not address and oppose cultural ideals about bodies that run counter to emotional wellness. Thus, body liberation is a social justice issue.

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Please note that in all the places where we use the words *woman* and *women*, we are including anyone who identifies as a woman.

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The Counselors for Social Justice Code of Ethics (Ibrahim et al., 2011) provides a set of guiding principles that assist us in practicing our ethics in a justice-minded way. The principles are: social justice, social action, eradication of all forms of oppression and abuse, the dignity and worth of all people, embracing diversity, and integrity. We are called to be aware of, and then mitigate the impact of, our biases. This Code of Ethics reminds us that we are to go beyond simply understanding the oppression faced by our clients: we are also responsible for taking intentional action to dismantle the injustices that cause suffering.

We believe that body liberation is a vital concept for all therapy, not simply an abstract ideal attached to the area of eating disorders and body image concerns. There is no reasonable ethical argument against advocating for body liberation, which includes supporting weight-inclusive communities and approaches, encouraging fat acceptance, and addressing the deep familial, cultural, and systems-based perpetuation of anti-fat bias. Indeed, in consideration of the extreme harm caused by anti-fat bias, we must do this work in order to serve our clients. It is our job to be aware of the internalized weight-bias we carry into our therapy offices everyday. In order to serve our clients, we must center the real work of liberation and justice above our own personal aesthetic, comfort, and worldview about body size. In conversations about health behaviors and endless strategies for weight loss disguised as health improvement, the impetus to learn about and address anti-fat bias in psychotherapy is often lost. We are required to extricate anti-fat bias and dieting culture from psychotherapy.

The Broken Lens

One might assume that therapists and counselors would not share the same strongly prejudiced views held by the rest of society, or at least would have an awareness of them. However, it seems fair to assume that, at least to some extent, therapists and counselors in Western countries share their society's collective views, thus fat oppression seeps into their work (Moller, 2014). Indeed, academics and clinicians have reported on the prevalence and negative implications of weight stigma in psychotherapy since the 1980s (e.g., Agell & Rothblum 1991; Berman, 2017; Brown, 1989; Chrisler, 1989; Davis-Coelho, Waltz, & Davis-Coelho, 2000; Reader, 2014; Teachman & Brownell, 2001; Young & Powell, 1985), so it is distressing to note that not much has changed since then. New clients come to our offices whose previous psychotherapists had referred them to a mainstream diet program to solve the problem of their body. Psychotherapists are falling prey to the same stereotypes and discriminatory thinking about body size that are prevalent in mainstream culture. To be effective, clinicians must be able to

help people as they are without colluding with the cultural mandate of thinness.

Fabello (2014) defined dieting culture as "a society that is so inundated with dieting propaganda, often times imperceptibly, that it affects how we relate to ourselves and each other" (para. 1). Diet culture is predicated on the fear of fatness; it asserts that some bodies, particularly thin, White, and able bodies, matter more than others. It equates weight loss with health, although much of what we may do in the name of weight loss does not promote physical or emotional well-being. Diet culture plays a part in the clinical impulse to recommend a weight-loss plan instead sitting in the discomfort of body dissatisfaction with a client. Dieting culture blames the dieter, but never the plan, despite the lack of peer-reviewed evidence that dieting can actually result in sustainable weight change (Aphramor, 2005, 2008; Aphramor & Bacon, 2011; Howard et al., 2006; Mann et al., 2007; NIH, 1992).

Healthism, a term first coined by Robert Crawford (1980), deconstructs the idea that health is the "be all, end all" of our existence and asserts that the pursuit of health has been elevated to a "super value." Healthist ideals place responsibility for health and wellness on the individual while ignoring the impact of the many social determinants of health. Changes in health behaviors account for as little as 5–25% of differences in health outcomes (Aphramor, 2017), but mainstream health, weight-loss, and nutritional advice, whether delivered in the offices of physicians, psychotherapists, or health coaches, aggrandizes the possibility of and necessity for behavioral change. When clinicians emphasize behavior change without awareness or inclusion of the influence of health disparities, they may cause harm through supporting unsustainable efforts and/or contributing to marginalization. Clinicians must consider that, if our clients are hustling for health, they are likely to be hustling for a sense of worthiness in a culture that conflates the two.

Health at Every Size[®] (HAES[®])¹ is an approach grounded in a social justice framework that offers a counter-focus to mainstream health discussion in clinical work. The model evolved as a response to the weight-biased treatment of higher-weight people; it offers a compelling alternative to defining health by the body mass index. It includes practices that clients can engage in, if they choose, that reference their internal wisdom about what they need.

As Burgard (2010) explained, the HAES paradigm operates on both the individual and community levels. On the individual level, it includes things that improve well-being, such as joyful movement, restful sleep, nourishing

¹Health At Every Size and HAES are registered trademarks of the Association for Size Diversity and Health and used with permission.

food, social support, and freedom from stigma. On the community level, it includes changing the elements of our cultural environment that harm our well-being. Although the HAES approach has made a case for a paradigm shift in the helping professions from a weight-focused framework to a one based on size acceptance framework (e.g., Bacon, 2011; Burgard, 2010; Tylka et al., 2014), this perspective still lives in the margins of the therapeutic community, and people who live in larger bodies are still suffering. A wider lens is needed to untangle our collusion with healthism and body size as a problem focus.

Anti-Fat Bias

Anti-fat bias reflects negative attitudes and beliefs about people who are perceived as being fat (Dánielsdóttir, O'Brien, & Ciao, 2010). This bias operates as a fundamental script that people adopt at an early age, in part, because we are regular witnesses to the social currency and privilege bestowed with thinness. We contend that unquestioned assumptions about weight and fatness allow weight stigma to thrive. Calogero and colleagues (2016) described a recognizable cultural weight narrative that underscores and fuels anti-fat bias among scholars and laypeople, including the claims that “obesity is a disease,” “obesity costs us money,” “weight loss improves health,” “weight loss is within personal control,” “weight loss is an effective solution to obesity,” and “thinner equals happier.” Given the pervasiveness of this bias (Puhl et al., 2015), people across the weight spectrum feel the effects of weight stigma: the fat woman who blames her large body for all of the harassment she has received, the thin person who cannot get thin enough to feel safe from potential rejection, and people who witnessed weight bias and discrimination against their own parents and have resolved never to let that happen to themselves.

Anti-Fat Bias in the Therapeutic Context

Anti-fat bias in our profession works against us. Puhl and colleagues' (2013) study of eating disorder treatment professionals showed that anti-fat bias is common. Professionals with stronger anti-fat bias were more likely to attribute weight to behavioral causes, express frustration about treating fat patients, and perceive poorer treatment outcomes. Anti-fat bias gets further wrapped up and reframed as a health concern, which only serves to perpetuate this system of injustice. Oppressed people are expected to fix and better themselves in response. This expectation is emotionally violent and ignores the impact systemic injustice has on their well-being. For example, telling fat women that we are concerned about their physical health because of her size not only ignores the scientific data that have

refuted a causal negative association between fatness and health, but also dismisses and erases the effects of social determinants on both weight and health, as well as the impact of institutional fatphobia on their mental health, all of which end up doing more harm than good for fat women.

Anti-fat bias can impact many layers of therapist/client interactions. It is not only present in attitudes and stereotypes, it is even a factor in how we set up the physical spaces in which we work. If we cannot see the limitations of our own office furniture, how will we learn to see the limitations in our own belief systems? Often, the pursuit of weight loss is diagnosable in thin clients and supported in larger ones. It is our lens, our gaze, and the assumptions behind it that are the problem. Diagnosis by sight is inaccurate and essentially biased. We simply cannot know who engages in overeating and who engages in restrictive eating based on the size and shape of the body in front of us. As professionals, it is our ethical duty to unpack and address this prejudice and to shift our focus and commitment to the human being who inhabits the body.

Body-Based Oppression and Microaggressions in the Therapeutic Relationship

In the therapeutic context, anti-fat bias may be experienced in explicit ways, but also quite often in the form of microaggressions. Sue (2010) defined microaggressions as “everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership” (p. 3). Schafer (2014) wrote about the ways that weight bias in the therapy room could be understood through the lens of microaggressions. In her qualitative study, the most common microaggression experienced by clients was therapists attributing weight as the cause of their presenting issue and then recommending weight loss as the solution. Both Schafer (2014) and Granger (2012) discussed the ways that microaggressions hurt the therapeutic relationship, which is the most important healing factor in our work.

Examples of microaggressions experienced in the therapeutic context abound (see also Akoury et al., Meulman, and Harrop, this issue). Clients have shared with us their stories of being shamed into believing they would develop diabetes based on weight alone, told about a therapist’s own dieting success during a therapeutic session, and referred to a therapist’s favorite mainstream fad diet. Some clients have been told that they don’t *look* like they have an eating disorder, as if an eating disorder has a certain look; other clients who are trying to recover from an eating disorder have been told not to worry, “we won’t make you fat.” Therapists often make an

assumption that fatness is always indicative of trauma and that a resolution or healing of that trauma will result in weight loss. Our clients reported having been told that they could not possibly love themselves if they were fat or that self-love is dangerous. A client shared a story about having her therapist's chair break underneath her; the following week, she was offered a lawn chair as a replacement instead of a better chair. One trainee shared with us that her client's previous therapist had advised her that, when she is bingeing, she should "picture her arms falling off from diabetic necrosis" to shame herself into stopping. It is hard to imagine any other topic in psychotherapy garnering this much damaging "advice." In sessions, clients have cited their reason for having avoided seeking mental health care as the commonplace nature of weight stigma and size-based microaggressions.

The current focus on weight loss as a path to health runs the risk of leading clinicians to violate our mandate to uphold ethical principles, such as beneficence and nonmaleficence (Tylka et al., 2014). When clinicians recommend or support weight change, they bypass an opportunity to address the underlying concern that troubles many people who occupy a body they do not like. Instead, we can introduce the possibility that people can learn to occupy a body unapologetically, one that does not uphold unnecessary and unrealistic ideals. This is a vision of body autonomy that avoids collusion with the weight-based constructs in our culture that cause harm to people's relationship with their bodies.

Ten Ways to Shift Your Therapeutic Lens

We are clinicians who intentionally offer weight-inclusive psychotherapy, a term used to describe a practice that counters the mainstream "weight normative approach" by promoting size acceptance, refuting the medicalization and shaming of fat bodies with scientific evidence, and honoring the fundamental rights of fat people to exist without prejudice, discrimination, and recrimination for not pursuing weight loss (Tylka et al., 2014). Our weight-inclusive practices focus on healing relationships with food and bodies and have been filled with clients who for years have been referred to mainstream weight-loss and 12-step programs by their former therapists as an antidote to their body shame and dissatisfaction. We are inundated with stories about how psychotherapists inadvertently cause harm, so here is what it can look like if we move forward in an intentionally inclusive way. It can be a relief to know that many of the tools and modalities that work are already available. In this section, we offer some practical ways in which providers might begin to recognize sizeist attitudes and anti-fat bias in their therapeutic work with clients and show how to transform them.

1. Consider the Four Steps in Liberatory Consciousness

We use the framework of liberatory consciousness as we teach weight-inclusive practice to other clinicians. Love (1997) wrote about the development of a liberatory consciousness as a framework for changing systems of oppression. She outlined four developmental steps: awareness, analysis, action, and accountability. Bringing a liberatory consciousness to our work against anti-fat bias means noticing how this form of oppression shows up in the world around us, in the lives of our clients, and in our own body stories. A therapist does not have to occupy a larger body herself to witness that all bodies are not treated equally. As our critical consciousness grows, our analysis grows stronger. Once we notice it, then we work to educate ourselves and analyze it.

Yet, anti-fat bias is not something that we can change by simply being aware of our own thoughts and behaviors because “the power to name must be accompanied by the power to act” (Breton, 1984, p. 36). Moving to action could be advocating for a client, making a donation, making sure our offices are accessible, or finding ways to remove barriers for someone with whom we are working. Then, we accept accountability to ourselves and to our clients for the consequences of the action that has been taken or not taken, and we learn from the experience in order to practice what Reynolds and Hammoud-Beckett (2018) called “justice-doing.” Reynolds explained justice-doing as a stance that allows therapists to respond to the pain of our clients as activists, who work for the structural changes that create more social justice. We must take the time to learn all we can about weight oppression. But, that is not enough. Learning about oppression should unsettle our complacency and demand some action from us.

2. Interrogate Your Intentional or Unintentional Promotion of Diet Culture

Diet culture and healthism, much like anti-fat bias, impact nearly everyone. They lead most people to try to improve their bodies, but impact people with large bodies the most. It is dieting culture that has emboldened people to advise everyone from friends to clients about food and dietary choices. Dieting culture has encouraged clinicians to address “obesity” through the lens of “health” instead of orienting our clients toward liberation and well-being.

As professionals who are compassionate and ethical, we should all be unequivocally opposed to dieting and seek to eradicate weight stigma. It is time to question why our governing associations have task forces on combating obesity instead of combating body oppression. It is necessary to question whether giving advice about diets has entered our scope of practice. We are supposed to provide treatment that does not harm or

discriminate and shows some evidence of efficacy, yet we continue to cause widespread harm by waging a war on fatness. We require cultural competence, but anti-fat bias is rarely addressed in the mental health field. *The work of therapy is not to help people adjust to oppression.* Mental health professionals cannot, in good conscience, continue to obscure the impact of oppression and its associated traumas on mental health and recommend “treatments” for single individuals that leave the biased sociocultural environment intact. Instead, prepare yourself to name, dissect, and have conversations about diet culture with your clients. Doing so will create opportunities to externalize the parts of diet culture that become internalized and potentially deepen the therapeutic process and create a milieu conducive to liberatory healing.

3. Stop Diagnosing Body Size as a Disease

One of the strongest ways that bias against fat bodies operates is through the automatic association we make between fat and poor health. We simply cannot know the health status of someone based on body size or shape, and we assert that bias itself contributes to health conditions. “Controlling for the demographic characteristics, discrimination based on weight was associated with an almost 60% increased risk of mortality” (Sutin, Stephan, & Terraccinno, 2015, p. 4). Medicalizing body size treats higher-weight bodies as a deviation rather than a variation. Bacon and Aphramor (2011) discussed the harm inherent in a weight-centered paradigm and pointed toward Health At Every Size as a shift in practice that is accountable to an ethic of justice. It is not helpful to blame weight for disease when there are countless co-factors that cannot be named. A helpful technique to consider when feeling drawn to blame a presenting concern on the body of a fat client is what you might offer a thin(ner) client with that same concern. Then offer that instead.

4. Consider the Link between Emotional Health and a Fat-Oppressive Culture

Exposure to body-based oppression can result in traumatic stress (Goodman & West-Olatunji, 2008). As clinicians, we must be prepared to consider the signs and symptoms of trauma in people who have experienced systematic body-based oppression and incorporate trauma-informed approaches into all facets of our work with our clients (Substance Abuse and Mental Health Services Administration, 2015). Psychotherapists have the skill and power to honor the therapeutic relationship, while also naming both seen and unseen “oppressive and marginalizing discourses and social processes” (D’Arrigo-Patrick, 2017, p. 8). We can hold space for all.

People often disconnect from their bodies when they are seen as “wrong,” whether because of size, race/ethnicity, gender expression, ability, or age. Interventions that are rooted in mechanistic, physiological explanations that disregard the impact of anti-fat bias and reinforce personal blame, shame, and internalized oppression are potentially problematic. Addressing systemic harm and addressing internalized oppressions require a move away from “control discourse” regarding food and body (Brady, Gingras, & Aphramor, 2013). We should not be in the business of helping people to become thinner, but in helping them to address internalized weight stigma and to claim their right to exist in their bodies as they are. For example, therapists should not suggest that weight loss will help clients with their depression, but expand the frame to acknowledge that depression may be a possible and appropriate response to a fat-oppressive culture. Our focus can be healing, not for the sake of weight loss, but for the sake of liberation. We can learn to assist clients in changing their relationship to distress and working for social change related to the root of that distress.

5. Do Your Own Work

It is necessary for clinicians to change the idea that large bodies represent a certain “reality” to which we should “wake up” our clients. Body weight is not the unacknowledged problem, our bias against it is, and our biases about weight can impede our clients’ healing process. As clinicians, it is our own projections about body size that shut down the potential for a depth of exploration that could invite body acceptance. Fat phobia is logical in a system where people are punished for higher weight and rewarded for weight loss.

Therapists do not want to be the cause of further marginalization in their clients’ lives. In order to make sure we are helping and not hindering, and that we are not reinforcing the messages that are harming our clients, we must do our own healing work. It may be uncomfortable, but “we do not get to be courageous and comfortable at the same time” (D. Adaway, personal communication, June 23, 2017). Therapists can take steps to uncover any hidden biases by consulting questionnaires designed to assess levels of fat stigma (see Daníelsdóttir et al., 2010). Doing our own work involves examining our own body stories, including our personal history with disordered eating and dieting. Clinicians must consider whether their own beliefs about health, food, and body are informing the recommendations they make to clients. It is possible to move toward a worldview that includes limitless body acceptance for all.

6. Make Your Office Space Inclusive

At the most basic level, we must make sure that our offices are spaces of equity. From our attitudes toward fat clients, to the magazines and artwork on display, to the accessibility of the furniture, we are consistently communicating who is and is not welcome in our space. If spaces are created for the largest bodies, then they will also work for smaller bodies. It is important to be aware, and at a minimum inform potential clients, if there are spatial constraints or if access is limited to those who are able-bodied.

7. Be Mindful of Your Language

Any language that assumes that there is one ideal body is worthy of the kind of analysis that liberatory consciousness asks of us. As professionals, we should challenge ourselves to learn to speak with inclusive language about bodies and to avoid terminology that pathologizes or stigmatizes, such as “obesity” and “overweight,” which imply that there is a norm and all other sizes are a deviation from that norm. The “person-first” language that is often recommended can increase stigmatization of fat bodies (Meadows & Daníelsdóttir, 2016). Saying “person with obesity,” while presumably intending not to define someone by a characteristic (“obese person”), implies a judgment in that the characteristic is something from which we need to be separated. Further, it implies that it is something that people are burdened by and can get rid of.

We should encourage our clients to challenge us on our language and to let us know if they find our language shaming. Our words reflect our culturally constructed values, such as (but not limited to): normal, natural, feminine, pretty, and average. In clinical practice, this also includes speaking with non-stigmatizing language about our own bodies.

One example is the call from the weight inclusive/fat acceptance movement to reclaim the word *fat* as a neutral descriptor of a body similar to the juxtaposition of the words tall and short. It is true that not all clients will resonate with this reclamation, however there is power in psychoeducation about the origins of the language we use to describe our bodies and the role it can play in healing. We should also be mindful of what our assumptions are and what we promise our clients. We have had many clients report that previous therapists have assured them that, when their bingeing stops, they will lose weight. Clients in eating disorder treatment report having been told, “Don’t worry, we won’t make you fat,” as a way to build motivation for engaging in treatment. Investigate the distinction between “meeting our clients where they are” and using language that upholds the dominant culture.

8. Invite Social Justice into Psychotherapy

As clinicians, we can invite social justice into our therapeutic practice by questioning and interrogating our clients' attempts to achieve a culturally prescribed body because to support that attempt is to encourage assimilation. As people move further and further into the margins, the repercussions of the pursuit of thinness are felt ever more deeply. Weight stigma intersects with sexism, racism, ableism, healthism, ageism, homophobia, transphobia, classism, and more, which impacts people's ability to inhabit their bodies comfortably. The dominant narrative about what a "good," "beautiful," or "healthy" body is also rooted in Whiteness as well (Patton, 2006).

It is necessary to deconstruct all of the oppressions that determine the ways in which we value people and whose bodies have access to rights and resources. What does it mean to occupy the world in a body that is simultaneously fat, Black, and queer? How do we find out without eradicating lived experience? If we are not doing the work to be anti-oppressive, then we are being oppressive. Weight oppression is so pervasive and unquestioned that, if we are not dismantling it, we are colluding with it. Remember that people's lives are on the line.

9. Keep Questioning

We each must hold ourselves responsible to a radically honest awareness about what we believe we know about bodies and weight. We must ask ourselves these questions: How do I know what I know? Where did I learn it? What do I believe about my own body? Do my beliefs and experiences translate to the lived experience of others? Is my practice creating more space/permission for other people, or is it reinforcing the status quo? Whose bodies matter? What and who determines worth? What is my definition of wellness? What will I do to unlearn my fat bias? How will doing this work benefit and challenge me? How can I make my commitments visible? This work can be discomforting, and we may unintentionally make mistakes. We propose that it is best to "be humble and ready to fumble" (E. Hines, personal communication, June 23, 2017). Take a deep breath, stay out of the shame spiral, and extend ourselves some kindness. After all, as therapists, we ask our clients to step beyond their comfort zones all the time.

10. Celebrate Resistance

Our specific focus in psychotherapy is on healing, not fixing, clients' relationships with food and body. As an integral part of this work, we celebrate

resistance. It is not enough to help people to heal from the effects of oppression and then send them right back into oppressive systems. We need to resist systems that decide whose bodies are worthy and valuable and whose are not. Working alongside our clients to make a more socially just world invites activism into our work, which can improve psychological well-being (Kupers, 1993; McKinley, 2004; Roffman 2008).

Let us celebrate the reclamation of voice and activism in our clients. Brown-Bowers, Ward, and Cormier (2016) called our profession forward by asking psychology to stop locating the problem of fat shame inside of people's bodies and to place it onto society where it belongs. She asked us to stop offering tools to help our clients change the shape of their bodies and instead offer tools to resist shame and oppression. The problem of stigma is never solved by weight change.

Conclusion

As working psychotherapists, we all joined this profession for a reason, and it was probably not to divide people from themselves. This is an opportunity to consider what we do in our practice that promotes or challenges anti-fat bias, and how we are doing so, through the lens of liberation. We cannot speak of healing if we are not speaking of justice and liberation as well (D. Adaway, personal conversation, June 25, 2017). We have a collective responsibility to re-orient our ways of thinking from the individual to the larger social context because systemic and structural oppression impacts mental and physical health (Prilleltensky, 1994; Prilleltensky & Prilleltensky 2003; Puhl & Latner, 2007). It is not enough to change only our ways of thinking. We have to deconstruct sociocultural power structures before body liberation is possible. *Body size is not the problem; oppression is what makes fat people's lives hard.* We cannot claim an inclusive, feminist, or culturally competent lens if we do not address and oppose the cultural ideals that harm us all. We must all confront our feelings about fat, seek to learn about weight and size from a cultural lens, and dismantle the weight-biased beliefs that we all hold. As members of professions committed to social justice, we must all get to work to make sure that people's bodies are safe in our therapy rooms.

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