

Just because your client is fat doesn't mean that you can assume certain things about her lifestyle or mental or physical health, argues *Jo Reader*

When I turned 29, I told myself I wanted to be happy with my body by my 30th birthday. I was determined to do something about it. I felt I had wasted my 20s waiting for my life to start, in the belief that if I could become slim I would be acceptable and therefore confident enough to do anything I wanted. I thought the only way to do this was to lose weight but a few things happened to me that year that cumulatively changed this belief and I realised there was another solution to my predicament: to love my body as it is.

'Hey fatty. You need to lose weight. Hey fatty? Didn't you hear me? You need to lose weight. You're too disgusting to be out looking like that' (Park Street, Bristol, 18 June 2011).

Being verbally attacked like this is still frightening, even though it has been happening to me in some form for most of my 40 years. The insults usually come from a faceless, cowardly individual in a moving car, but whenever I hear them I am engulfed in vulnerability. I feel naked. Catching a 'glimpse of the hatred'¹ is extremely painful, especially if you secretly agree with it.

I'm not sure what age I was when I realised how unacceptable my body was to the rest of the world, but the message was clear and I learnt it quickly: I was repulsive and it was all my own fault. My earliest memory of wanting to be thin was at 12 years old when I was admitted to hospital for a tonsillectomy. What I was dreading most, more than being put under anaesthetic and having part of my body removed, was being weighed before the operation. I remember being relieved and delighted that I weighed less than I thought. At 12 years old, losing weight was already something I felt good about. I was born big (9lb 3oz) and was always the biggest in the class. I was always

made to feel that I had caused my fatness, but I remember being puzzled: I didn't seem to eat differently from my friends and I was a keen swimmer (until I got messages that I was too fat to be in a swimsuit and became so self-conscious that I gave up my much-loved sport for over eight years).

Nevertheless, as the years went by, the message got through that I was fat because I ate unhealthily, I ate too much and I had no self-control. This spiralled into a horribly distorted view of myself and I became very depressed.

As I stood at the bus stop that evening, furious this was happening again and even more furious that it was still making me cry, I was also invigorated. I had a renewed sense that this story needed to be told. I had started my MSc in counselling and had decided to research whether the attitudes about fat in our society can affect the ability of a therapist to remain non-judgmental. Up until that moment I had been struggling with how to make the case for the relevance of fat oppression in counselling and I was grappling with the limitations of autoethnography as a research methodology. Mine is just one white, English, middle-class female's experience, not necessarily the experience of *all* fat people. Yet, remembering how this discrimination had slowly destroyed my self-worth, led me to blame all my problems on being fat and took me finally into therapy, desperate for a resolution to my self-hatred, my research suddenly felt very necessary. If humans are treated like this in our society simply for being bigger, it *will* erode their self-worth and they might then come for therapy. So we need some guidance for therapists so that clients' experience of discrimination will be

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believed and understood, and to ensure their therapist will not say something that will inadvertently reinforce the stigma – which had happened to me.

Qualitative research aims to gather an in-depth understanding of human experience: the why and how, not just what, where and when. I was interested in other people's experiences but I chose autoethnography for my methodology because I realised I had a wealth of evidence from my experience that would tell the story of living in a fat body in a different way from existing therapeutic literature – a story that might help counsellors stand back from societal views of fat and consider it from a different perspective.

Autoethnography has 'the power to transform and make positive use of some of life's most perplexing and painful issues'² and can throw light on things that aren't necessarily in the mainstream.³ My main intention in using this methodology was not to prove a single, valid truth but to create questions and curiosity around the subject and ultimately to encourage a deeper and more open-minded reflection and consideration of the implications of what fat means to the counsellor, our practice and our clients. I felt that my own therapist could add validity to the research, so I also conducted a semi-structured interview with her. I then wrote a narrative that I hoped would prompt counsellors to consider and confront their own biases and attitudes towards fat and encourage them to explore how prejudice may leak into their therapy room.

Fat prejudice

Most people would agree that the sort of verbal abuse I experience in public

is outrageous and uncalled for, but this doesn't mean we don't discriminate against fat. Everywhere I go I hear women making negative comments about their own body. In surveys women say they would rather be run over by a truck than fat, rather be blind than fat,⁴ that to be obese would be worse than alcoholism or herpes,⁵ that they would prefer to marry a drug user or shoplifter than someone who was fat.⁴ The most tragic thing I have read is a fat woman saying, 'I wish I could get cancer or some other wasting disease so at least I could die thin.'⁶

I am sure we do not think we are showing prejudice or intend hurt when we say or think these things; we justify these beliefs on the grounds that it is unhealthy to be fat. But I think, as a society, we have so deeply internalised the belief that fat is bad that we don't see it as discrimination or a social construction.

One might hope and expect that counsellors would not share the same strongly prejudiced views held by society, or at least would have awareness of them. However, by the same token, it seems fair to assume that, to some extent, counsellors in Western countries are likely to share their society's collective understanding of the benefits of being slim and therefore might not realise

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the subtle ways in which fat oppression seeps into their work.

There are a lot of studies and reports about how unhealthy it is for us to be fat, so I assumed there would be a lot of therapeutic literature about working with fat clients, but I found very little. Where it is mentioned (in behavioural therapy programmes that demonstrate genuine sympathy for the discrimination suffered but insist the solution is to lose weight, and in a person-centred book that used only negative examples of fat people and constantly asserted that over-eating is 'the problem' from which all fat people need to be 'cured'), it is referred to as a 'problem' or 'condition', and therefore not without judgment either.

I did find a lot of evidence (even in the 'anti-fat' literature) about the psychological damage of being fat, with bullying and discrimination as the most immediate, common and 'greatest adverse effect'.⁸ This, together with the evidence that stigmatisation leads to low self-esteem, depression and isolation and potentially significant mental health problems,⁹⁻¹² would suggest that fat oppression, not fat itself, could be the greatest risk to people's health and therefore very relevant to therapists.

Justifying judgmentalism

The only literature I could find that offered non-judgmental advice to counsellors and didn't describe fat as something that needed to be changed was a collation of research from the US, published in the late 1980s, about fat oppression in therapists.¹³ The writer, Laura Brown, suggested that, because most Western women hold 'fat-oppressive and fat negative attitudes' towards their own bodies, by inference they will unconsciously also hold them

towards those of other women.¹³ She argued that this kind of prejudice is ‘unlike other oppressive perspectives’, such as racism, sexism and homophobia, which therapists will have explored and of which they will have good awareness, and that negative attitudes towards fat are ‘embraced, excused or rationalised... on the grounds that fat per se is unhealthy... and that it is thus a target worthy of stigma and intervention’. Even among the most aware and open-minded of therapists, fat oppression is ‘still the norm’, she argued.

I found a press release on the BACP website publicising an article in the October 2008 issue of *Healthcare Counselling & Psychotherapy Journal* titled ‘Fat is a Mental Health Issue’. The title encouraged me, until I read on: ‘In a bid to tackle Britain’s obesity crisis, those who are overweight need not only to eat less and exercise more, they also need counselling to address the underlying issues, such as comfort eating, behind their weight problem.’¹⁴ This tone and language seemed incongruous with ethical practice on so many levels. Surely, as ethical practitioners, we should accept our clients unconditionally and let them tell us what their issues are, rather than make assumptions based simply on their outward appearance and deny them the autonomy to decide what is best for themselves?

How do such attitudes embody BACP’s ethical principles of autonomy (respect for a client’s right to be self-governing and self-directing ‘within therapy and all aspects of life’;¹⁵ of ‘justice’ (‘the ability to appreciate differences between people [and avoid] discrimination [against] legitimate personal social characteristics’;¹⁵ and the advice that ‘a practitioner should

not allow their professional relationships with clients to be prejudiced by any personal views they may hold’?¹⁵

Through their rigorous training and client supervision, most trained counsellors will be acutely aware of how prejudice, discrimination and oppression can affect therapeutic relationships, having learnt how oppression is created not only by overt prejudice but also by deeply ingrained, often unconscious social, political and cultural influences. That we may not have been exposed to positive examples of fat people and that the only information we have is what we are told by the media and by medics are not an excuse for failing to search out alternative views.¹⁶

It is challenging not to assume that someone who is fat has a poor diet, doesn’t exercise or has some sort of pathology, but is it our role to diagnose our clients anyway? Carl Rogers insists that we avoid diagnosis and questions its value in therapy, arguing that it leaves the client at risk of giving over the responsibility for improving their situation to their therapist.¹⁷ What are we doing if we use or collude with a client’s use of words like overweight or obese? In simply using the word ‘over’, we create a conflict between offering unconditional positive regard and insinuating that there is a correct weight that would be acceptable. But it’s more insidious than this: these words are categories used in the Body Mass Index (BMI) – a common calculation of so-called healthy weight/height ratio – and have come to mean ‘unhealthy’. If we use these words, we risk our client thinking this is what we mean, even if we don’t.

These BMI categories put Brad Pitt and George Clooney into the ‘overweight’ and ‘obese’ categories,

respectively.¹⁸ Does knowing this automatically suggest that George needs some basic nutrition advice for his ‘problem’? It’s a facetious example, but it is useful in highlighting how illogical it might be to generalise people on the basis of their BMI. Furthermore, we don’t need to look very far to find a lot of research about the shortcomings and inconsistency of the BMI. It doesn’t acknowledge lifestyle, family history, state of mind, diet, natural diversity of body sizes and body composition; it encourages us to believe that healthy habits are irrelevant unless we are slim, and that slim people can dispense with healthy habits because they are already healthy. Of course, many people who *are* fat might have issues that might benefit from therapy (how am I to know if George and Brad have eating, body-image or self-worth issues just by looking at them?), but we should be careful not to put the two issues carelessly together and not to forget that our clients are individuals.

In my research interview with my therapist she initially said her training in mindfulness might have contributed to her ability to separate herself from social attitudes to fat. Towards the end of the interview she also wondered if being born on a Pacific Island, where being big-bottomed and wide-hipped was seen as positive and revered and women were proud to be this way, might have influenced her ability to be non-judgmental and allowed her to embrace large women in this country in a positive way. This struck me as fundamental and I suddenly realised that I had assumed that a very slim, white woman wouldn’t have any insight into being fat. I had assumed she would be judgmental behind her therapist mask.

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It also made me realise how difficult we in the West find it to view big women positively when we are bombarded with so much that is so negative about fat.

Fat and proud

I don't have space here to describe the completely life-changing epiphany of self-acceptance that followed my bus stop revelation, but there followed one of the happiest, healthiest, most peaceful yet productive, successful and meaningful periods in my life, and I was probably the fattest I have ever been! I had spent so long criticising my body that I had completely ignored its wonderful capabilities. I discovered a new world of being fat and proud, fat and fit and fat and healthy, and this led me to discover just how misrepresented fat people's lifestyle, diet and health can be, even in their own eyes and minds. I discovered I did have healthy habits. I even had medical tests done as part of my research and these confounded the assumptions about the unhealthiness of bodies as big as mine: there was nothing wrong with me. I became hugely empowered and was determined to prove that my body was capable of all I wanted it to do.

As I began to question fixed views about beauty and challenged the messages that told me fat was unacceptable, I also began to discover that the risks associated with obesity are not as clear-cut as we have been led to believe. For example, there is little or no correlation between weight and health in the large majority of large-scale epidemiological studies about fat.^{11,18} Indeed, repeated dieting causes more long-term damage than keeping active with a stable body weight – the fittest people live the longest, however much they weigh.¹⁹ Dieting damages

'the delicate balance of our bodies [which] cannot withstand repeated or constant semi-starvation'.²⁰ Indeed, it has been argued that, once women stop the obsession with dieting, their compulsive eating tendencies subside and their lifestyles usually return to responding to a natural urge of hunger and a natural desire to exercise and take care of themselves, whatever their weight.⁹ Based on his review of the research, Gaesser claims that 'most people can rely on good diet and exercise to normalize most health problems [...] without losing any weight'.¹ Researchers have also admitted that they are asked to 'portray obesity in the worst way possible' because the diet and pharmaceutical industry rely on research to justify their products and they are the companies who sponsor their research.¹⁸

My MSc research confirmed that the most effective approach when working with fat and body image is rooted in Rogers' core conditions and in the BACP *Ethical Framework*. In this respect it didn't uncover anything new, but it does raise awareness of something I think we might have neglected to consider fully. In 1989 Brown found that fat oppression was still the norm, even among the most aware and open-minded of therapists.¹³ My research is obviously very small and would clearly benefit from being extended across a wider cross section of the profession, but I do not sense the situation has changed considerably in the 25 years since her work was published.

Therapists need to know that being fat is not *necessarily* bad for everyone's health; there are multiple truths about body shapes and one kind of body does not represent health. Even though our society has labelled obesity a 'condition', it is important to look beyond this social

conditioning and remember that, just because your client happens to be fat, it doesn't mean you can assume certain things about her lifestyle or health.

The crucial part of my work with my therapist was its validation and honouring of my experiences of surviving discrimination. It helped me look at the choices that lay ahead, leave the victim behind, step into life and take charge of it and not wait to be slim to do the things I really wanted to do. By promoting a loving acceptance of my body it enabled me to view myself as a confident, capable and physically healthy woman at the weight I am.

Brown appreciates that 'challenging one's own internalized fat oppression is a uniquely difficult and painful task',¹³ not least because it calls into question issues that might have governed our whole life: eating, dieting, weighing, feeling personally good about weight loss and praising others for theirs. However, if we confront how fat discrimination enters our lives, therapy can become a safer place where clients' feelings of inadequacy can be challenged; where they can be encouraged to occupy a place of knowing that they are good enough with the body they already have.

Therapy helped me find a sense of self-acceptance and self-worth that I never had before. I had believed that being slim would mean I could start to enjoy life because I would be acceptable and therefore confident enough to do anything I wanted to do; suddenly this was possible with the body I had had all along. ■

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